KIDNEY ASSOCIATES OF THE TRISTATE

Patient Registration & Consent to Treat

Patient Information

Social Security #: _____ Last Name: _____ First Name: _____ Middle: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Email: _____
Date of Birth: _____ Marital Status: _____ Race: _____ Sex: _____
Emergency Contact: _____ Phone Number: _____
Preferred Pharmacy: _____ Phone Number: _____
Referring Provider: _____

PERSON WHO SHOULD RECEIVE THE BILL – RESPONSIBLE PARTY (Guarantor)

☐ SAME AS ABOVE

Relationship to Patient: ◉ Self ○ Parent ○ Spouse ○ Other: _____
Social Security Number: _____ Name: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Ext: _____ Email: _____
Date of Birth: _____ Marital Status: _____ Race: _____ Sex: _____
Employer: _____
Employer Address: _____ Employer Phone: _____

No Insurance ☐

Primary Insurance Company Name: _____
Subscriber Relationship to Patient: ◉ Self ○ Parent ○ Spouse ○ Other: _____
Subscriber Name: _____ Date of Birth: _____ Social Security #: _____
Employer: _____ Primary Care Physician: _____ Co-pay: _____

Secondary Insurance Company Name: _____
Subscriber Relationship to Patient: ○ Self ○ Parent ○ Spouse ○ Other: _____
Subscriber Name: _____ Date of Birth: _____ Social Security #: _____
Employer: _____ Primary Care Physician: _____ Co-pay: _____

I understand that I am responsible for payment for all services rendered. I hereby assign and authorize direct payment of my medical benefits to Kidney Associates of the TriState. However, I understand and agree to pay all charges or amounts not timely paid by my insurance policy or plan including, but not limited to, any co-pays or deductibles. I acknowledge that it is my responsibility to know and understand the terms of my insurance policy or plan. I authorize Kidney Associates of the TriState to release all of my medical and other information to third-party payers, benefit administrators, or other persons as necessary to verify benefits to authorize medical services to be received, to process claims for benefits, to represent me in a third-party payer's hearing or appeal process, and/or to collect any payments. I permit a copy of this authorization to be used in place of the original. I authorize the use of "signature on file" to be used in all of my insurance submissions. I understand that I am responsible for notifying the office of any precertification or referral needed for my insurance. In accordance with recognized coding standards, I understand that I may receive separate charges for procedures, physicals, and/or other problem-oriented treatment during a single visit.

I further authorize the access and release of my clinical and medication information for treatment by my Specialty Care Provider and to any and all providers involved in my care.

I give my consent to Kidney Associates of the TriState to provide medical care and treatment to me as deemed necessary and proper by my physician. I authorize Kidney Associates of the TriState billing or my provider's office to contact me by my cellphone. Y / N

Signature: X_____ Date: _____
Witness: _____