HYPERTENSION NEPHROLOGY ASSOCIATES, PC - REGISTRATION FORM

(Please Print)

Today's date:	Referring Provider:
PCP:	PCP PHONE:

PATIENT INFORMATION

Suffix:	Last Name:	First:	Middle:
Birth Date:	Age:	Sex:	SS#:
Marital Status:	Ethnicity:	Preferred Language:	Race:
Address:		Cell Ph:	Home ph :
Work Ph:	Occupation:	Employer:	
Email (For secure access to your records)(1):		**Email (For secure access to your records)(2):**	
Pharmacy:		**Phone:**	**City:**
Lab:		**Phone:**	**City:**

INSURANCE INFORMATION

Person Responsible for bill:	Address:	Phone:	
Employer:	Employer ph #:		
Name of primary insurance:	Subscriber's name:	Subscribers SS#:	Subscriber's Birth Date:
Group #:	Policy #:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	
Name of secondary insurance:	Subscriber's name:	Subscriber's SS#:	Subscriber's Birth Date:
Group #:	Policy #:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (primary):	Relationship to patient:	Home ph:	Work ph:
Name of local friend or relative (primary):	Relationship to patient:	Home ph:	Work ph:

The above information is true to the best of my knowledge. I authorize the release of any medical information, including information to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I authorize payment directly to Hypertension Nephrology Associates, PC for services rendered. I understand that I am responsible for services performed without a valid HMO authorization form from my primary care physician, if my insurance does not guarantee coverage and/or payment. I further understand that I am responsible for payment of services rendered whether denied by my insurance company or in the case I have no insurance coverage.

Patient/Guardian signature *Date*

ELECTRONIC MEDICATION TRANSMISSION AUTHORIZATION

Your signature below authorizes HNA to download your medication history from the national SureScripts database and submit medication requests to the pharmacy using SureScripts clearinghouse.

Patient/Guardian signature *Date*

Laboratory Services Notice: ***HNA patients utilizing Biotech Laboratories located in the main HNA office at 18302 Middlebelt Road, Livonia, MI 48152, have the option to seek laboratory services elsewhere. Being a patient of HNA does NOT require the patient to use this facility for laboratory testing.***

Privacy Notice: ***HNA is required by law to maintain confidentiality of patient health information (PHI). HNA works hard to ensure PHI is kept confidential and will NOT share PHI with individuals/entities not involved in services provided by HNA. (For a copy of HNA's Privacy Practices please contact our office at (248) 478-1500.) HNA will NOT distributed your email address for any reason.***

Authorization for Release of Medical Records

I, _____, authorize the practice of Hypertension Nephrology Associates, P.C. and its Physicians, agents and employees to provide for photocopy or to allow for my medical records to be inspected or reviewed for the express purpose of:

1.) Management and coordination of clinical services and care.
2.) Benefit and payment determinations.
3.) Quality assurance and or quality improvement activities.
4.) Personal use.

I authorize the release of the medical record information specified below to Hypertension Nephrology Associates, P.C. located at 18302 Middlebelt Rd., Livonia, MI 48152 for the purpose indicated above. The following medical information is the subject of this authorization:

- ☐ The entire medical record and history of care.
- ☐ Portions of the medical record for the period _____ to _____
- ☐ Specific diagnosis:_____
- ☐ Office and progress notes for the period _____ to _____
- ☐ Hospital admissions and discharge summaries.
- ☐ Hospital notes.
- ☐ Operative reports, notes, findings, etc.

I understand and agree that my patient records released may include:

- Alcohol and/or drug abuse information protected under the regulation in 42 code of Federal Regulations, Part 2.
- Psychological and/or social service information.
- Information about HIV, AIDS, or ARC protected under MCL 333.5131 or any communicable disease.

This authorization is valid for a maximum of 2 years from the date of the signature below or until expressly revoked by the undersigned.

_____ _____
Signature of Patient/Patients Legal Representative Date

_____ _____
Patient Caregiver Patient Date of Birth

Hypertension Nephrology Associates, P.C. Acknowledgement of Receipt of Practices Privacy Notice

I acknowledge that I have received and/or reviewed the notice of the Privacy Practices of this office. I am aware that this notice of the Privacy Practices is posted in the office where I can review it if I desire.

