Kidney-Hypertension Clinic, PC

Duluth **Lawrenceville** **Norcross**
Monroe **Snellville** **Winder**

Patient Info:

Name:_____ Sex: Male or Female
(Last) (First) (MI)

Street Address:_____.
City:_____ State:_____ Zipcode:_____.
Home Phone #:_____ Cell Phone #:_____.
Work Phone #:_____ Email:_____.
Date of Birth:_____ Social Security #:_____.
Driver's License #:_____.

Referral Information:

Primary Physician: _____ Primary Phone #:_____.
Referring Physician:_____ Referring Phone #:_____.
Self Referred, Yellow Pages, Google Search, Other:_____.

Pharmacy Info:

Name of Pharmacy:_____.
Pharmacy Type: Local or Mail-Order Pharmacy Phone #:_____.
Street Address:_____.
City:_____ State:_____ Zipcode:_____.

Insurance Info:

Employer's Name:_____.
Employer's Address:_____.
Employer's Phone #:_____.

Primary Insurance:_____ HMO/PPO/POS/Other
Policy #:_____ Group #:_____ Co-Pay: _____.

Secondary Insurance:_____ HMO/PPO/POS/Other
Policy #:_____ Group #:_____ Co-Pay: _____.

Emergency And/Or Protected Health Information Contact Persons:

Name:_____ Relationship:_____.
(Last) (First) (MI)
Phone #: _____Cell #:_____ Email_____.

Name:_____ Relationship:_____.
(Last) (First) (MI)
Phone #: _____Cell #:_____ Email_____.

Signature:_____ Date:_____.

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Regarding Referrals from Primary/Another Specialist:

All patients who are insured by the following plans (HMO/PPO/QPOS) cannot be seen without a written referral from a primary care/specialist. *The referral must be obtained prior to making an appointment with our office.* This is a provision of your insurance policy, and the patient is ultimately responsible for obtaining the referral. If you are seen without the referral, you will be responsible for payment of the bill. It is the patient's responsibility to inform the office of any changes to insurance coverage such as, termination, change of plan, policy #, group #, and/or policy holder. Medicare patients who do not have a supplemental insurance will be responsible for the 20% that Medicare does not pay, at the time of service. *All Co-pays are to be paid at the time of service as well. If you do not pay at the time of service we may refuse to provide services to you.* This is a provision of your insurance as well.

Please Sign below to indicate your understanding of this **Referral Policy**:

Signature:_____ Date:_____.

Release of Protected Health Information (PHI):

I authorize the release of any and all medical information necessary to process any and all of my medical claims. This notice shall be effective and valid as original until I revoke it in writing.

Signature:_____ Date:_____.

Assignment to Pay the Insurance Benefit:

I hereby authorize the payment directly to Kidney-Hypertension Clinic, PC or its physicians of the basic benefits as well as the major medical (catastrophic) benefits herein specified and otherwise payable to me but not to exceed the regular charges of this period of treatment/service. I also undersigned that I am financially responsible for all the charges provided by Kidney-Hypertension Clinic, PC and its Physicians. *A finance charge may be applied on any outstanding unpaid balance after 30 days at a rate of 18% per annum.*

Signature:_____ Date:_____.