RENAL PHYSICIANS, INC.

PLEASE PRINT

PATIENT INFORMATION:

NAME: LAST_____FIRST_____MI_____

STREET_____CITY_____STATE_____ZIP_____

SOCIAL SECURITY#_____ DATE OF BIRTH_____AGE_____ SEX_____

HOME#_____CELL#_____ WORK#_____

EMAIL ADDRESS_____

PATIENTS EMPLOYER_____ EMPLOYER'S ADDRESS_____

SPOUSE'S NAME_____SSI#_____ DOB:_____

SPOUSE'S EMPLOYER_____PHONE#_____

PRIMARY CARE (FAMILY) DOCTOR:_____ PHARMACY NAME:_____

PHARMACY #_____ LIVING WILL (☐ Yes ☐ No) -- (Please send copy to us)

Can message be left (☐ Yes ☐ No) If so, at what number—Cell_____Home_____Work_____

Emergency contact:

Name_____ Address:_____Phone#_____

INSURANCE INFORMATION:

Primary: Name:_____Subscriber:_____DOB:_____

Address:_____Phone#_____

Policy#_____Group#_____Eff Date:_____

Secondary: Name:_____Subscriber:_____DOB:_____

Address:_____Phone#_____

Policy#_____Group#_____Eff Date:_____

RESPONSIBLE PARTY: (If other than patient)

NAME: Last_____ First_____ MI_____ Ph#_____

ADDRESS_____CITY_____STATE_____ZIP_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign title to all medical/surgical benefits to **Renal Physicians, Inc.** and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. This signature indicates consent for treatment by Renal Physicians, Inc.

SIGN HERE:_____DATE:_____

Rev: 1/20/14