Southern Kidney Specialists

Date: _____-_____-_____

New Patient Registration Form

PRIMARY CARE PHYSICIAN NAME:		PHONE NUMBER: ( )	
REFERRING PHYSICIAN NAME:		PHONE NUMBER: ( )	
PATIENTS FIRST NAME:	MIDDLE:	LAST:	
DATE OF BIRTH:	SSN:	GENDER: MALE ☐	FEMALE ☐
ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE: ( )	CELL PHONE: ( )	PREFERRED METHOD OF CONTACT: EMAIL ☐	PHONE ☐
CURRENT MARITAL STATUS: SINGLE ☐	MARRIED ☐	DIVORCED ☐	WIDOWED ☐
EMPLOYER NAME:		WORK PHONE: ( )	
EMERGENCY CONTACT FULL NAME:		PHONE NUMBER: ( )	
NAME OF RESPONSIBLE PARTY FOR PAYMENT (If not Patient):		PHONE NUMBER: ( )	
ADDRESS:	CITY:	STATE:	ZIP CODE:
SPOUSE'S NAME:		SPOUSE'S DATE OF BIRTH:	
SPOUSE'S SSN (If insured through Spouse):			
POLICY HOLDER INFORMATION (Information applies to the person whose name the insurance falls under**)**			
PRIMARY INSURANCE COMPANY NAME**:**			
INSURED NAME:		DATE OF BIRTH:	
EMPLOYER:		SSN:	
POLICY OR ID NUMBER:		GROUP NUMBER:	
ADDRESS FOR CLAIMS:			
CITY:	STATE:	ZIP CODE:	
SECONDARY INSURANCE COMPANY NAME:			
INSURED NAME:		DATE OF BIRTH:	
EMPLOYER:		SSN:	
POLICY OR ID NUMBER:		GROUP NUMBER:	
ADDRESS FOR CLAIMS:			
CITY:	STATE:	ZIP CODE:	

PHARMACY NAME:	PHONE:	
PHARMACY ADDRESS:		
CITY:	STATE:	ZIP CODE:

***Appointment Reminders are sent via E-mail. Please provide an E-mail Address to receive appointment reminders and to receive access to our online patient portal.**

E-MAIL: _____

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

Southern Kidney Specialists Patient Consent Form

I, the undersigned, hereby consent to administration & performance of all treatments, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medications, performance of diagnostic procedures/tests, taking & utilization of cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the provider or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions &/or infectious diseases, including but not limited to blood-borne diseases.

I understand that Southern Kidney Specialists, PLC includes consent at satellite offices under common ownership. I, the undersigned, acknowledge that Southern Kidney Specialists, PLC will use and disclose my information for the purposes of treatment, payment and health care operations.

Treatment includes, but is not limited to, the administration & performance of all treatments, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking & utilization of cultures & of other medically accepted laboratory tests, all of which the judgment of the provider or their assigned designees, may be considered medically necessary or advisable.

Payment includes, but is not limited to, the authorization of payment directly to Southern Kidney Specialists, PLC of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing & collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designees. I understand that I am financially responsible for charges not covered. I have read and understood the letter stating that there will be a fee for any appointments that are missed or not rescheduled with 24 hours advanced notice. I acknowledge that patient records will be stored electronically & I may receive updates on my treatment via cell phone &/or e-mail. Health care Operations include, but are not limited to, release of my medical information to any of my physicians & their offices or insurance companies, participating in my care or treatment and the quality of that care. A photocopy of this consent will be considered as valid as the original. If there is an exposure and the patient's test is positive, the provider will notify the patient, any person exposed, and the Nashville Metropolitan Public Health Department and appropriate counseling will be offered.

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Southern Kidney Specialists, PLC. I acknowledge that I have been given the Notice of Privacy Practices by Southern Kidney Specialists, PLC. I understand that if I have questions or complaints that I should contact the corporate office.

I certify that I have read & fully understand the above statements & consent fully & voluntarily to its contents.

INITIALS: _____

PRINT NAME: _____

SIGNATURE: _____

DATE: _____