_____ _____

Patient, Patient Representative, Parent or Legal Guardian Date

_____

Patient Care Giver

Documentation of "Good Faith Effort"

Patient Name:_____

The patient presented for the treatment on this date and was provided HNA's Privacy Notice. A good faith effort was made to obtain written acknowledgement of receipt. A written acknowledgement was not obtained because:

_____ Patient refused to sign, with the reason:_____

_____ Patient is unable to sign due to:_____

_____ There was a medical emergency preventing a timely signature, and an attempt will be made to obtain acknowledgement later.

_____ Other:_____

_____ _____

Signature of HNA Representative Date

Patient Request to Release Protected Health Information

Dear Patient, you have requested all or part of your protected health information be provided to another provider or entity indicated below. Michigan law required we have your signed authorization to release this information. You must complete this form prior to our release of the needed information.

Patient Name_____ Date of Birth:_____

SSN:_____ Doctor's Name:_____

Practice Name: HYPERTENSION NEPHROLOGY ASSOCIATES, PC

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:
Name:_____(FAMILY/FRIEND)_____
DOB:_____ City, State: _____ Zip Code: _____
Phone: ( )_____Fax: ( )_____

This request and authorization applies to health care information relating to the following treatment and condition for:

Dates of Treatment: _____

☐ All health care information available at this practice.

☐ Other:

The above information may be released by: Mail ☐ Fax ☐ Phone ☐ Other ☐

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave my permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement, I can:

- *Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Healthcare Information" or*

Write a letter to the doctor or practice. If I write a letter, it must state that I want to cancel my authorization to disclose my healthcare information. My letter must include the name or the specific identification of the person(s) that I no longer want to receive information. I (or authorized representative/care giver) must sign and date the letter.

Once my doctor gives out the information that I want to release, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or State privacy laws may no longer protect the information.

_____ _____
Signature of patient/patients authorized representative Date signed

_____ _____ _____
Parent, legal guardian, caregiver Relationship Date signed

Hypertension Nephrology Associates, PC

Financial Policy

1. **PAYMENT. PAYMENT IS EXPECTED AT THE TIME OF VISIT.** Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service. **REFILL REQUESTS WILL BE DENIED UNTIL PAYMENT IS MADE ON OUTSTANDING BALANCES.**
2. **SELF-PAY.** Self-pay patients are expected to pay for service in FULL at the time of the visit. **35% discount will apply to full, self-pay payments received at the time of service.** Your signature below indicates you are not eligible for Medicare, Medicaid or Tricare if you are a Self-Pay/Cash Pay patient.
3. **INSURANCE**. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS.** If you have insurance we will send all claims to your insurance first. Please remember that we are a business providing a service. Our agreement to accept your insurance is a "value adding" service we provide to our customers. Your insurance is a contract between YOU and the insurance company. Payment will come from either you, your insurance, OR BOTH in the case of deductibles and copays; ultimately, you are responsible for payment. If your insurance company does not pay the practice within a reasonable, and contractually agreed upon time, you may be billed for the services we provided to you. If we later receive payment from your insurance we will refund you any overpayment you made. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. **Many web sites have erroneous information and are NOT a guarantee of coverage.**
4. **REFERRALS.** Certain health insurances (HMO, PPOs, etc.) require that you obtain a referral from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral, you are responsible for obtaining it. Alternative payment arrangements or rescheduling your appointment may be necessary if not obtained.
5. **ADDITIONAL FEES**
    1. **RETURNED CHECKS** will incur a **$35.00** service charge. You will be asked to bring in cash, certified fund, money order, or credit card to cover the amount of the check plus the $35 service charge.
    2. **LATE FEES.** A late fee of $10.00 will be added to balances not paid by the due date indicated on your billing statement.
    3. **COLLECTION FEES.** A fee of $10.00 will be added to all balances forwarded to collections. In addition, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the account balance, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.
    4. **MISSED APPOINTMENTS.** From the moment you schedule your appointment we incur costs to provide care to you as a customer. A $20.00 charge is applied to your account for missed appointments (aka, "No Show").
    5. **FORM FEES.** There may be a fee charged for the completion of forms (example: Family Medical Leave Act forms).
    6. **MEDICAL RECORD COPIES.** We charge for copies of medical records; Rates listed below are acceptable based on Michigan state law, Medical Records Access Act 47 of 2004, 333.23269 Section 9. HNA reserves the right to change rates without notice to outside parties within compliance of the law.
6. **RELEASE OF INFORMATION.** I hereby authorize and direct Hypertension Nephrology Associates, PC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
7. **REFUNDS.** In the event of an overpayment to our practice, your claim will be investigated and a refund will be issued accordingly.

I have read and understand the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time-to-time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print the name of the patient