PATIENT REGISTRATION
Kidney & Hypertension Consultants

PRIMARY PHYSICIAN____

Sex:__M __F Birth date:________________ Marital Status:__________

Name:____SS#:______________
First Middle Last

Address:____ City:______________

State:_____ Zip:___________ Home Phone:(____)______________________

Alternate Phone:(____)__________________

Occupation:__________________________ Work Phone:(_____)___________

EMERGENCY CONTACT/AUTHORIZATION TO RELEASE INFO.

Name:____Relationship:___________
First Middle Last

Home Phone:(___)_________________ Alternate Phone(___)________________

OPTIONAL

Pref. Language: __English __Spanish __Arabic __French Other:__________

Race: __White/Caucasian __Black/African American __Hispanic Other:__________

Ethnic Group: __Hispanic or Latino __Not Hispanic or Latino __Unknown

X____

PATIENT OR LEGAL GUARDIAN SIGNATURE (RELATIONSHIP) DATE

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I hereby voluntarily request, consent to and authorize the physician, his/her associates, assistants or other practitioners to provide medical and minor surgical treatment, including, but not limited to diagnostic procedures, x-rays, medication administration, physical examination and screening services, including drug/alcohol screening, as deemed necessary and advisable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.

X____

Signature of Patient/Patient Representative Relationship Date

I authorize Kidney Disease & Hypertension Consultants to release to any third party payer, or its representative, including Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations ins 42, CFR, Part2, if any, and social services record, if any psychological service records including communications by me to a social worker or psychologist.

I further understand that my treatment may require more than one date of service, therefore this consent shall carry full force and effect from the date of signature until I am discharged from treatment.

I hereby assign payment directly to Kidney Disease & Hypertension Consultants of the insurance benefits otherwise payable to me but not to exceed the balance due to Kidney Disease & Hypertension Consultants for charges of these services.

I assume full financial responsibility for payment of all services provided to me, including any portion of my bill is not paid by insurance, workers disability compensation or social agencies.

I acknowledge that I have received or have been offered a copy of this offices' Notice of Privacy Practice Form. I understand the content and significance of this form, and my questions have been answered.

X____

Signature of Patient/Patient Representative Relationship Date

MSP Questionnaire

Patient Name: ______________________ **Date:**______________

Is the patient employed?.. Yes No

Is the spouse employed?.. Yes No

Is the patient covered by employer group health plan (EGHP)
From own or family member's current or former employment?.............................. Yes No

If yes, does the employer that sponsors the EGHP have
20 or more employees?.. Yes No

Does this employer that sponsors patient's EGHP have
100 or more employees?.. Yes No

Is the Patient or Spouse retired?.. Yes No

Patient's Retirement Date: ______________________

Spouse's Retirement Date: ______________________

Patient entitled to Medicare because of end stage renal disease (ESRD)............ Yes No

Patient entitled to Medicare because of Disability, other than ESRD?.................. Yes No

Patient entitled to benefits through the Department of Veterans Affairs?............... Yes No

If yes does the patient want the VA to be contacted
for authorization.. Yes No

Patient entitled to benefits under the Federal Black Lung Program..................... Yes No

Is the illness/injury covered by a worker's compensation claim?.............................. Yes No

Is the illness/injury the result of a non-work related accident?................................ Yes No

Are services covered by a Public Health Service or Research Program?.................. Yes No

Are services covered by a Public Health Service or Research Program?.................. Yes No

Information is being supplied by: X______________________

This person's relationship to the patient is: ______________________