FOOTHILLS NEPHROLOGY, PC –PATIENT'S INFORMATION

Patient Name (Last, First, MI):	Home Telephone ( )	Cell Phone ( )	Social Security Number:	
Mailing Address:		Primary Care Physician's Name: Referring Physician's Name:		
City	State	Zip	DOB:	Sex ❑M ❑F
Employer Name and Address: Phone number: ( )		Employment Status ❑Full time ❑Part Time ❑Retired ❑Not Employed	Patient Student Status ❑Full Time ❑ Part Time ❑ Not a Student	
Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed	Emergency Contact Phone Number: ( )_____ Name & Relationship: _____			

Required for Reporting Purposes: PLEASE CHECK ONE OF EACH

Gender Identity: _____Male _____Female _____ Other (Please specify) _____

Ethnicity: ❑Hispanic or Latino ❑Non Hispanic or Latino ❑ Decline to Specify

Race: ❑American Indian or Alaska Native ❑Asian ❑African American ❑Hispanic ❑White ❑Other ❑Decline to Specify

PHARMACY:

Responsible Party For Billing (if patient is a minor)

Responsible Party Name:	Home Telephone ( )	Cell Phone ( )	Social Security Number:	
Mailing Address:		City	State	Zip
Patient Relationship to Responsible Party ❑Self ❑Spouse ❑Child ❑Other:_____	DOB:	Employer Name & Address: Phone number: ( )		

Primary Insurance

Subscriber Name	DOB		Patient Relationship ❑Self ❑Spouse ❑Child ❑Other:_____
Insurance Carrier	Group Number	Policy ID Number	Does your insurance require a referral to see a specialist? ❑ Yes ❑No

Secondary Insurance

Subscriber Name	DOB		Patient Relationship ❑Self ❑Spouse ❑Child ❑Other:_____
Insurance Carrier	Group Number	Policy ID #	Does your insurance require a referral to see a specialist? ___yes ___no

Consent to Treat and Insurance Assignment and Release: I Authorize Foothills Nephrology, PC to render necessary treatment to the above named patient. I authorize direct payment to Foothills Nephrology, PC of any insurance benefits otherwise payable to, on, or behalf of the patient for all medical services. It is understood that I am financially responsible for the charges not covered by this assignment. Authorization is also given to release any and all medical information to the insurance companies involved to allow them to process any claims for all services rendered.

_____

Patient/Parent/Guardian Signature Relationship of other than patient Date: _____

AUTHORIZATION - COMPOUND

This authorization permits **FOOTHILLS NEPHROLOGY, 126 Dillon Drive, Spartanburg, SC 29307** to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Patient Name:_____ **Date of Birth:** _____

Address:_____

May we discuss your medical condition/billing/financial with other person(s) ___yes ___no

If the answer is yes, please list below:

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

This practice will verify the identity of any person/entity requesting protected health information. In order to release any protected information the patient and the above listed must present a password each time. Please list the password below and make sure you give to your names listed above:

Password:_____

DUE TO GOVERNMENT REGULATIONS PLEASE PROVIDE ALL METHODS OF COMMUNICATION..

HOME/CELL PHONE _____
MAY WE LEAVE A MESSAGE IN REFERENCE TO ANY OF THE FOLLOWING? YES ___ NO____
Appointment time _____ Results of lab test or x-rays _____ Other _____

EMAIL: _____
MAY WE SEND A SECURE MESSAGE IN REFERENCE TO ANY OF THE FOLLOWING? YES___ NO__
Appointment time _____ Results of lab test or x-rays _____ Other _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration dates or event: This authorization shall be enforce until revoked by the patient or _____.

Verification method or code: This practice will verify the identity of any entity/person requesting protected health information. Verification information will be the password you (the patient) provide.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I CERTIFY THAT YOU MAY USE ALL OF THE ABOVE LISTED METHODS OF COMMUNICATION TO CONTACT ME AND THAT ALL PREVIOUS COMPOUND AUTHORIZATIONS WILL BE REVOKED FROM THIS DATE:

_____Date_____

Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

****

Office Use Only:

Receiving Employee:_____ Date received:_____

_____ copy given to patient

Acknowledgement of Receipt of Notice of Privacy Practices For

FOOTHILLS NEPHROLOGY

126 DILLON DRIVE
SPARTANBURG, SC 29207

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____

Signature: Patient's Name / Personal Representative (as defined by HIPAA)

_____

Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- ☐ Document presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other _____
  _____

Employee preparing document signature:

_____ **Date:** _____

FINANCIAL POLICY OF FOOTHILLS NEPHROLOGY, PC

Please read all information and acknowledge by signing below.

1. We ask that you present your insurance card and picture ID at the time of your initial visit and/or if needed at follow-up visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of name, address and/or telephone number, please notify the receptionist.
3. We will collect your estimated deductible, co-payment, coinsurance, and/or non-covered services/supplies at the time of service. Each year, you will be expected to pay the allowed amount until your deductible is met. If you have a balance after your insurance(s) have paid you will be expected to pay that amount. If your insurance denies all or part of our charge, you will be billed for that amount.
4. Patients with no insurance are expected to pay in full at the time of service unless other arrangements have been made prior to date of service.
5. We are participating providers with most major insurance companies, and will bill accordingly for all covered charges.
6. You are expected to pay your balance in full within 30 days or call our billing department to establish a payment plan.
7. We accept Cash, Most Credit Cards. There is a $45.00 returned check fee.
8. When an appointment is scheduled, time is especially allocated for you. We understand that there may be times when you are unable to keep an appointment, however, we ask the courtesy of a phone call to cancel your appointment. Please give us a 24 hour notice of cancellation. Foothills Nephrology reserves the right to charge a $35.00 fee for missed appointments and no shows.

If you have questions or concerns regarding our financial policy, please contact our office at 864-327-1212.

I have read the above and a full understanding of the financial policy of Foothills Nephrology. I understand that is of courtesy that Foothills Nephrology if filing my insurance and that any charges or money incurred are only estimated and whether or not my insurance pays, I will be responsible for the balance.

_____ Date:_____

Signature of Patient/Parent/Guardian/Legal Representative

_____Relationship if other than patient

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UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet Date form started:

Name:	Address:
Phone Number:	
Birth Date:	
Emergency Contact/Phone numbers:	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To /Describe Reaction:	Allergic To /Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name

Refer to back of form for directions, benefits of using the form, and how to get more copies.

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4. Patients with no insurance are expected to pay in full at the time of service unless other arrangements have been made prior to date of service.
5. We are participating providers with most major insurance companies, and will bill accordingly for all covered charges.
6. You are expected to pay your balance in full within 30 days or call our billing department to establish a payment plan.
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_____

Employee preparing document signature:

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