Tarrant Nephrology Associates

1000 W. Cannon Ft. Worth, TX 76104
Revised 7/1/11

Patient: _____ DOB: _____
Last Name First M.I.

SS #: _____Marital Status: _____

Race: circle one below

American Indian or Alaska Native
Asian
Native Hawaiian or Pacific
Black or African American
White
Hispanic
Other race
Other Pacific Islander
Unreported / refused to report

Ethnicity: circle one below

Hispanic or Latino
not Hispanic or Latino
refused to report

Language: circle one below

English
Other
Indian (includes Hindi & Tamil)
Spanish
Russian

Home Address: _____

City: _____ State: _____ Zip:_____

Home #:_____ Cell #:_____ Email: _____

Pharmacy Name: _____ _____ Phone #: _____

Employer Name: _____

Business Address: _____ Business #:_____

Spouse: _____Employer Name: _____

Employer #: _____ Cell #:_____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

NAME OF NEAREST RELATIVE OR FRIEND NOT LIVING AT THE SAME ADDRESS

Name: _____ Relationship: _____ Phone #: _____

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Insurance Information

____CHECK HERE IF YOU HAVE NO INSURANCE COVERAGE (CASH ACCOUNT)

Insurance Carrier #1: _____

Insured Party: _____

ID#: _____ Group/Plan #: _____

Insured Party SS #: _____ Insured DOB:_____

Insurance Carrier #2:_____

ID#: _____ Group/Plan #: _____

Insured Party: _____

Insured Party SS #:_____ Insured DOB:_____

I have received a copy of the Tarrant Nephrology Associates Billing Policy (cash patients) or Patient Billing Instruction (insured patients)

I hereby authorize payment directly to Tarrant Nephrology Associates for medical services rendered. I understand I am financially responsible for all charges not covered by my insurance.

Printed name_____

Signature _____ Date: _____

Tarrant Nephrology Associates

Acknowledgment of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have certain rights to privacy regarding their protected health information. By signing below you, the patient, acknowledge the following regarding the management of your protected health information. Your protected health information will be used to:

- **Conduct, plan and direct treatment by the physicians employed by Tarrant Nephrology Associates and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.**
- **To obtain payment from third party payers.**
- **To conduct normal healthcare operations such as quality assessments and physician certifications.**

By signing below you agree that you have either received or waived your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Tarrant Nephrology Associates has previously released relying on this consent.

Print Patient Name: _____

Do we have permission to:

1. **Leave a message at your home regarding appointments and/or treatments.....__Yes __No**
2. **Leave a message at your place of employment regarding appointments and treatments….__Yes __No**
3. **Leave a name and call back number at your home and place of employment.....__Yes __No**
4. **Mail test results and appointment information to your home address currently on file.....__Yes __No**
5. **Email you at the email address currently on file regarding appointments and treatments..__Yes __No**
6. **Discuss your personal information, including appointment and treatment with someone other than you?..... ……...__Yes __No**

NAME	RELATIONSHIP	CONTACT NUMBER

Patient signature:_____ Date:_____

Notice of Privacy Practices
(Medical)

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

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identified health information used or disclosed by this office in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.**
- **Health operations include the business aspects of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.**

We may also create and distribute re-identified health information about treatment or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and, we are required to honor and abide by that written request, except to the extent that we have already taken actions in relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by its terms. We reserve the right to change the terms of our privacy practices and to make the new policy provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You may recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for information:
Tarrant Nephrology Associates

For more information about HIPPA or to file a complaint:
The U.S. Department of Health and Human Services

Patient Name: _____ Date of Visit: _____ Patient Acct #:_____

Tarrant Nephrology Associates

FINANCIAL POLICY

Thank you for choosing Tarrant Nephrology Associates (TNA) as your health care provider. We are committed to providing you with the best medical care and to build a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. The following information is provided to avoid any misunderstandings or disagreement concerning payment for professional services.

Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

1. **Canceled Appointments**: If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule. This will allows us to provide that time slot to another patient.

2. **Co-pays/Co-insurance** –The patient is expected to present an insurance card at each visit. All co-payments / co-insurance and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

3. **Insurance** – As a courtesy to our patients, we will file claims on all visits and procedures, whether they are delivered in our office or the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to Tarrant Nephrology Associates (that is, the insurance company will pay Tarrant Nephrology Associates directly). You are responsible for payment of all deductibles, co-insurance and non-covered services. Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.

4. **Referrals** – You are required to 1) know whether or not your insurance requires a referral and 2) obtain that referral before you are scheduled to see our physicians. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your covered benefits. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.

5. **No Insurance** – Patients who do not have insurance are expected to pay for all services rendered. We will request a payment for outpatient procedures in advance of having the procedure performed. We understand that individual situations may make it difficult to meet these financial expectations and are happy to discuss other payment arrangements as needed.

6. **Returned Checks** – The charge for a returned check is $30.00 for each returned check and is payable by cash or money order.

7. **Past Due Accounts** – Patients who have not made an effort to make payment arrangements, or have not expressed an interest in meeting their financial obligation to TNA, may be turned over to a collection agency. Patients who have allowed their account to be turned to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by our physicians. If you consistently refuse to pay for services rendered, TNA may choose to cease providing services to you.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Patient Statement:
I have been informed of Tarrant Nephrology Associates financial policy and agree to its terms. If Medicare or my insurance company denies payment, I agree to be personally and fully responsible for payment.

_____
Print Name

_____ _____
Signature Date