# Patient Registration

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

| **PATIENT DEMOGRAPHICS** | | | | |
|---|---|---|---|---|
| Patient Name | Date of Birth | Sex | Age | Race |
| Parent if Patient is a Minor | | Marital Status | | |
| Patient's Social Security Number | Driver's License Number | | | |
| Home Address | City | State | Zip | |
| Mailing Address if Different | City | State | Zip | |
| Home Telephone Number | Work Telephone Number | | Cell Phone Number | |
| Email Address: | | | | |
| Occupation | Employer's Name | | | |
| Employer's Address | City | State | Zip | |
| Spouse Name | Employer | | | |
| Other Physician's Name | | | | |
| Whom May We Thank for Referring You to Our Practice? | | | | |
| **NOTIFY IN CASE OF EMERGENCY** | | | | |
| Name | Relationship | | | |
| Address | City | State | Zip | |
| Home Telephone | Work Telephone | | Cell Phone Number | |
| Nearest Relative (not living with you) | | | | |
| Home Telephone | Work Telephone | | | |
| **FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES** | | | | |
| **Primary Insurance:** | Telephone | | | |
| Policy # | Group# | | Effective Date: | |
| Are you the subscriber? Yes No | | | | |
| Subscriber's Name | Subscriber's Date of Birth | Subscriber's SSN#. | | |
| **Secondary Insurance :** | | | | |
| Policy# | Group# | | Effective Date: | |
| Subscriber's Name | Subscriber's Date of Birth | Subscriber's SSN# | | |

South Texas RENAL CARE GROUP

# Consent For Treatment

I authorize and direct any of the following physicians, M. Reza Mizani, M.D., Varshasb Broumand, M.D., Naushad Zafar M.D., Luis E. Velez M.D., Qasim Ali Butt M.D., Abhijeet Goyal M.D., John W. Idoux M.D., Carolina Arias, M.D., Christine L. Gear, M.D., Yanilda Nunez, M.D., Lauren E. Tarbox, M.D., Pavan Devulapally, M.D., Samy Riad, M.D. and such associates, technical assistants and other health care providers as they deem necessary to perform any necessary diagnostic tests and evaluations on me as deemed medically indicated and provide me with treatment and prescriptions, including administering medication to me. I understand that any such test or treatment provided to me will be explained to me prior to its performance and that I may ask questions about such test or treatment.

_____

Patient Signature *(or responsible party)*

_____

Patient Name *(or responsible party) (please print)*

_____

Date

# Lifetime Insurance Authorization and Assignment of Benefits

Provider name: M Reza Mizani, MD PA dba South Texas Renal Care Group.

I authorize the release of any medical information necessary to process claims.

I also authorize payments under my insurance programs to be made directly to the above provider for any services furnished to me.

This authorization also permits the release of information by HCFA (its intermediaries or carriers) on any UNASSIGNED Medicare claims to the above.

I further permit copies of the authorization to be used in place of the original.

_____

Patient Signature *(or responsible party)*

_____

Patient Name *(or responsible party) (please print)*

_____

Date

# Receipt of Notice of Privacy Practice

*In order to respect the privacy of your protected health information, please take a moment to answer the following questions:*

- Please list any family members or individuals involved in your care that we may discuss your medical condition with.

**Spouse:** Yes No Name: _____

**Other:** _____

*Name* *Relationship* *Phone Number*

_____

*Name* *Relationship* *Phone Number*

_____

*Name* *Relationship* *Phone Number*

- If for any reason, we are unable to contact you via phone, may we leave a detailed message on your answering machine?

Yes No

- I have received the South Texas Renal Care Group Notice of Privacy Practice.

Yes No

_____ _____

*Printed name of Patient* *Date of Birth*

_____ _____

*Signature of Patient* *Date*

_____ _____

*Signature of Legal Guardian/Representative (if applicable)* *Date*

____ *Parent or Legal Guardian*

___*Power of Attorney/Medical or Health Care*

South Texas RENAL CARE GROUP

# Financial Policy Acknowledgment

We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. Your clear understanding of our Financial Policy will enhance our professional relationship. Thank you for your review and acceptance of this policy

- All new patients must complete our Patient Information Packet before seeing the doctor.
- Full payment for our services is due at the time of service, unless other mutually agreed upon arrangements are made with our office staff.

- **Insurance**
  You are responsible for timely payment of your account. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, nor can we become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. We cannot be held responsible to know every plan and every payment that will be made. There are some procedures performed in our offices that are not surgical procedures, but we are required by the insurance guidelines to report the procedure under an insurance code, which your insurance company may classify as surgery. If these procedures go towards your deductible, you will be billed for the charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

- **HMO and PPO**
  Co- payments and deductibles must made at the time of your visit, when applicable.

