NEPHROLOGY ASSOCIATES of the Carolinas, PA

your hometown kidney specialists!

REGISTRATION

Name_____ Birth Date_____

Address _____ Sex: Male__ Female__

_____ZIP_____ Telephone (home)_____

Social Security #_____ (work,moble) _____

Married__ Single__ Widow__ Separated__ Divorced__ **EMAIL**_____

Race: African/American__Caucasian__Hispanic__Asian__American Indian__other___

RESPONSIBLE PARTY

Name_____ Telephone_____

Address_____ _____

_____ZIP_____ Relationship_____

PRIMARY INSURANCE

Insurance Company_____ Policy ID #_____

Address_____ Policy Holder_____

_____ZIP_____ DOB_____

SECONDARY INSURANCE

Insurance Company_____ Policy ID #_____

Address_____ Policy Holder_____

_____ZIP_____ DOB_____

RELEASE OF INFORMATION REQUEST:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and other medical professionals and medical institutions that I may be referred to for treatment. This authorization also includes pharmacy prescription history. I understand that this information will be used to review, investigate, or make payment of claim, and to review records for complaint resolution. I authorize payment directly to Nephrology Associates of the Carolina's, P.A. for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

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Signature of Patient, Parent, or Personal Representative Date

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