Print Form Clear Form

WASHINGTON NEPHROLOGY ASSOCIATES

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PATIENT REGISTRATION FORM

New patient Update

Last Updated 6/3/13

NAME Last First Middle			HOME PHONE
HOME ADDRESS Street City State ZIP			WORK PHONE
Male Female	DOB (MM/DD/YYYY)	Marital Status Single M W D	CELL PHONE
Social Sec No	E-mail Address	Preferred Communication Method Home Work Cell Mail Email	

Race (check one)
Hispanic or Latino.
Not Hispanic or Latino
Decline to Specify
Unknown

Ethnicity: (check one)
White
Black or African American
American Indian or Alaskan Native
Asian
Chinese
Filipino
Guamanian or Chamorro
Japanese
Korean
Native Hawaiian or Other Pacific Islander
Samoan
Vietnamese
Decline to Specify
Some other race
Unknown

Primary Language: (check one)

English	Persian
Arabic	Polish
Chinese	Portuguese
French	Russian
French Creole	Spanish
German	Tagalong
Greek	Thai (Laotian)
Hindi (URDU)	Vietnamese
Italian	Yiddish
Japanese	Decline to Specify
Korean	Unknown

Employer/School	Employer/School Address Street City State ZIP

_____ _____

Signature of Patient Date

00"<<

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Person Financially Responsible (if other than patient)

Name	Telephone	Patient relationship to responsible party: Self Spouse Child Other:……

PRIMARY INSURANCE

Company Name	Address Street City State ZIP		
Telephone	Subscriber (Insured)	Patient relationship to insured: Self Spouse Child Other:……	Insured SS# (if not self)
Effective Date (MM/DD/YY)	Policy Number	Group Number	

SECONDARY INSURANCE **MEDIGAP** (please check)

Company Name	Address Street City State ZIP		
Telephone	Subscriber (Insured)	Patient relationship to insured: Self Spouse Child Other:……	Insured SS# (if not self)
Effective Date 00"<<	Policy Number	Group Number	

Primary Care Physician	Referring Physician (if different)

Emergency Contact Name	Emergency Phone No.	Relation to Patient

_____ _____

Signature of Patient Date (MM/DD/YY)

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

Washington Nephrology Associates, L.L.P. ("WNA") obtains and maintains health information relating to my past, present or future physical or mental condition, and provision of health care or payment for health care, referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by WNA for purposes of treatment, payment or health care operations, including, but not limited to:

. Planning for my care and treatment

. Calling me with appointment reminders and lab results

. Submitting a claim to my insurer or health plan

. Assessing the quality of care provided to me

WNA'S Notice of Privacy Practices contains a more complete description of how my Protected Health Information may be used or disclosed and how I can obtain access to this information. I understand WNA reserves the right to change its Notice and practices and I can request a copy of its current Notice.

I understand that I have the right to request restrictions as to how my Protected Heath Information may be used or disclosed by WNA. WNA is not required to agree to my request but if WNA does agree, the requested restrictions will be binding on WNA.

I further understand that, at any time, I may revoke this consent in writing, except to the extent that WNA has already taken action in reliance on it.

By signing this form below, I consent to WNA'S use and disclosure of my Protected Health Information for the purposes of treatment, payment and or health care operations.

_____ _____

Signature of Patient or Legal Representative Witness

_____ _____

Print Name Date (MM/DD/YY)

_____

If Patient's Legal Representative, State Relationship to Patient

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PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of Washington Nephrology Associates, L.L.P. ("WNA") to protect the privacy of your individually identifiable health information, or Protected Health Information as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("Information"), in providing for your medical treatment and needs.

Purposes For Which WNA May Use or Disclose Your Medical Information With Your Consent
WNA may request your consent for the use and disclosure of your information for treatment, payment or health care operations as described below:

- **Treatment Purposes:** For example, your information may be disclosed to your primary care physician or to another specialist who referred you to WNA for treatment.
-
- **Payment:** For example, your information may be used and disclosed to submit claims to your insurer and/or to obtain payment for services provided.
-
- **Health care Operations:** For example, your information may be used and disclosed by WNA to engage in case management, coordinate your care, schedule your appointments and inform you of your lab results.
-
- **Health Care Services:** Your information may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent
Your information may be disclosed to a family member, friend or other person designated by you or as designated by the law, if you verbally agree. With your verbal consent, directory information also may be used and disclosed.

Uses and Disclosures with your Authorization
Except as provided below, your information with not be used for any non-routine purposes unless you give WNA your written authorization to do so. WNA may request your authorization to use and disclose your information for research purposes. If you give WNA written authorization to use or disclose your information for a purpose that is not described in this notice, then, with certain exceptions, you may revoke it in writing at any time. Your revocation will be effective for the information WNA maintains, unless WNA has taken action in reliance of your authorization.

