PENINSULA KIDNEY ASSOCIATES

REGISTRATION FORM

(Please Print)

Today's Date:	Primary Care Physician:

PATIENT INFORMATION

Patient Last Name: First: Middle:			Marital Status (circle one) Single/ Married / Divorced / Separated/		
Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	Race:	DOB:	Age:	Sex:
Street address:				Social Security#	
P.O. Box:	City:	State:		ZIP Code:	
Home Phone#:	Mobile Phone#:	Work Phone#:	Email Address:		
Occupation:	Employer:		Employer phone#:		
Referred to practice by (please check one box):	☐ Dr.		☐Insurance Plan	☐ Hospital	

In Case of Emergency: Friend or Relative (not living in your home) Relationship: Phone#:

Pharmacy Name: Pharmacy #:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Policy Holder's Name: Date of Birth:

Primary Insurance:	ID#:	Group#:	Effective Date:
Secondary Insurance:	ID#:	Group#:	Effective Date:

Spouse Name: DOB: SSN:

HIPAA ACKNOWLEDGEMENT / FINANCIAL AGREEMENT

HIPAA Acknowledgement: All Parties Must Sign/Initial one of the Following:

By signing below, I certify that the Notice of Privacy Practices has been made available to me to review and I have had the opportunity to ask questions about the use and disclosure of my protected health information.

___________ I hereby acknowledge that the Notice of Privacy Practices has been made available to me but decline to accept at this time.

Patient/Guardian Signature Date

Financial Agreement and Insurance Assignment

I hereby apply for the treatment by Peninsula Kidney Associates. Treatment may include urinalysis, injections and/or other office procedures they deem necessary. I understand I am responsible for obtaining all the referrals necessary for each visit to PENINSULA KIDNEY ASSOCIATES as required by my insurance policy with my chosen insurance company. Deductible, co-payment and "non-covered" amounts are the responsibility of the patient. They are due at the time of service. PLEASE DO NOT ASK US TO WAIVE CO-PAYMENT OR DEDUCTIBLES, AS THIS IS A VIOLATION OF YOUR INSURANCE CONTRACT. I authorize the release of information and use of the signature for filing of any insurance. I, the undersigned, assign medical benefits, if any, directly to PENINSULA KIDNEY ASSOCIATES for the service rendered. I understand that filing my insurance by PENINSULA KIDNEY ASSOCIATES is done as a courtesy and that I am financially responsible for all charges , whether or not paid by my insurance. In the event my account is turned over to a collection agency, I agree to pay the collection fee of 33 1/3% and/or attorney fees that may be assessed on this account.

Patient/Guardian Signature Date

PENINSULA KIDNEY ASSOCIATES

DEMOGRAPHIC UPDATE FORM

(Please Print)

Today's Date:			
Primary Care Physician:		PCP Phone#:	
Pharmacy Name:		Pharmacy #:	
PATIENT INFORMATION			
Patient Last Name: First: Middle:		Marital Status (circle one) Single/ Married / Divorced / Separated/ Widow	
Street address:		Social Security#	
P.O. Box:	City:	State:	ZIP Code:
Home Phone#:	Mobile Phone#:	Work Phone#:	
Email Address:			
In Case of Emergency: Friend or Relative (not living in your home)		Relationship:	Phone#: