New Patient Packet

Date of Birth: ______________________ Sex: ☐ Male ☐ Female

Name: ____ Social Security #: ______________________________________

Address: ______________________________________ Emergency Contact: ____________________________________

______________________________________ Phone: ____________________________ ☐ Hm ☐ Wk ☐ Other

City, State, Zip: _________________________________ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Primary Phone: __________________ ☐ Hm ☐ Wk ☐ Other **Referring Physician:** ___________________________________

Secondary Phone: _________________ ☐ Hm ☐ Wk ☐ Other **Primary Physician:** ____________________________________

Primary Language: ________________ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Declined

Email address: ___________________________________ Preferred Pharmacy: ___________________________________

Patient Employment

☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled Date Retired: _________________ Date Disabled: __________________

Employer: ____ Employer Phone: __________________________

Employer Address: ____ City: ______________ State: ______ Zip Code: __________

Insurance

Primary Insurance Company: ______________________________ Insured ID: _________________ Policy Group: _________________

☐ **Check if Same as Patient:** ***Insured party***: ______________________ Relationship to Patient: __________Social Security #: ______________

Employer: ____ Employer Phone: _________________ Date of Birth: __________________

Secondary Insurance Company: ______________________________ Insured ID: _________________ Policy Group: _________________

☐ **Check if Same as Patient:** ***Insured party***: ______________________ Relationship to Patient: __________ Social Security #: ______________

Employer: ____ Employer Phone: _________________ Date of Birth: __________________

Guarantor: (where bill is to be mailed)

☐ **Check if Same as Patient:** ***Guarantor:*** ______________________Relationship to Patient: ____________ Phone number: ________________

Address: ____ City: _______________ State: ______ Zip Code: ___________

Authorization to Release Medical Information

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I understand that a photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time. I hereby authorize any physician, whether past or present, following my care to disclose medical information, by mail or fax to:

Austin Kidney Associates, PA
3000 N. IH-35, Ste. 635
Austin, TX 78705

Signature ______________________________ **Date** __________________________________

By my signature below, I hereby certify that the demographic and insurance information is correct or I have made appropriate changes to this form to reflect the correct information.

Patient's Signature ____ Date ____________________

IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE. OTHERWISE YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

HIPAA Release of Information

Patient's Name ________________________________ Date of Birth: ____________

Appointment Information

Please check all of the following message delivery methods that are available in case we can not reach you. Please include your daytime/work telephone number. For each number, please authorize name(s) with which we may arrange or confirm your appointment information.

1. Home Phone # ________________________
   a. Can we leave a detailed message on this voicemail? YES / NO
   b. We may arrange or confirm your appointment with:
   Self Only Spouse Mother Father Child Other
   Name of child/Other: _______________________________

2. Daytime/Work Phone # _________________________
   a. Can we leave a detailed message on this voicemail? YES / NO
   b. We may arrange or confirm your appointment with:
   Self Only Spouse Mother Father Child Other
   Name of child/Other: _______________________________

3. Mobile phone # ________________________________
   a. Can we leave a detailed message on this voicemail? YES / NO
   b. We may arrange or confirm your appointment with:
   Self Only Spouse Mother Father Child Other
   Name of child/Other: _______________________________

Medical Information

With whom may we discuss or disclose your medical information?

Name _________________________ Relationship ______________ Phone # _____________

Name _________________________ Relationship ______________ Phone # _____________

Name _________________________ Relationship ______________ Phone # _____________

I have received a copy of the Notice of Privacy Practices from Austin Kidney Associates. I will inform Austin Kidney Associates with any changes of the above disclosure information.

Patient's Signature __________________________________ Date ___________________

Austin Kidney Associates, PA
Office Policy- **Please Read Carefully**

Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks, MasterCard Visa, Discover, and American Express. We will charge a return check fee of $25.00.

We are providers for several PPO and HMO insurance plans and will be happy to file your claim for you. Co-payments are due prior to seeing the physician at the time of service. You are responsible for obtaining any necessary referral or authorization from your primary care physician. You are responsible for any non-covered charges. If your insurance does not make payment within 45 days, you may be asked to call them for the status of the claim.

Frequently, insurance companies may require additional information from the patient before processing a claim. If you receive such information in the mail, please fill out the form and mail it back to your insurance company as quick as possible. Failure to do so will make you responsible for the entire bill regardless of our contract status. We will expect payment of the deductible and coinsurance amounts at the time of service, or proof that your deductible has been met. We allow 60 days for processing of your insurance claims. At the end of that time if your insurance has not paid, the entire balance becomes your responsibility.

Medicare: Austin Kidney Associates, PA will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your 20 percent and, if not met, your yearly deductible at the time of your visit.
Medicaid: Austin Kidney Associates, PA will file claims to Medicaid on your behalf. You must present a current copy of your Medicaid eligibility letter at each visit.

Assignment of Benefits
I hereby authorize payment of insurance benefits to be paid directly to Austin Kidney Associates, P.A. for any services furnished to me. I authorize Austin Kidney Associates, P.A. to release to the Health Care Financing Administration, the Centers for Medicare and Medicaid Services or any commercial insurance carrier any information needed to determine the benefits or the benefits payable for related services not covered by insurance or prepayment programs. I hereby authorize the release of my medical records to other physicians and insurance companies deemed necessary.

Consent For Treatment
I hereby authorize evaluation and treatment by the physicians of Austin Kidney Associates, PA. I understand that the signature and date on this form will not expire without written notice or in the case that a minor reaches an adult, and that a photocopy of this form is considered valid as the original.

CriticalConnection Central Texas Membership
Austin Kidney Assoc. is a member of CriticalConnection Central Texas, a doctor-owned community medical co-op that permits physicians to more easily share medical information when they are providing care to the same patient. Your medical information will only be released to your physicians, their staff (as necessary), and other physicians authorized to provide you care if your physician is not available (referred to as “covered physicians”). Your health information will only be released with your consent or when otherwise allowed under state or federal law. For example, we may share limited health information with a healthcare provider for emergency service if you are unconscious and unable to provide consent. By my signature below, I represent understanding.

Notice of Privacy Practices
I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Cancellation/No show Policy
We require a 48 hour advance notice for a Nutritionist appointments and a 24 hour advance notice is required for all other appointments. Patients who fail to arrive for their scheduled appointment or cancel with less than the required advance notice will be charged an administrative fee of $25.00. This administrative fee is NOT covered by any insurance plan and will be the patient’s responsibility.

My signature below represents understanding of the office policies listed in this form.

Patient’s Signature ____ **Date** ____________________