LAST NAME:	**FIRST NAME :**	**MI:**
STREET ADDRESS:	**APT/PO BOX:**	
City:	**State:**	**Zip:**
Current Employer:		**Full-time Part-time**
Home Phone:	**Work Phone:**	
Email:	**Ethnicity: Hispanic or Latin Non Hispanic or Latin**	
Race: White Hispanic African American Asian Native American Other		
How did you hear about us? Website PCP Specialist Family /Friend Hospital Yellow Pages Other:		
Date of Birth:	**Social Security No.**	
Marital Status: Married Single Widowed Divorced Other	**Referring Dr.**	
Cell Phone No.	**Primary Dr.**	
Pharmacy: **City :**	**Pharmacy Phone No.**	
Which lab do you use: Quest Labcorp Virtua Memorial Lourdes BC Other		
Emergency Contact:	**Phone No.**	
Relation to Patient:	**Your Preferred Language:**	

INSURANCE POLICY INFORMATION

Primary Insurance Company:		
Policyholder Name:	**DOB:**	**SS#**
Insured's ID No.	**Group No.**	
Patient's relationship with insured: Self Husband Wife Child Other		
Coverage through: Active Employment Retirement Benefit Disability Benefit		
Current employer's name:		

Secondary Insurance Company

Secondary Insurance Company:		
Policyholder Name:	**DOB:**	**SS#**
Insured's ID No.	**State & Zip:**	
Coverage through: Active Employment Retirement Benefit Disability Benefit (circle one)		
Patient's relationship with insured: Self Husband Wife Child Other		
Current employer's name:		

Medicare Entitlement—Including Medicare HMO Coverage

Is your Medicare entitlement through: Age Disability ESRD Other _____		
Are you currently employed: Yes No	**Is your spouse employed: Yes No**	
Do you have group health benefits based on your or your spouse's employment? Yes No		
If yes, does the employer have at least 20 employees? Yes No		

Privacy Notice

Have you received a copy of The Center for Kidney Care's Privacy Notices? Yes No

Please Sign Here:

_____Date_____

The Center for Kidney Care

ASSIGNMENT OF BENEFITS

I, _____request the payment of authorized insurance benefits to be made on my behalf to The Center for Kidney Care. I authorize The Center for Kidney Care to release to my insurance company and its agents any information needed to determine these benefits.

I understand my signature request that payment be made and authorizes the release of medical information necessary to pay the claims. My signature authorizes the release of information to my insurance company or its agents. In the event my account is sent to a collection agency, an additional 30% fee will be added to my balance.

I understand that I need to give a least 24 hours notice if I need to reschedule an appointment and I agree to pay a $50 fee if I do not show up or if I reschedule an appointment with less than 24 hours notice.

(***) Medicare***: The Center for Kidney Care agrees to accept the charge determination of the Center for Medicare and Medicaid services or its agents as the full fee. The patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are determined by CMS or its agents.

(***) Medicare*** Supplement: Name of Carrier _____ Policy # _____

( ) ***Insurance***: Name of Carrier: _____
The patient is responsible for all deductibles, coinsurance, and non-covered services. It is the patient's responsibility to secure all referrals and pre-approvals for services as outlined in the patient's insurance policy guidelines. Insurance coverage is a contract between the insured (patient) and the insurance company.

Patient Signature: _____ **Date:** _____

****

MEDICAL RELEASE AUTHORIZATION

I, _____, hereby authorize physicians, specialists, and facilities who hold my medical records to release to The Center for Kidney Care, copies of my medical records. I understand this release includes primary care physicians, specialists, medical & diagnostic facilities. I further authorize the release of the name of my insurance carrier and my policy numbers to The Center for Kidney Care. I recognize that the sharing of this confidential information is solely and necessary to facilitate payment for my medical care.

_____ _____
Patient Signature **Patient Date of Birth**

_____ _____
Date **Witness Signature**

Phone: 856-222-1975 Fax: 856-222-0721