Cleveland Kidney Disease Associates **Andrew E. Lazar, M.D.**

Patient Information

Date_____/_____/_____

Patient Name____
Last First MI

Address____
Street City State Zip

Home Phone________________________ Cell Phone_____________________________

Date of Birth_____________ Sex (circle) M F SS#______________________

Employer ____________________________________ Work Phone_________________

Primary Care Physician______________ Physician Sending You Here______________

Emergency Contact____
Name Relationship Phone number

Responsible Party (person responsible for payment) – Usually this is the Policy Holder
(If different than patient)

Name____
Last First MI

Address____
Street City State Zip

Home Phone________________________ Work Phone____________________________

Date of Birth_____________ Sex (circle) M F SS#______________________

Employer ___________________ Relation to patient (circle) Spouse Father Mother
Father Guardian Other____

Insurance Information

Primary Insurance Company______________________ Secondary Insurance_________

Does your insurance company require a referral for office visits? _____Y_____N

Does your insurance company restrict which hospital system you can use?_______

Have you recently been hospitalized? _____Y (date ___/___/___) _____N

Hospital Name_________________________ Admitting Physician_________________

PLEASE GIVE YOUR INSURANCE CARD(S) TO RECEPTIONIST FOR COPYING.

PLEASE COMPLETE OTHER SIDE

NOTICE OF PRIVACY PRACTICES AND PERMISSION TO SHARE HEALTH INFORMATION

By signing below, I am acknowledging that I have received a copy of the CKD Associates Notice of Privacy Practices.

Patient Signature____________________________________ Date_____/____/_____

Authorized Representative____________________________ Date_____/_____/_____

Relationship to patient?__________________________

Refusal to sign______________________________________ Date_____/_____/_____

If you would like to authorize disclosure of your personal health information to parties other than your referring physician and primary care physician, you will need to complete a HIPPA Supplemental Disclosure Form. Please ask the receptionist for this form.

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician of CKD Associates and authorize payment directly to the physician (CDC-PO) of the Medical and/or Surgical benefits, if any, otherwise payable to me by Medicare or any other insurance company, for his services, and I assume responsibility for any unpaid balance including not covered services except as limited by law. I also hereby authorize the physician to release any information to my referring physician and/or primary care physician, Health Care Financing Agency, or its agents, to third party payors and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney, consultants, and to my insurance company as acquired in the course of my examination or treatment. This authorization will remain in effect until revoked by me in writing.

CKD Associates' financial policy is displayed in the reception area.

I have reviewed and accepted the Financial Policy and Authorization, Assignment and Information Release.

____/_____/_____

Signature of Patient or Responsible Party Date