TAMPA BAY NEPHROLOGY ASSOCIATES, PL

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2021 PATIENT REGISTRATION (please print)

Patient's Name: ______________________________________ **Birthdate:**_______________________
Address: ____
City____ **State**_______________ **Zip**________________
Home phone: (______)_________________________ **Social Security#:** ________________________
Gender: Male____ Female____ **Marital Status: Single / Married / Divorced / Widowed**
Cell Phone: (____)_____________________ **Email Address:**___________________________________

Can we text you for appt reminders? Yes / No ***Can we email you appt reminders? Yes / No***

Pt's Employer's Name (If Applicable) ___________________________ **Occupation:**_____________
Address/City/State/Zip: _____________________________________ **Phone: (____)**______________

Primary Care Physician (PCP):____
PCP Phone: (_____)________________ **PCP Fax: (____)**___________________________________
Referred By: ______________________ **Ph: (_______)**_______________ **Fax: (_____)**_____________

Spouse / Guardian or Parent's Name:____________________________ **Ph#: (____)**_____________
Address, City, State, Zip:____

Emergency Contact Name: _____________________________________ ***Ph#:(____)***________________
Relationship To Patient:________________ ***Address, City, State, Zip:***__________________________
Health Surrogate's Name: _______________________ ***Living Will: Yes // No (Give copy if available)***

Patient's Primary Insurance ***(ie: Medicare, or other Private Insurance Company) see copy of card***
Name:___________________________________ **Subscriber ID #:**______________________________
Phone: (_______)_______________________ **Group #:** __________________________________
Name of Insured, (If Other Than Patient): ____

Patient's Secondary Insurance ***(ie: Medicaid, or other Private Insurance Company) see copy of card***
Name: ________________________________ **Subscriber #:** _________________________________
Phone: (_______)______________________ **Group #:** _____________________________________

Pharmacy Information:
Name of Pharmacy: _______________________ **Ph#: (____)**_________ **Fax#: (____)**______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION – **I agree and understand the following:** (1) The insurance policy is a contract between my insurance company and me; (2) I request payment of authorized benefits to the above named medical(s) office on my behalf, for any services provided to me; **it is my responsibility to notify this office of any insurance changes at the time of the visit or I will be responsible for costs due to my error of omission;** (3) I agree to pay for all charges incurred whether or not paid by the above stated insurance; (4) I authorize and direct payment to Tampa Bay Nephrology Associates, PL for the benefits, if any, payable to me under the terms of my insurance company; (5) I may be charged 1.5% interest rate per month on any unpaid balance and I am responsible all costs incurred in the collection of balance; (6) I authorize any holder of medical and other information about me to be released to Health Care Financing Administration, Medicare, its agents, insurance company, third party payers, state medical assistance agency, any other governmental or private payer responsible for paying such benefits, and any information needed to determine these benefits or related services. **By signing this form or giving my verbal authorization via telehealth, I authorize:** (1) my email and cell phone, if indicated above, as a form of communication, (2) a copy of this form can be used in place of the original, (3) I received a copy/or have access to Tampa Bay Nephrology Associates' Notice of Privacy Practice, describing how my health information is used and shared, (4) I will notify the office to reschedule an appointment within 24 hours or I will be charged $25.00. I have read or have been read and agree to the above. ***Valid for 1 year.***

____ ____
Patient Signature **Date**

____ ____
Name of Person Obtaining Verbal Consent via Telehealth **Signature** **Date**

Revised 02/24/21 pab

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