CSRA RENAL SERVICES

PLEASE COMPLETE THE ENTIRE FORM AND PROVIDE COPIES OF ID AND INSURANCE CARD(S)

HIPAA Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

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

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Social Security #: _____ - _____ - _____ Date of Birth: ____ / ____ / ____ **Sex**: ☐ Male ☐ Female

Email Address: _____

Employer: _____ ☐Full Time ☐Part Time ☐As Needed

Race: ☐American Indian / Native American ☐Asian ☐Black / African American ☐White ☐Other

STATUS: ☐ Single ☐Married ☐Widowed ☐Separated ☐Divorce

Primary Insurance

Insurance Company: _____

Policy Number: _____

Policy Holder's Name:

_____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

Patient Relation to Cardholder:

_____

Secondary Insurance

Insurance Company: _____

Policy Number: _____

Policy Holder's Name:

_____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

Patient Relation to Cardholder:

_____

PLEASE READ THE TERMS CAREFULLY. I authorize CSRA RENAL SERVICES, LLC 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.

BY SIGNING BELOW, I ACKNOWLEGE THAT I FULLY UNDERSTAND AND AGREE TO AUTHORIZE THE PAYMENT OF THE INSURANCE BENEFITS FOR PROFESSIONAL SERVICES RENDERED:

Print Patients Name: _____ **Date:** _____

Print Guarantor's Name and relationship to patient:

_____

Patient/ Guarantor Signature:

_____

CSRA RENAL SERVICES

Primary Care Physician

We are a specialty office; it is required that you remain under the care of a Primary Care Physician for your basic medical needs.

Primary Care Physician: _____

Office Location: _____

Consent to Obtain Pharmacy Information Electronically

CSRA RENAL SERVICES, LLC currently participates in the E-Scribe system. This allows us to electronically prescribe medication, which provides a convenience to the patients and providers and will also reduce medication error. An additional portion of this service allows for the electronic receiving of medication information such as medications, dosages and prescriptions filled from participating pharmacies. This too, reduces error in medication entry into the medical record and provides your provider with an up-to-date medication profile.

Please sign below, you give CSRA RENAL SERVICES, LLC permission for your medication history to be sent to your pharmacy: ☐ YES ☐ NO

Local Pharmacy (Name, Street, City and State):

_____

_____

Mail Pharmacy (Name, Street, City and State):

_____

_____

Print Patients Name: _____

Signature: _____ **Date:** _____

LAB

OUR PREFERED LAB OF CHOICE HERE AT CSRA RENAL SERVICES IS LAB CORP AND ALL ORDERS WILL BE SENT ELECTRONICALLY

Lab (Name, Street, City and State):

_____

_____

_____

_____

CSRA RENAL SERVICES

Communication Preference

I request that CSRA RENAL SERVICES, LLC please contact me with appointment reminders and furthermore give permission to leave the appointment date and time on my telephone answering machine or voice mail or whomever answers my phone if I am unavailable. 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 our office to better serve you, please indicate your communication preferences:

What is your primary phone contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

May we leave a message on answering machine or voice mail? ☐ YES ☐ NO

What is your preferred form of contact? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Letter

Acknowledgement of Receipt of Notice of Privacy Practices

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

☐EMERGENCY CONTACT ☐ AUTHORIZED TO OBTAIN MEDICAL INFO

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ PHONE #: _____

☐EMERGENCY CONTACT ☐ AUTHORIZED TO OBTAIN MEDICAL INFO

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ PHONE #: _____

☐EMERGENCY CONTACT ☐ AUTHORIZED TO OBTAIN MEDICAL INFO

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ PHONE #: _____

I WISH TO HAVE THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:

_____

_____

BY SIGNING BELOW, I ACKNOWLEGE THAT I FULLY UNDERSTAND AND AGREE TO THE POLICIES AND PRACTIES OF CSRA RENAL SERVICES, LLC. I ALSO AGREE THAT ALL THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ **DATE:** _____

PRACTICE REPRESENTATIVE WITNESS: _____ **DATE:** _____