Uses and Disclosures Without Your Consent or Authorization

- **As required by law**: WNA must provide your information to the U.S. Department of Health
- And Human Services and to you, upon request.
-
- **To Business Associates:** Your information may be disclosed to WNA's business associates who require the information to perform a function for WNA (i.e. accountant). Each business associate of WNA must agree in writing to ensure the continuing confidentiality and security of your information.

Additionally, your information may be used and disclosed without your consent, opportunity to agree or disagree or authorization for other reasons including, but not limited to:

- To comply with legal proceedings, such as a court or administrative order or subpoena;
-
- To law enforcement officials for limited law enforcement purposes;
-
- To a coroner, medical examiner, or funeral director about a deceased person;
-
- To an organ procurement organization in limited circumstances;
-
- To avert a serious threat to your health or safety or the health or safety of others;
-
- To a governmental agency authorized to oversee the health care system or government programs;
-
- To federal officials for lawful intelligence, counterintelligence and other national security purposes;
-
- To public health authorities for public health purposes; and
-
- To appropriate military authorities, if you are a member of the armed forces.

Your Rights

You may make a written request to WNA to do one or more of the following concerning your information:

- To put additional restrictions on WNA's use and disclosure of your information.
-
- To communicate with you in confidence about your information by a different means or at a different location than WNA is currently doing.
-
- To see and get copies of your information.

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Continue from previous page:

- To correct your information
- To receive a list of disclosures of your information that WNA, and its business associates, make for certain purposes for six (6) year prior to your request (after April 14, 2003), with certain exceptions permitted by law including exceptions for disclosures made to you or made pursuant to your authorization.
- To send you a paper copy of this notice if you receive this notice by e-mail or on the Internet.

If you want to exercise any of these rights described or require further information about WNA's privacy practices, please contact WNA's Privacy Officer at the address below. Please know that in certain instances, WNA does not have to agree to your request. WNA will give you the necessary information and forms for you to complete and return. WNA will charge you a fee of .60 per page for copying and a preparation or retrieval fee, plus postage and handling.

Complaints

If you believe your privacy rights have been violated by WNA, you have the right to complain to WNA or to the Secretary of the U.S. Department of Health and Human Services. You may file a written complaint with WNA by Contacting WNA's Privacy Officer at the address below. WNA will not retaliate against you if you choose to file a complaint with WNA or with the U.S. department of Health and Human Services.

Contact Office

To request additional copies of this notice or to receive more information about WNA's privacy practices or your rights, please contact *Ernest Durst* at:

Contact Office: Washington Nephrology Associates, L.L.P.
4915 Auburn Avenue #200
Bethesda, MD 20814
Telephone: 301-907-4646 / Fax: 301-907-7796

Acknowledgment

I acknowledge receipt of this notice.

_____
Signature of Patient or Patient's Legal Representative

_____ _____
Print Name Date (MM/DD/YY)

_____
If Patient's Legal Representative, State Relationship to Patient

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PATIENT AUTHORIZATION WAIVER FOR DISCLOSURE OF INFORMATION TO ANY WASHINGTON NEPHROLOGY ASSOCIATES ADMINISTRATIVE STAFF EMPLOYEE TO DISCUSS ANY MEDICAL CONDITION (S) WITH FAMILY MEMBERS OR DESIGNATED PERSON (S)

I am a patient of Washington Nephrology Associates, L.L.P. (WNA) and hereby authorize the support staff. I.e. secretaries, medical assistants, nurses, etc. to discuss my medical condition with the following members of my family.

Parties to whom the information will be disclosed:	Relationship to patient:
_____	_____
_____	_____
_____	_____

The patient or the patient's legal representative must read and sign the following statements:

A. I understand that the provision of health care and the payment of health care will not be affected if this form is not signed.
B. I understand that I may revoke this authorization at any time by notifying Washington Nephrology Associates in writing, but it will not affect any actions taken by Washington Nephrology Associates prior to receiving the revocation.

_____
Signature of Patient or Patient's Legal Representative

_____ _____
Print Name Date (MM/DD/YY)

_____
If Patient's Legal Representative, State Relationship to Patient

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

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MEDICAL RELEASE AUTHORIZATION AND INSURANCE ASSIGNMENT

I, _____ hereby authorize Washington Nephrology Associates to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I understand and agree that, regarding of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

I request that payment of authorized Medicare benefits be made to Washington Nephrology Associates for any services rendered. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. Myself may revoke this authorization at any time in writing.

I authorize Washington Nephrology to release and/or send medical information regarding my case to other consulting and/or referring physicians.

FINANCIAL RESPONSIBILITY AGREEMENT

I, _____ understand that my insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Washington Nephrology Associates, and that I am still fully responsible for all fees. Should timely payments of this account not be made, I authorize Washington Nephrology Associates to retain the services of an attorney and/or collection agency to assist with the collection of only outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

_____ _____

Signature of Patient Date (MM/DD/YY)

_____

Print Name

Print Form Clear Form