KIDNEY SPECIALISTS OF THE PALM BEACHES

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540 West Sagamore Avenue; Suite: E, Clewiston, FL 33440
1100 South Main Street, Belle Glades, FL 33430
120 JFK Drive; Suite 120 Atlantis, FL 33462

Phone (561) 792-5877 *Fax (561) 792-5880*

Consent to Treat

1. I _____ give permission for **Kidney Specialists of the Palm Beaches, LLC** to give me medical treatment.

2. I give permission to **Kidney Specialists of the Palm Beaches, LLC** to obtain information from pharmacies and medication vendors I use.

3. I allow **Kidney Specialists of the Palm Beaches, LLC** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Kidney Specialists of the Palm Beaches, LLC** may have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

4. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my provider.

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature (for children under 18) Date

_____
Print name

DEMOGRAPHIC INFORMATION

(Required By Federal Government)

Please circle the correct answers below and fill in the blanks as necessary:

NAME: _____.

RACE: White Black Asian Other: _____.

ETHNICITY: Non-Hispanic Hispanic.

PREFERRED LANGUAGE: English Spanish Other: _____.

COMMUNICATION PREFFERED: Home Phone Cell Phone US Mail.

SMOKING STATUS: Never Smoked Quit Smoking

Current Occasional Smoker Current Daily Smoker.

MARITAL STATUS: Married Never Married Legally Separated Divorced Widowed Domestic Partner Annulled

PREFFERED PHARMACY: _____.

_____ _____

Signature **Date**

MEDICAL HISTORY

Date: ___/___/_____

Name: _____

Have you had? (Anytime in your life)

Please circle yes or no, if yes, provide the date.

Colonoscopy Yes Date: ___/____/_____ No

Mammogram Yes Date: ___/____/_____ No

Pneumonia vaccine Yes Date: ___/____/_____ No

Flu vaccine Yes Date: ___/____/_____ No

If you are diabetic, have you in the past year had?

1. Diabetes eye exam Yes Date: ___/____/_____ No
2. Diabetes foot exam Yes Date: ___/____/_____ No

PATIENT REGISTRATION

DATE: _____/_____/_____

PATIENT NAME_____ DATE OF BIRTH_____/_____/_____

SEX ___ M ___F E-MAIL_____@_____

ADDRESS: _____

_____

_____

HOME PHONE ( )_____-_____CELL PHONE ( )_____-_____ WORK PHONE ( )_____-_____

BEST TIME AND PLACE TO REACH YOU: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PRIMARY PHYSICIAN NAME: _____

PRIMARY CARE PHYSICIANS OFFICE PHONE ( )_____-_____ FAX ( )_____-_____

IN CASE OF EMERGENCY, CONTACT

NAME _____

HOME PHONE ( )_____-_____

CELL PHONE ( )_____-_____

WORK PHONE ( )_____-_____

RELATIONSHIP _____

NAME: _____

HOME PHONE ( )_____-_____

CELL PHONE ( )_____-_____

WORK PHONE ( )_____-_____

RELATIONSHIP _____

INSURANCE AND BILLING INFORMATION

DATE: _____

PATIENT NAME _____ DATE OF BIRTH _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____

PRIMARY INSURANCE

INSURANCE COMPANY _____ INSURANCE ID/SUSCRIBER # _____ GROUP # _____

INSURANCE COMPANY ADDRESS _____
STREET CITY STATE ZIP

SECONDARY INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ___ YES ____NO

INSURANCE COMPANY _____ INSURANCE ID/SUSCRIBER # _____ GROUP # _____

INSURANCE COMPANY ADDRESS _____
STREET CITY STATE ZIP

_____INSURANCE ASSIGNMENT AND RELEASE

I CERTIFY THAT I (AND /OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. _____ ALL INSURRANCE
NAME OF INSURANCE COMPANY

BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE- NAMED PHYSICIAM MAY USE MU HEALTH CARE INFORMATION AND DISCLOSE SUCH INFORMATION
TO THE ABOVE-NAMED INSURANCE COMPANY AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____MEDICARE/MEDIGAP AUTHORIZATION

MEDICARE NO. _____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS AND, IF APPLICABLE, MEDIGAP BENEFITS, BE MADE EITHER TO ME OR ON MY BEHALF TO _____ FOR ANY SERVICES FURNISHED TO
NAME OF DOCTOR, CLINIC, HEALTHCARE PROVIDER OR SUPPLIER

PERMITTED BY LAW, I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, MY MEDIGAP INSURER, AND THEIR AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES.

