PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:

Sex: Male Female	Date of Birth: MM/DD/YYYY	Marital Status: Single Married Widowed Divorced	Social Security #:

Address:	City/State:	Zip:

Cell Phone:	Home Phone:	E-Mail:

Race:	Ethnicity:	Language:

Student? Full Time Part Time	Employed? Full Time Part Time	Employer:	Work Phone:

BILL TO

Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip:

Emergency Contact:	Emergency Contact Phone Number:

PRIMARY INSURANCE COVERAGE

Insurance Company:		Insured's Social Security #:
Insured's Name (If not the patient):	Relationship:	Date of Birth: MM/DD/YYYY

SECONDARY INSURANCE COVERAGE

Insurance Company:		Insured's Social Security #:
Insured's Name (If not the patient):	Relationship:	Date of Birth: MM/DD/YYYY

COPIES OF YOUR INSURANCE CARDS AND PHOTO ID ARE REQUIRED

PRIMARY CARE PHYSICIAN: ______________________________

REFERRING PHYSICIAN: ______________________________

WOULD YOU LIKE TO BE INVITED TO THE PATIENT PORTAL? YES NO

(please make sure your e-mail address is povided above)

*******PLEASE COMPLETE SECOND PAGE*******

Acknowledgements

Patient Initials	**Assignment of Insurance Benefits:** I hereby authorize direct payment of my insurance benefits to Omaha Nephrology, PC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay balance due that Omaha Nephrology, PC is unable to collect from my insurance carrier for whatever reason.
Patient Initials	**Medicare/Medicaid/Champus Insurance Benefits:** I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Omaha Nephrology, PC or the physician on my behalf.
Patient Initials	**Lab/X-Ray Diagnostic Services:** I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay balance due for these services if they are not reimbursed by my insurance for whatever reason.
Patient Initials	**Authorization to Mail, Telephone or E-mail:** I understand the potential risks of the use of mail, telephone and e-mail. I hereby authorize an Omaha Nephrology, PC representative or my physician to mail, telephone , or E-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Omaha Nephrology, PC to that effect in writing.
Patient Initials	**Consent to Treatment:** I hereby consent to evaluation, testing, and treatment as directed by my physician or his/her designee.
Patient Initials	**Acknowledgement of Receipt of Notice of Privacy Practices:** I have been given a copy of the Notice of Privacy Practices. I understand this medical practice has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy at their office. The undersigned does hereby acknowledge receipt of the Notice of Privacy Practices. (HIPAA)
Patient Initials	Please indicate the names and relationships of any individuals you would like to give authorization to discuss your medical information. NAME RELATIONSHIP

Print Patient Name:	Patient Signature (If Minor, Personal Rep MUST sign):
Date:	