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KIDNEY CARE CENTER OF GEORGIA

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Office: 678-450-0202
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PLEASE PRINT ON FORM **PLEASE USE BLACK INK**

Demographic Sheet

Account # :_____

Personal Information

Patient Name:_____ Date of Birth:_____/_____/_____
Birth Sex:____ Social Security # :_____-____-_____ Marital Status:_____
Race:_____ Primary Language Spoken:_____
Home Phone:_____-_____-_____ Cell Phone:_____-_____-_____
Address:_____ State:_____ Zip:_____
Email:_____ Primary Care Dr _____

Emergency Contact

Name:_____Phone Number:____-____-_____Relationship:_____
This is for Emergency Contact ONLY. This does not give permission for Release of any information related to the pt's care: See Release of Information Form*

Insurance Information

(Please Fill Out Completely. If left Blank you are stating you do not have Insurance. Even if we have a copy of your Cards.)

Primary Insurance:_____
Subscriber ID:_____ Group:_____
Insurance Claims Address:_____State:_____Zip:_____
Insurance Provider Phone#:_____-_____-_____
(If Insurance is through someone other than the Patient)
Subscriber Name:_____DOB:____/____/____SSN:_____-_____-_____

Secondary Insurance:_____
Subscriber ID:_____ Group:_____
Insurance Claims Address:_____State:_____ Zip:_____
Insurance Provider Phone#:_____-_____-_____
(If Insurance is through someone other than the Patient)
Subscriber Name:_____DOB:____/____/____SSN:_____-_____-_____

I authorize **Kidney Care Center of Georgia** to release medical Information to my insurance companies about treatment and diagnosis necessary to process claims. I authorize assignment of benefits, including Medicare, to be paid on my behalf to **Kidney Care Center of Georgia** for services rendered. I recognize that my insurance policy is a contract between my insurance company and me and that I am ultimately responsible for paying the claim should my insurance company deny payment. If not covered by insurance, I understand that payment is expected at the time service is rendered, unless I have made prior arrangements.
A photocopy of this shall be considered as valid as the original.

_____ _____/_____/_____

Patient / Representative Signature **Date**

Kidney Care Center of Georgia

Release of Information

Kidney Care Center of Georgia is committed to protecting the Privacy of our Patients. Therefore, we will **not** give **Test Results, Medical Information, Financial Information,** or other **Private Health Information** to anyone ***other than*** the ***Patient, Guardian, or Referring Doctor,*** nor leave messages about test results on voicemail or an answering machine without your permission.

Please indicate your preferences below:
You may contact me at the **Phone Number(s) listed below with Test results**. I have **checked the number** I prefer you to call. *If no numbers are listed we will only call the home number listed in our records.* **Note: (Reminder calls about appointment will be left on answering machines or voicemail by our automated system)**

Yes No You may Leave a Message on my Answering Machine or Voicemail.

- ❑ **Home: _____/_____/_____**
- ❑ **Work: _____/_____/_____**
- ❑ **Cell: _____/_____/_____**
- ❑ **Other: _____/_____/_____**

Yes No You May Text me appointment Reminders at: _____/_____/_____

Yes No You may email me my appointment reminders at:_____@_____

Yes No You may Provide my/patient Private Health Information to the individuals indicated below.
*(Information will be provided **ONLY TO THOSE LISTED** on this page.)*

Please only list non-medical persons (Family Members or Friends). Medical Doctors do not need to be listed on this Form

Name *example: John Doe*	**Relationship** *example: Husband*	**Medical** (ie Labs, Medication, Apts)	**Financial** (ie Bills, Balances, Insurance)
1)		❑	❑
2)		❑	❑
3)		❑	❑
4)		❑	❑

** Under HIPAA regulations, we may provide private health information to other healthcare entities involved in your care and insurance companies for billing purposes without your written permission.*

By signing this form, I understand that the information provided above supersedes all previous notifications and will remain in force until I provide different written instructions.

Print **Patient Name**: _____

Patient or Guardian *Signature*: x_____ **Date:**_____/_____/_____

updated 02/22/2018

Relationship of Guardian (If applicable): _____

Kidney Care Center of Georgia
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The Following is a summary of our identification and payment policy.

Identification Requirements

This practice is committed to safeguarding your identity. Federal regulations now require us to verify your identity at each visit and ensure the identity of anyone presenting medical insurance identification. **To satisfy the federal requirements, we must have a copy of you photo ID on file. we will ask for your medical insurance identification at every visit.** When possible, we will take a digital photograph of you that is attached to your electronic file. This photograph allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent you being seen by our physicians.

