JACKSONVILLE NEPHROLOGY
Kidney Diseases and Hypertension

Date: _____

A. PLEASE CONFIRM THAT THE FOLLOWING INFORMATION IS CORRECT.

IF REVISIONS ARE NECESSARY, PLEASE DO SO ON THIS FORM

Patient Information:

Patient Name: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone:_____

Preferred Phone Number to Contact for Appointment Reminders:

Home Cell Work

Employer Name: _____

Marital Status: _____ Date of Birth: _____

Social Security Number: _____Race: _____

O Hispanic O Non-Hispanic Primary Language: _____

Would you like to have access to your medical records online? Yes No

If yes, please provide a **non-work** email address:

_____

Pharmacy Name or Location: _____

Pharmacy Phone: _____

Primary Care Physician: _____

Emergency Contact Information:

Emergency Contact Name*: _____

Phone Number: _____

Relation: _____

***Do you authorize this person to have access to your medical records?**
YES NO

Insurance Information

Primary Insurance: _____

Subscriber Name: _____

Subscriber Sex (circle one): *M* *F*

Subscriber Date of Birth: _____

Subscriber ID: _____Group Number: _____

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Sex (circle one): *M* *F*

Subscriber Date of Birth: _____

Subscriber ID: _____Group Number: _____

I certify that the above information is true and correct.

Initial _____

B. ASSIGNMENT AND RELEASE

I hereby authorize release of information necessary to file a claim(s) with my insurance company and assign benefits otherwise payable to me to Jacksonville Nephrology, P.A. I understand I am financially responsible for any balance not covered by my insurance carrier.
Medicare: I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or suppliers agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature:_____
Date: _____

C. NOTICE OF PRIVACY PRACTICE

I, _____, consent to the release of protected health information by the Jacksonville Nephrology, P.A. (JN) that is required to carry out treatment, payment activities or healthcare operations on my behalf.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that JN is not required to agree with my requested restrictions. I also understand that once JN agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement to JN that is signed by me.
- I understand that JN must immediately comply with my request to revoke consent, except to the extent that JN has already taken some action that was based on my original consent.
- JN has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and will inform all patients via our website www.jaxnephrology.com, and by posting the modifications and new Notice of Privacy Practices in our office waiting room.

Patient Signature:_____
Date: _____

D. PROTECTED HEALTH INFORMATION WAIVER

I, _____, authorize Jacksonville Nephrology, P.A. (JN) to use and provide medical and demographic information to the following named individuals (i.e. spouse, child, parent, care giver) if they request it on my behalf:

_____

_____
Name

- The information to be used or disclosed may be: entire medical chart, including current and past medical history including patient demographic and billing information.
- This information can be used by the entire Jacksonville Nephrology staff as needed to coordinate and facilitate my care.

This authorization expires when so determined by the individual patient and I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

Patient Signature:_____
Date: _____