- **Medicare**
  We are participating Medicare providers, thus we accept assignment of payment for your claims. We are required by Medicare to file your claims for you. Medicare will pay us directly and provide you with an EOB

  (Explanation of Benefits) detailing allowances, payments, and/or denials.

- **Third–Party (not HMO/PPO) or supplemental (secondary)**
  We do not file claims to insurance carriers for which we are not providers or with which Medicare does not coordinate benefits. We will provide you with the information you need to submit your primary or secondary claim.

I have read and acknowledge the Financial Policy as set forth by South Texas Renal Care Group.

Signature: _____ Date: _____

Patient Name (or responsible party) (Please Print): _____

South Texas RENAL CARE GROUP

# Authorization for Use and Disclosure of Protected Health Information (PHI)

| Patient's Legal Name | Birthdate | Social Security No. (*optional)* |
|---|---|---|
| Address | | |
| City | State | Zip Code |

| Information to be Released to (requestor) | Facility (Covered Entity Provider) authorized to release PHI |
|---|---|
| Name | Name |
| Address | Address |
| City State Zip | City State Zip |

This authorization shall expire on the following date or event:_____. If I fail to specify an expiration date or event, this authorization will expire (12) months from the date on which it was signed.

Purpose of disclosure:

___Medical Care ___Legal ___Insurance ___Personal ___Other: _____

Description of Information to be Used or Disclosed Starting: _____ Ending: _____

| | Starting Date | Ending Date | | Starting Date | Ending Date |
|---|---|---|---|---|---|
| __ All PHI in the medical records | | | __ Consultation Reports | | |
| __ History & Physical Reports | | | __ Discharge Summary | | |
| __ Progress Notes | | | __ Itemized Billing Statement | | |
| __ Diagnostic Reports | | | __ Patient Information Form | | |
| __ Laboratory Reports | | | __ Other Specified:_____ | | |

The Protected Health Information (PHI) listed below **WILL BE** released when included in the above medical information unless specifically indicated otherwise.

Psychiatric/Mental Information AIDS/HIV/Genetic Information

Alcohol/Drug/Substance Abuse Information OTHER: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I understand that I have the right to revoke this authorization at any time in writing and must present the written revocation to the provider authorized to release the protected health information. I understand if I do revoke this authorization it will not apply to information that has already been released to this authorization.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorized the disclosure of the Protected Health Information as stated:

Patient Signature:_____ Date: _____

| Patient Representative Signature (if applicable): | Relationship to Patient: | Date: _____ |
|---|---|---|

# South Texas Renal Care Group
# Missed, Late and Cancelled Patient Appointment Policy

We strive to provide our patients with exceptional medical care and we make every effort to accommodate our patients' scheduling needs. Patients who: (i) do not show up for scheduled appointments, (ii) arrive late for scheduled appointments, or (iii) cancel scheduled appointments without providing at least **twenty-four** hours' advance notice inconvenience other patients who need timely access to medical care. We would like to remind our patients of our policy regarding missed, late and cancelled appointments.

If a patient is unable to keep his or her scheduled appointment, please notify us at least **twenty-four** hours in advance of the appointment by calling (**210) 212-8622**. Patients who do not reach a member of our staff should leave a detailed voicemail message on our answering machine or with our answering service and a member of our staff will promptly return each patient's call or email to reschedule his or her appointment.

*No-Shows; Missed Appointments.* A "no-show" is defined as a patient who fails to show up for a scheduled appointment without calling to cancel an appointment.

*Late Cancellations.* A patient is deemed to have cancelled late if a patient cancels his or her appointment with less than **twenty-four** hours' advance telephone or email notice.

*Late Appointments.* A patient is deemed to have arrived late to his or her appointment if such patient has not arrived by the scheduled appointment time, **regardless of whether a patient calls in advance to notify us that he or she may be late.**

We reserve the right to discontinue providing care to patients who miss **two** or more appointments or who cancel **two** or more appointments late by providing less than **twenty-four** hours' advance notice. We also reserve the right to discontinue providing care to patients who are late to **three** or more appointments. This policy is applicable to all of our patients, regardless of race, religion, color, sex, age, disability, national origin, sexual orientation, genetic makeup or any other basis or protected class covered by federal, state or local law.

Signature: _____ Date: _____

Patient Name (or responsible party) (Please Print): _____