Payment is expected at the time of service

Payment of copays and outstanding charges is required at the time of services are rendered unless other arrangements have been made in advance. Kidney Care Center of Georgia accepts **cash, personal check (in-state only), VISA, MasterCard, American Express and Discover.** There is a service charge for all returned checks. We do not accept post-dated checks. Checks are Electronically deposited by our office at the end of each day.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

Insurance

Plans in which we are contracted (In-Network):

You are responsible for all charges. We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments at the time of service. Applicable deductibles, coinsurance, and other financial responsibilities deemed appropriate by your carrier, will be billed to you. Charges billed to you are due at the time we send you a statement.
In the event you have a procedure(s) performed, we will file with your carrier and ALL applicable deductibles, coinsurance, and other financial responsibilities are your responsibility. If you have any questions about your financial responsibility, please speak with your provider or our financial counselors, prior to services being performed.

Plans in which we are NOT contracted (Not Accepted/Out of Network):

You are responsible for all charges at the time of service. Once paid, we will file your charges (upon request) to your carrier as a courtesy to you. You are responsible for any further information (follow-up) requested by your carrier.

Refunds:

Overpayments will be refunded upon request to the responsible party within 30 days.

Outstanding and Unpaid Balances:

I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for cost of collections.

Missed Appointments and Late Cancellations:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are to be requested 24-hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Kidney Care Center of Georgia Financial Policy.

Print Patient Name:_____

Signature of Patient or *Authorized Representative: x*_____ Date:
_____/_____/_____

Printed Name of Authorized Representative (If Different than Patient): _____

updated 02/22/2018

Kidney Care Center of Georgia

INSURANCE POLICY

In order to better serve the needs of our patients, we have enrolled in numerous managed care plans including HMO, PPO, and POS products.

Each Of these managed care plans have different requirements. We make every effort to keep our records updated on each plans individual requirements. However, we must ultimately depend on you, the insured to advise us on the requirements for your individual plan so that we may comply with your plans guidelines.

Providing quality medical care for our patients is our primary concern, and we are very willing to recommend physicians and/or facilities within your plans guidelines provided the care is medically necessary. Please familiarize yourself with the following information provided in your insurance.

1) If your insurance company requires that lab services be provided by a specific lab, **please advise us before your lab services are obtained**. Please, also be advised that lab services are billed separately by the lab company and will be your responsibility.

2) Please Check with your insurance company and advise us ***if your plan requires precertification*** **before** a procedure is performed in the physician's office.

3) If your insurance company requires a referral from your primary care physician (PCP) before you can be seen, **you are responsible for confirming that the Dr's office has obtained that referral**. If you are seen without a referral and the insurance company denies payment, you will be responsible for the entire balance.

In the event that your coverage has changed, lapsed or expired on the date that services are rendered, all charges will be denied and ultimately become your responsibility. In order to avoid this, **Please Provide us with your most current insurance card each time you are seen in our office and keep up advised of ANY insurance changes as they occur.**

In order to provide our physicians care and follow the requirements of your insurance company, it is imperative that we have current information regarding your insurance coverage, type of plan (HMO,POS, PPO, etc.) and Primary Care Physician (PCP).

Plans in which we are contracted (In-Network):

You are responsible for all charges. We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments at the time of service. Applicable deductibles, coinsurance, and other financial responsibilities deemed appropriate by your carrier, will be billed to you. Charges billed to you are due at the time we send you a statement.

In the event you have a procedure(s) performed, we will file with your carrier and ALL applicable deductibles, coinsurance, and other financial responsibilities are your responsibility. If you have any questions about your financial responsibility, please speak with your provider or our financial counselors, prior to services being performed.

Plans in which we are NOT contracted (Not Accepted/Out of Network):

You are responsible for all charges at the time of service. Once paid, we will file your charges (upon request) to your carrier as a courtesy to you. You are responsible for any further information (follow-up) requested by your carrier.

If you have any questions or need assistance, please know our staff is available to help you in any way that we can. By working together, we will help you receive the maximum benefits and provide the quality medical care that you deserve.

I understand that ALL applicable charges are my responsibility and payment is due in full at the time of Services.

I have Read and Understand the Kidney Care Center of Georgia Insurance Policy as stated above and agree to accept responsibility as described.

Print Patient Name:_____

Signature of Patient or *Authorized Representative:* x_____ Date:

_____/_____/_____

Printed Name of Authorized Representative (If Different than Patient): _____

updated 02/22/2018

Kidney Care Center of Georgia

PF-200 **Acknowledgment of Receipt of Notice of Privacy Practices**

(HIPAA)

Kidney Care Center of Georgia Reserve the right to modify the privacy practices outlined in the notice.

Signature

I have viewed and/or received a copy of the Notice of Privacy Practices for **Kidney Care Center of Georgia**.

Print Patient Name:_____ **Date:** _____/_____/_____

Signature of Patient or *Authorized Representative*: x_____

*Printed Name of Authorized Representative (if Different than Patient):*_____

*Relationship of Authorized Representative (If Different than Patient):*_____