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