_____ _____
SIGNATURE DATE

_____ _____
PLEASE PRINT NAME OF GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO BENEFICIARY

PATIENT CONSENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE MY CONSENT FOR KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUTH ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO). KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC. NOTICE OF PRIVACY PRACTICE PROVIDES A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURE.

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGHNING THIS CONSENT. KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC RESERVES THE RIGHT TO REVISE THEIR NOTICE OF PRIVACY PRACTICES AT ANYTIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO

KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC

11301 OKEECHOBEE BLVD; SUITE 5A, ROYAL PALM BEACH, FL 33411

10151 ENTERPRICE CENTER BLVD; SUITE: 104, BOYNTON BEACH, FL 33437

542 WEST SAGAMORE AVENUE; SUITE: E, CLEWISTON, FL 33440

1100 SOUTH MAIN STREET, BELLE GLADES, FL 33430

205 JFK DRIVE; SUITE B, ATLANTIS, FL 33462

WITH CONSENT, KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC MAY CALL MY HOME OR OTHER ALTERNATIVE LOCATION AND LEAVE A MESSAGE ON VOICE MAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALLS PERTAINING TO MY CLINICAL CARE, INCLUDING LABORATORY RESULTS AMONG OTHERS.

WITH THIS CONSENT, KIDNEY SPECIALIST OF THE PALM BEACHES, LLC MAY MAIL TO MY HOME OR OTHER ALTERNATIVE LOCATIONS ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, SUCH AS APPOINTMENT REMINDER CARDS AND PATIENTS STATEMENTS AS LONG AS THEY ARE MARKED PERSONAL AND CONFIDENTIAL.

WITH THIS CONSENT, KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC MAY E-MAIL TO MY HOME OR OTHER ALTERNATIVE LOCATION ANY ITEMS THAT ASSIST THE PTACTICE IN CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, SUCH AS APPOINTMENTS REMINDER CARDS AND PATIENTS STATEMENTS.

I HAVE READ THE RIGHT TO REQUEST THAT KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC RESTRICTS HOW IT USES OR DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRYING OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THE PRACTICE HOWEVER IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF IT DOES, IS BOUND BY AGREEMENT. BY SIGNING THIS CONSENT FORM, I AM CONSENTING TO KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC USE AND DISCLOSURE OF MY PROTECTED HEALTHINFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURE IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC MAY DECLINE TO PROVIVE TREATMENT FOR ME.

PATIENT'S NAME (PLEASE PRINT)

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

PLEASE PRINT LEGAL GUARDIAN NAME (IF OTHER THAN PATIENT)

PEOPLE WE CAN DISCUSS YOUR CARE WITH ARE...

PATIENT NAME: _____

1. NAME: _____

   RELATIONSHIP: _____

   PHONE: ( ) _____ - _____

   CELL: ( ) _____ - _____

2. 2. NAME: _____

   RELATIONSHIP: _____

   PHONE: ( ) _____ - _____

   CELL: ( ) _____ - _____

3. 3. NAME: _____

   RELATIONSHIP: _____ _____

   PHONE: ( ) _____ _____

   CELL: ( ) _____ - _____

4. 4. NAME: _____

   RELATIONSHIP: _____

   PHONE: ( ) _____ - _____

   CELL: ( ) _____ - _____

DID YOU LIST EVERYONE THAT YOU WOULD ALLOW US TO SPEAK WITH? YES or NO

_____ _____

Signature Date

CONSENT FOR RELEASE OF MEDICAL RECORDS

DATE: _____

TO: _____

_____

_____

I _____ HEREBY REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

KIDNEY SPECIALISTS OF THE PALM BEACHES, LLC

11301 OKEECHOBEE BLVD; SUITE 5A, ROYAL PALM BEACH, FL 33411
10151 ENTERPRISE CENTER, SUITE: 104, BOYNTON BEACH, FL 33437
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PHONE: (561) 792-5877 FAX (561) 792-5880

FROM _____ TO _____

_____ SIGNATURE

_____ PRINT NAME

_____ DATE OF BIRTH

_____ WITNESS

_____ **LABS** _____ **NOTES** _____ **DIAGNOSTIC TESTING**

CURRENT MEDICATION LIST

NAME: _____ DATE: _____/_____/_____

PHARMACY NAME: _____

ADDRESS: _____

_____

PHONE: ( ) _____-_____ FAX: ( ) _____-_____

MEDICATION	STRENTH	DIRECTIONS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

ALLERGIES:

_____ _____ _____

_____ _____ _____