2500 E. Hallandale Beach Blvd Ste 207
Hallandale Beach FL 33009-4835
Office: (954) 800-0953
Fax: (954) 800-0956

kidneyplus

Today's Date _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/_____/_____ Age: _____

Social Security #: _____/_____/_____ Sex: _____ Marital Status: _____

Permanent Address: _____

_____
(City) (State) (Zip)

Please provide us with two different contact numbers: _____
(Home Phone) (Cell Phone)

E-mail address: _____

Emergency Contact: Name: _____ Phone Number: _____

TODAY'S VISIT INFORMATION

Primary Reason for your visit today: _____

Primary care physician name:_____Tel:_____Fax:_____

Pharmacy Tel:_____

MEDICAL/ INSURANCE INFORMATION

Primary insurance: _____ Policy number: _____

If you do not have insurance, how will you be paying for the visit? Cash_____/Credit card_____/Debit card_____

Allergies: _____

Disclaimer: I fully understand that I am directly and fully responsible for all medical bills and payments to KIDNEY PLUS for services rendered. This agreement is make solely for KIDNEY PLUS's protection.
I understand that payment is not contingent upon any settlement or judgment or insurance payment by which I may eventually recover said fee.
Authorization to pay benefits to Physician: I hereby authorize payment directly to the undersigned Physician of the medical benefits, if any otherwise payable to me for the services as described, but not to exceed reasonable and customary charges for said services. I understand that I am fully financially responsible for charges not covered by this authorization. I understand that payment is neither contingent upon any settlement or judgment nor insurance payment by which I may eventually recover said fee. I understand that information may need to be released to other parties such as insurance agencies to facilitate payment.
I understand that records may also be sent to my other physicians and family members, unless I instruct the clinic otherwise.

_____
(Full Name) (Signature) (Date)

Privacy Practices Acknowledgement

I have been provided with the opportunity to review and reviewed the Notice of Privacy Practices posted in this office.

_____
(Full Name) (Signature) (Date)

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my Physician or Physician Assistant, and/or another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to KIDNEY PLUS unless revoked by me in writing.

_____ _____

Date Patient Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand this information will only be furnished (1) to my insurer(s) to which my medical bills have been assigned for payment; (2) as required by law; (3) upon my written authorization on a form acceptable to KIDNEY PLUS.

I understand that my medical information will not be released to any other than those, named without my express written permission. I also understand that with my written permission, my entire record including my HIV status can be released to the healthcare provider as specified in my written request. Any revocation of this release must be submitted in writing to KIDNEY PLUS.

For the purpose of this release, "medical information" shall mean copies of all medical records, tests, x-rays, reports and/or other material in the possession of KIDNEY PLUS, relating to my medical condition and proposed or actual treatment.

I UNDERSTAND THAT BY SIGNING THIS CONSENT I AM ALSO AUTHORIZING RELEASE OF ANY INFORMATION CONTAINED WITHIN THE MEDICAL RECORD WHICH MAY BE RELATED TO AIDS AND/OR HIV ANTIBODY OR ANTIGEN TESTING.

By signing this Consent to Release Medical Information, I agree not to hold liable KIDNEY PLUS, the office staff, agents or employees, or any unfavorable outcomes as the result of releasing this information.

_____ _____

Date Patient Signature

CONSENT TO OBTAIN RECORDS

Recognizing the importance of accurate follow up in maintaining quality care, I hereby authorize KIDNEY PLUS to obtain medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment and care offered or rendered to me, as well as my records. This information will be treated as part of the medical record of KIDNEY PLUS. This consent remains in effect until revoked by me in writing.

_____ _____

Date Patient Signature