C.S.R.A. Renal Services, LLC — PATIENT REGISTRATION

PLEASE PRINT

____

PATIENT'S NAME **(Last, First, Middle Initial)**

______/______/________ ________-_____-________ ☐ **Male**

Date of Birth **Social Security Number** ☐ **Female**

____

Mailing Address **City** **State** **Zip**

Please provide an email address if you would like correspondent sent: ____

Phone (   ) ____________________ ☐ **Employed** ☐**Disabled** ☐ **Retired**

MARITAL STATUS:☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RACE: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Other Race: ____________

ETHNICITY: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Primary Care Physician ____________________________ **Phone Number:** __________________

Do you give permission for your medication history to be sent to the pharmacy: ☐ **YES** ☐ **NO**

Pharmacy: __________________________________ **City, State** ______________________

INSURANCE INFORMATION (PLEASE PROVIDE CARDS TO FRONT DESK RECEPTIONIST)

Primary ____

Secondary ____

If patient is <u>NOT</u> the policy holder, please provide the following information on the policy holder:

Name _____________________________________ **Date of Birth** _____/______/______

SS # _________-_______-__________ ☐ **Employed** ☐**Disabled** ☐ **Retired**

IN CASE OF EMERGENCY

NAME __________________________________ **RELATIONSHIP** ________________________

TELEPHONE: (Home) ____________________ **(Work)** ____________________ **(Cell)** __________________

I authorize CSRA Renal Services to release any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ABOVE ON THIS FORM.
<u>YOU SHOULD READ THOSE TERMS CAREFULLY</u>.

X____ **DATE** __________________________

SIGNED (PATIENT, OR PARENT IF UNDER 18 YEARS OF AGE.)

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________________, understand that as part of my health care, **CSRA Renal Services, LLC** originates & maintains paper &/or electronic records describing my health history, symptoms, examination & test results, diagnoses, treatment, & any plans for future care or treatment.

I understand that **CSRA Renal Services, LLC** may at times have a student health care provider accompany their physician or nurse practitioner. I understand that I have the right to refuse to allow this student to be present in the exam room.

I understand & **have been provided with a *Notice of Privacy Policies*** that provides a complete description of information uses & disclosures in addition to my rights.

I understand that **CSRA Renal Services, LLC** is not required to agree to any restrictions requested by me. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also understand that by refusing to sign this consent or revoking this consent, this organization *may* refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **CSRA Renal Services, LLC** reserves the right to change their notice & practices in accordance with Section 164.520 of the Code of Federal Regulations. Should **CSRA Renal Services, LLC** change their notice an updated copy will be available upon my next visit to the practice &/or I may request a copy be sent to my address. I also may visit the office at any time to obtain a current copy of the practice *Notice*.

I wish to have the following restrictions to the use or disclosure of my health information:
____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

***** I fully understand and **(circle one)** **[accept / decline]** the terms of this consent.

__________________________/___/____   ____________________________/___/____

Patient's Signature   Date   Practice Representative Witness - Date

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I request that CSRA Renal Services, LLC please contact me by phone at ____________________
*With appointment reminders & furthermore **give my permission** to leave the appointment date and time on my telephone answering machine or with whomever answers my phone if I am not available. I understand that no other information will be provided in granting permission to leave the date and time and I further understand that I may revoke this authorization at any time in writing to CSRA Renal Services, LLC.*

____________   ______________

Initial   *Date*

FOR OFFICE USE ONLY
[ ] Consent received by ____________________________________ on ________________________.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Notice provided to patient. Consent form not signed due to:________________________________
Action to be taken:____.