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KIDNEY CARE CENTER OF GEORGIA

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PLEASE PRINT ON FORM

Demographic Sheet

PLEASE USE BLACK INK

Account # :_____
(Office Use)

Personal Information

Patient Name:_____ Date of Birth:_____/_____/_____

Birth Sex:_____ Social Security # :_____-_____-_____ Marital Status:_____

Race:_____ Primary Language Spoken:_____

Primary Phone Number:_____-_____-_____ *H / C / W (Please Circle One)*

Address:_____ State:_____Zip:_____

Primary Care Physician:_____ PCP Telephone: _____-_____-_____
_____
(Doctor's First and Last Name Please)

Insurance Information

Please Fill Out Completely

Primary Insurance:_____

Subscriber ID:_____ Group:_____

(If Insurance is through someone other than the Patient)

*Subscriber Name:*_____*DOB:*____/____/____*SSN:*_____-_____-_____

Secondary Insurance:_____

Subscriber ID:_____ Group:_____

(If Insurance is through someone other than the Patient)

*Subscriber Name:*_____*DOB:*____/____/____*SSN:*_____-_____-_____

I authorize the Kidney Care Center of Georgia to release medical Information to my insurance companies about treatment and diagnosis necessary to process claims. I authorize the 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**

This Form is only valid for 12 months after signed date

Kidney Care Center of Georgia

Release of Information

The 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). DO NOT list Medical Doctors on this Form

Emergency Contact	**Name** *example: John Doe*	**Relationship** *Husband*	**Phone Number** *(770) 123-0000*	**# Type** *Home, Cell, Work*	**Allow Access to *MyChart***
❑	1)		( ) -		❑
❑	2)		( ) -		❑
❑	3)		( ) -		❑

**** 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**: _____ **Date:**_____/_____/_____

Patient or Guardian *Signature:* x_____

Relationship of Guardian (If applicable): _____

This Form is only valid for 12 Months after signed date

updated 1/01/2021

Kidney Care Center of Georgia

INSURANCE & FINANCIAL POLICY

As a courtesy to our patients, we participate in many health care insurance programs. Insurance is considered a method of reimbursing the patient for professional fees paid to the doctor and is not a substitute for your responsibility of payment for services provided.

- As the patient, it is your responsibility and obligation to understand your health insurance policy benefits and obligations. This includes your financial obligations for services provided, by the participating physician, and to obtain prior authorization when necessary.
- It is your responsibility to inform us prior to services being provided of any potential third-party coverage, including but not limited to health insurance policies or workman's compensation.
- Health care regulations require the collection of all co-payments, deductibles, balances and non-covered professional fees at the time of service. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.
- If the event your insurance company requests a refund of payment or denies coverage for the services provided, you will be responsible for the balance due.
- If your insurance company does not pay for professional services within a reasonable time period, we have the right to bill you for the balance of your account.
- All fees and co-payments are collected at the time you receive services. Insurance co-payments are collected at every visit. Kidney Care Center of Georgia accepts **cash, personal check (in-state only), VISA, MasterCard, American Express and Discover.** *Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.*
- Please refer to your benefit plan details as it may require you to be responsible for a portion of your services rendered by our providers.
- An Administrative fee is charged on all returned checks.
- A fee may be charged for a no-show visit in accordance with the no-show policy.
- An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to a collection agency. If your account is unpaid and turned over for collections, you will be responsible for accrued interest fees and/or all collection costs, including reasonable attorney's fees.
- 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.

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

Identification Requirements

To satisfy the federal requirements, we must have a copy of your photo ID on file. We will ask for your medical insurance and 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.

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 48-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.

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.

For your convenience, our billing office is staffed Monday through Friday from 9:00 AM to 4:00 PM. The phone number is 678-450-0202. Our knowledgeable staff will be happy to address any questions or concerns you may have regarding our financial policy or your account.

By signing below, I acknowledge that I have read and understand the financial policy of Kidney Care of Georgia. I accept financial responsibility for the professional services and understand that I will be responsible for any unpaid balance, on my account.

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

Signature of Patient or (*Authorized Representative):* *x*_____

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

This Form is only valid for 12 Months after signed date

updated 1/01/2021

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 to stay up to date with current government policies and healthcare regulations.

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):*_____

This Form is only valid for 12 Months after signed date

updated 1/01/2021