

CENTRAL TEXAS NEPHROLOGY ASSOCIATES, P.A
5940 CROSSLAKE PARKWAY, WACO, TEXAS 76712
PHONE: 254-666-8988 FAX: 254-666-2727

DATE: _____

PATIENT INFORMATION:

Patient First Name: _____ MI: _____ Last Name: _____

Male _____ Female _____ Date of Birth: _____ Marital Status: Married _____ Single _____ Divorced _____

Race/Ethnic Classification (circle one): Hispanic/Latino African American/Black White Other

English Speaking? Yes _____ No _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____

Email Address: _____

EMPLOYMENT INFORMATION: (Patient) Full Time _____ Part Time _____ Unemployed _____ Disabled _____ Retired _____

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date Last Employed: _____ Health Insurance Through this Employer? Yes _____ No _____

SPOUSE/PARENT INFORMATION: Employed? Full Time _____ Part Time _____ Unemployed _____ Disabled _____ Retired _____

Name: _____ Relationship to Patient: _____

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____ English Speaking? Yes _____ No _____

Health Insurance through this Employer? Yes _____ No _____

EMERGENCY CONTACT INFORMATION (If different from spouse or parent information):

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

TREATMENT CONSENT, PAYMENT AGREEMENT, AND INSURANCE RELEASE (ALL PATIENTS)

★ **Patient Name:** _____ **Birthday:** _____ **Social Security #:** _____

1. I hereby give consent for treatment of the above-named patient by any physician or other medical personnel providing services on behalf of Central Texas Nephrology Associates, P.A.
2. I understand that I am responsible for all charges incurred as a result of such treatment as well as those incurred in collecting for treatment charges. I realize that even though I may have insurance coverage, I am still responsible for payment. If legal action is instituted for payment of such treatment and/or services, I agree to pay reasonable attorney fees and all costs incurred herein.
3. Practice policy is that payment for services is expected at the time of treatment.
4. I authorize the release of any medical information necessary to process my insurance claim.
5. I request payment of benefits directly paid to my health care provider.
6. I authorize the use of this signature on all of my insurance claims submitted for me by my physician.
7. I authorize and request the release of all medical records to/from Central Texas Nephrology Associates concerning my illness and/or treatment from my primary care/referring physician from all legal responsibility that may arise from my authorization.
8. The Central Texas Nephrology Associates, P.A. Notice of Privacy Practices is posted and available upon request. I have had the opportunity to read the copy and ask questions.
9. I understand that all physicians at Central Texas Nephrology Associates, P.A. will be providing my care and appointments will not be assigned to a specific physician.
10. I understand that by missing three scheduled new patient visits I will not be scheduled here again.
11. I understand that if I miss three consecutive follow-up visits a new referral from my referring physician will be required, and my treatment will be that of a new patient.
12. I understand that labs are required before each scheduled visit, and my appointment will have to be rescheduled if I do not have lab results for that appointment. This event will count as a missed appointment.
13. I fully understand and accept the terms of this authorization.

★ **Signature of Patient or Guardian:** _____ **Date:** _____

Print name if different than patient: _____

Relationship to Patient: Self _____ **Other:** _____

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR 2 YEARS FROM THE ABOVE DATE UNLESS REVOKED IN WRITING.

I understand Central Texas Nephrology, P.A. (CTNA) is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize CTNA or his/her designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization by discussing with authorized staff and processing my request. My entire record authorizes the use or disclosure of all information in my medical record including, but not limited to demographic information, patient histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to alcohol and drug abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS), mental and behavioral health (other than psychotherapy notes) and developmental disability treatment, genetic information (including, but not limited to, genetic test results).

★ **Please disclose my health information to (example: spouse, child, friend):**

Name: _____ **Relationship: Self** _____ **Other:** _____

Address: _____ **Telephone:** _____

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR 2 YEARS FROM THE ABOVE DATE UNLESS REVOKED IN WRITING.

★ _____ (Initials) I authorize this information to be disclosed electronically.