MITTAL
KIDNEY & DIALYSIS

New Patient Information Sheet

Patient Name: _____ Date of Birth: _____

First *Middle* *Last* ***Please Print Clearly***

Address: _____

City: _____ State: _____ Zip_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave a message on your voice mail at Home_____ or Cell _____

Email Address: _____

Would you like us to send your email an invitation to the Patient Portal? Yes or No (please Circle One)

Marital Status: _____ Sex: Male or Female Social Security Number_____

Primary Care Doctor: _____

Emergency Contact

Name	Relation to the Patient	Phone

Authorization to Release Medical Information to: *(Family, and Friends that may handle appointments, refills etc. for you)*

Name	Relation to the Patient	Phone

In order to maintain compliance with Medicare and Federal regulations, our office will be communicating electronically with all pharmacies. All refill requests should be called into your pharmacy, not the office. Your pharmacy will send an electronic request to our office for approval.

Preferred Pharmacy:	
Pharmacy location:	
Pharmacy Number:	

Patient Name: _____

Primary Insurance

Insurance Company_____	**ID#_____**	**Group #_____**
Policy Holder_____	**Relation to Patient_____**	
Policy Holder Social Security Number_____	**Policy Holder Date of Birth_____**	**Policy Holder Male or Female**
Policy Holders Contact Phone Number	**_____**	

Secondary Insurance

Insurance Company_____	**ID#_____**	**Group #_____**
Policy Holder_____	**Relation to Patient_____**	
Policy Holder Social Security Number_____	**Policy Holder Date of Birth_____**	**Policy Holder Male or Female**
Policy Holders Contact Phone Number	**_____**	

Do you have an advance directive? YES or NO

If so, Please list the name of your advance directive _____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that you must cancel your appointment with a minimum of a 24 hour notice. Our office does charge a $50 ***NO SHOW*** *fee. We also understand that special unavoidable circumstances may cause you to miss your appointment, please contact office manager to reschedule and have fee waived. We believe firmly that good physician/patient relationship is based upon understanding and good communication.* ***Please initial acknowledgement of No show policy here_____.***

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITIES

I FULLY CONSENT TO MEDICAL TREATMENT BY Mittal Kidney and Dialysis, P.L.L.C. I agree to follow the instructions of the physicians and orders called in by the nurses and staff of the practice under the instruction of my physician. I will agree to have lab test as ordered and deemed necessary by the physician. I agree to take any and all medications as prescribed by my physician that he has deemed medically necessary.

I will provide to the office staff any changes in my phone number, addresses, or insurance policies, I authorize release of any information concerning my healthcare, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also realize that my physician electronically submits insurance claims and give full consent to the office for the filing and follow up of claims. If I do not agree I will take full responsibility for my account payment at the time of service and will file my own insurance claims.

I hereby give lifetime authorizations for payment of insurance benefits to be made directly to Mittal Kidney and Dialysis, P.L.L.C. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of theis agreement shall be a as valid as the original.

I also acknowledge that all copays, coinsurance, and deductibles are due prior to being seen by physician as your insurance companies contracts require.

I also agree to give Medical Insurance Filing Services, Inc. authorization necessary to file insurance for medical claims on behalf of Mittal Kidney and Dialysis, P.L.L.C.

Signature of Responsible party for Permission to Treat and Agreement to the above:

X_____ Date: _____

Printed Responsible Party's Name: _____ Relation to Patient: _____