AMERICARE KIDNEY INSTITUTE
Quality, compassionate kidney care in your neighborhood.

(Office Use Only)
Acct# _____

Date: _____ **SS#** _____-_____-_____

Name: _____

Birth Date: _____ **Gender**: F ____ M ____ Other (please specify) _____

Address: _____

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

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

Pharmacy Name: _____ **Street**_____ **City**_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other _____

If married Spouse/Life Partner's Name:_____ Spouse/Life Partner'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 _____ Advanced Directive?: Yes _____ No _____

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

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

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

INSURANCE INFORMATION:

Primary Insurance: _____ Policy # _____

Insured/Guarantor: ☐ Self ☐ Other _____

Secondary Insurance: _____ Policy # _____

Insured/Guarantor: ☐ Self ☐ Other _____

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Patient Consent & Authorization Form

Patient's Full Name _____ Date Of Birth _____

Social Security Number _____

ASSIGNMENT OF BENEFITS

In consideration of any medical care provided to the above-named patient, I hereby authorize and direct my insurance benefits to be paid directly to my personal physician or Americare Kidney Institute, LLC.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Americare Kidney Institute to release any information necessary to obtain payment for the rendered services. I understand that my information may be disclosed to other healthcare professionals to coordinate treatment or insurance carriers for medical record audit or claim payment.

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 their business associates, provided that the information will be appropriately safeguarded. I also understand that Americare Kidney Institute, LLC and/or their staff and the billing office will maintain the utmost respect for privacy.

This authorization may be revoked at any time by completing the Revocation of Authorization to Release Protected Health Information form.

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have been provided a Notice of Privacy Practice that describes uses and disclosures of health information. By signing this document I acknowledge that I have received a copy of this 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.

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

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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.

Without your consent, we cannot provide you with any medical services.

RECORDS REQUEST AUTHORIZATION

I hereby give my consent for Americare Kidney Institute, LLC 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

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SOCIAL HISTORY

Smoking status : □ Non Smoker □ Former Smoker □ Current Smoker □ Other Tobacco Use

Alcohol use : □ Non Drinker □ Occasional Drinker □ Moderate Drinker □ Heavy Drinker

IMMUNIZATION HISTORY

Flu shot Administered by: _____ Date administered:_____

Pneumonia Administered by: _____ Date administered:_____

ELECTRONIC HEALTH SUMMARY:

Email Address**:** _____ □ No email □ Other

Race	Ethnicity	Language
☐ American Indian or Alaska Native		☐ English
☐ Asian	☐ Hispanic or Latino	☐ Spanish
☐ Black or African American		☐ French
☐ Hispanic	☐ Not Hispanic or Latino	☐ Italian
☐ Native Hawaiian or Pacific Islander		☐ Russian
☐ White or Caucasian	☐ Refused to report	☐ Indian
☐ Refused to report		☐ Other _____
☐ Other Race _____		