Kidney Care and Hypertension Center, LLC
Xinye (Cindy) Wu, MD

49 Veronica Ave Suite 202 Somerset NJ 08873 Tel: (908) 393 2737
10 North Gastone Ave. Suite 101 Somerville NJ 08876 Fax: (908) 393 2738

Welcome Letter

Thank you for choosing Kidney Care and Hypertension Center for your medical care. Please read the following information so that we may make your experience with our practice a positive and productive one. Below is a few office policies:

1**Release of medical information:** you authorize Kidney Care and Hypertension Center, LLC to release your medical records to any physicians, hospitals, or agency involved in your medical care.

2. Prescription refills: Before calling our office for a refill, please check with your pharmacy if any refills are present. For proper medical care, patients must be seen within 12 months to obtain a refill. If your insurance company requests a three-month mail in order, please allow ample time for the order to be received through mail. The office staff will make every effort to refill prescription on the same business day it was requested. Always check with your pharmacy first before picking up your prescription.

3Referrals: Please check with your insurance company and your primary care physician's office whether you need referrals to see a specialist. Failure to provide referral at time of visit may result in charges billed directly to yourself.

4. No Show and Cancellation Fee: A 24-hour cancellation notice is required for all appointments cancellation. We reserve the right to charge a fee for repeated no show appointments.

5Medical Records: Written authorization from the patient/parent or guardian must be obtained to release medical records. At least one week? notice is required to complete your request for medical records. The cost is $1 per page when records are released directly to the patient. There is no charge if records are forwarded directly to a new physician.

6. Payment policy: Co-payments are to be collected at the time services are received. We accept cash, checks and credit cards. **A fee of $35 will be charged for all returned checks.** All medical services provided are directly charged to the patient or responsible party. The patient will be responsible for any balance that is not covered by his/her insurance policy. Private pay and non-insured patients will be asked for payment at the time of service.

7 Office policies subject to change without notice.

I have read and understand the office policy and agree to abide by its guidelines.

Print Patient Name _____

Signature of patient or responsible party _____

Date_____

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PATINENT INTAKE FORM

Last name: _____First Name: _____

Date of birth: _____SSN#: _____

Age: _____ Gender (circle one): Male Female

Home (mailing) address: _____

1st call phone number (cell or home) :_____

2nd call phone number (cell, home or work):_____

Email address (print): _____

Name of primary insurance: _____

Subscriber of primary insurance (circle one) : Self Spouse Parents

Subscriber infor: Name_____DOB_____

SSN: _____Name of employer: _____

Name of Secondary Insurance if you have one:_____

Subscriber of secondary insurance (circle one) : Self Spouse Parents

Subscriber info: Name_____DOB_____

SSN: _____Name of employer: _____

Emergency contact: Name_____Phone: _____

Relationship with you _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payments of benefits, and authorize the use of this signature on all insurance submissions.

By signing this form, I acknowledge that I have access to a copy of the **Notice of Privacy Practices** provided by Kidney Care and Hypertension Center on its website kidneycarenj.com. I have the opportunity to ask any questions about the notice and all my questions have been answered.

Print name:_____Signature: _____

Date: _____

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Somerset, NJ 08873 **Fax: (908) 393 2738**

Your name: _____

Your pharmacy name_____

Allergy to medications:_____

Please list ALL of your medications, vitamins, & supplements

Medication Strength When taken
(example: Aspirin 81mg Once a day)

1_____

2_____

3_____

4_____

5_____

6_____

7_____

8_____

9_____

Please use the back of this paper if you need more space.

Please list all your physicians you would like us to keep in contact with:

Physicians name Specialty Phone Number

1_____

2_____

3_____

4_____

_____

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RECORDS RELASE AUTHORIZATION

I hereby authorize_____to release my medical records.

Patient's Name:_____

Patient's Address: _____

Patient's Date of Birth:_____

Social Security Number: _____

Patient's Signature:_____

Date: _____

Please send records to :

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Comments:
Please send the following record:
_____All record
_____History and Physical
_____Progress notes
_____Consultation letters
_____Medication list
_____Lab result
_____Radiology record
_____Pathology record
_____Echo result
_____Other

Thank you for your prompt response.

Reivesed Jan 2019