Americare Kidney Institute LLC.

(Office Use Only)

Acct# _____

Date: _____

Name: _____

Birth Date: _____ Gender: F ____ M ____ **SS#** _____

Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Home #: _____ **Cell #**: _____ **Work #**: _____

Pharmacy Name: _____ Pharmacy #: _____

Email Address**:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

If married Spouse's Name:_____ Spouse's Date of Birth:_____ **(for insurance reasons)**

Are you currently employed: Y ____ **N**____ ☐ Retired **If yes: Full Time or Part Time** *(please circle one)*

Emergency Contact Name: _____ Phone#: _____

Relationship to Patient: _____

May we leave a message on your home answering machine/voice mail? Yes _____ No _____

Other than yourself, who may we speak to regarding your medical care?

Name/Relationship _____ Phone # _____

Do you have a Medical Power of Attorney (POA): Yes _____ No _____

P.O.A. Name: _____ Phone#: _____

Referring Physician: _____ **Phone #:** _____

Primary Care Physician: _____ **Phone #:** _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy # _____

Guarantor: ☐ Self ☐ Other _____

Secondary Insurance: _____ Policy # _____

Guarantor: ☐ Self ☐ Other _____

Americare Kidney Institute LLC.

Patient Consent & Authorization Form

Patient's Full Name _____ Date Of Birth _____

Social Security Number _____

ASSIGNMENT OF BENEFITS

In consideration of any medical care provided o the above-named patient, I assign Americare Kidney Institute, LLC. All my rights to any and all Medical insurance benefits to which I am or may be entitled by any health plan.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Americare Kidney Institute, LLC. to disclose individually identifiable health information created or received by Americare Kidney Institute, LLC, whether oral or recorded in any form or medium, regarding the above-named patient to any health plans that may be responsible for providing or paying the cost of rendered services in order to carry out payment activities.

I further authorize Americare Kidney Institute, LLC to disclose such health information to contractors or other persons who carry out, assist in the performance of, or perform function or activities for Americare Kidney Institute, LLC, including legal, auditing, consulting, data processing, billing and coding services, and services related to health core operations, provided that such persons have provided assurances that the information will be appropriately safeguarded.

This authorization may be revoked at any time except to the extent that actions have been taken in reliance thereon.

NOTICE OF PRIVACY PRACTICES (HIPPA)

I have been provided a Notice of Privacy Practice that describes uses and disclosures of health information, by signing this document I am acknowledging receipt of a copy of a Notice.

GUARANTEE OF PAYMENT

I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance or a health care payment program at the current rates established by Americare Kidney Institute, LLC or the applicable health care payment program for all services rendered to the above-named patient.

I hereby further agree that I shall be responsible for any expense of Americare Kidney Institute, LLC in collecting the amounts guaranteed hereby, including all court costs, reasonable attorneys' fees and all other collection expenses.

X_____ **X**_____

Signature of Patient or Legal Representative Date

If signed by Legal Representative:

Representative Capacity: □ Parent □ Legal Guardian □ P.O.A □ Other _____

_____

Representative's Full Name

Americare Kidney Institute LLC.

Patient Consent & Authorization Form

_____ _____
Patient's Full Name Date Of Birth

_____
Social Security Number

PATIENT CONSENT FOR EXAMINATION AND CARE

I hereby give my consent for the physicians and staff of Americare Kidney Institute, LLC to examine and render medical care and treatment to the above-named patient. I further authorize Americare Kidney Institute, LLC to perform such procedures and to administer such medication as they deem necessary and appropriate for the patient's diagnosis and treatment.

RECORDS REQUEST AUTHORIZATION

I hereby give my consent for Americare Kidney Institute, LLC, Inc. to request the partial or complete medical records concerning the illness and/or treatment from any and all physicians and health care facilities that the above-named patient may have sought medical care.

X_____ **X**_____
Signature of Patient or Legal Representative Date

If signed by Legal Representative:
Representative Capacity: □ Parent □ Legal Guardian □ P.O.A □ Other _____

_____
Representative's Full Name