

*Demographic Update & Office Policies*

**UPON ARRIVAL** CHECK IN WITH THE RECEPTIONIST. PRESENT YOUR INSURANCE CARD AND PICTURE ID. IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH THE CORRECT INFORMATION TO BILL YOUR INSURANCE.

**CO-PAYS WILL BE COLLECTED AT THE TIME OF THE VISIT**

1. **INSURANCES** YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS AND COVERAGE. WE WILL FILE TO YOUR PRIMARY AND SECONDARY INSURANCE.
2. **HMO INSURANCES** **YOUR REFERRAL OR AUTHORIZATION IS YOUR RESPONSIBILITY.** PLEASE MAKE SURE YOUR AUTHORIZATION IS UPDATED IN ORDER TO AVOID BEING RESCHEDULED OR BILLED.
3. **PRESCRIPTIONS** Please make sure you get any new or refill request at the time of your appointment
4. **\$25.00 CHARGE** for no shows & same day cancellations.
5. **PRIMARY CARE PHYSICIAN** You will need a PCP to render your general medical care
6. **WE ARE NOT RESPONSIBLE** for services and charges incurred outside this office. (for example, blood work, prescriptions, All Labs, Ultra sounds, X-rays, Scans, etc.)
7. **APPOINTMENT REMINDER** calls and emails are a courtesy only. It is your responsibility to remember the date and time.
8. **YOU MUST** give permission in writing in order for us to discuss you medical condition with your family, friends and co-workers.
9. *Attorney and insurance company copy fee charges are \$1 per page; payment must be made in advance. No charge for records being faxed to another healthcare facility.*

**COLLECTION PROCEEDINGS**

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO KIDNEY & HYPERTENSION SPECIALISTS OF CENTRAL FLORIDA PA. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY/ALL SERVICES RENDERED TO ME. STATEMENTS FOR ANY BALANCE DUE WILL BE MAILED EVERY 30 DAYS. SHOULD PAYMENT NOT BE RECEIVED FOR ANY/ALL SERVICES, COLLECTION PROCEEDINGS MAY BEGIN. I UNDERSTANT THAT A COLLECTION FEE OF 30% WILL BE ADDED TO MY ACCOUNT IF TURNED OVER TO COLLECTIONS.

**CONSENT FOR EVALUATION AND TREATMENT**

THE UNDERSIGNED HEREBY CONSENTS TO THE EVALUATION AND/OR TREATMENT AS IS DEEMED NECESSARY BY THE TREATING PHYSICIAN.

\_\_\_\_\_  
PATIENT/GUARDIAN

\_\_\_\_\_  
DATE



**Kidney & Hypertension Specialists of Central Florida, PA**  
**Adnan Ahmed MD FACP**  
**Board Certified Internal Medicine and Nephrology**  
**INSURANCE INFORMATION**

PRIMARY INSURANCE

Secondary insurance

Guarantors Name: \_\_\_\_\_

Guarantors Name: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #:(\_\_\_\_\_) \_\_\_\_\_

Phone #:(\_\_\_\_\_) \_\_\_\_\_

Policy # : \_\_\_\_\_

Policy # : \_\_\_\_\_

Group # : \_\_\_\_\_ Plan: \_\_\_\_\_

Group # ; \_\_\_\_\_ Plan: \_\_\_\_\_

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SIGNATURES REQUIRED

**Financial Policy**

- Patients are responsible for payment of services at the time they are received. We wish to limit billing for small amounts such as co-payments due to the costly nature of sending statements.
- When a patient's insurance company requires specialist visit to be pre authorized by a primary care physician **it is the responsibility of the patient to obtain the authorization prior to their appointment in our office. By contract with the insurance company we are unable to see patients without this authorization.**
- **There is a \$35.00 charge for all checks returned for insufficient funds.**
- **We must be advised by the patient of all changes in their insurance coverage or other information affecting services billed by our office. If we are not advised of changes and consequently are unable to obtain payment for our services from the insurance company, the patient will be held responsible for that payment.**
- **Patients will be held responsible for any services considered by their insurance company to be "NOT COVERED" or "NOT MEDICALLY NECESSARY".**
- **We advise our patients to be personally familiar with their insurance coverage and benefits to avoid confusion and unexpected financial inconveniences.**

**I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY**

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

**I consent to treatment** as necessary by Adnan Ahmed, MD to the patient named above, including but not restricted to whatever services, medications, performance of operations and conduct of lab, x-ray and other diagnostic procedures.  
I authorize direct payment by my insurance company (companies) for surgical/medical benefits to Adnan Ahmed, MD for services rendered by him or a provider under his supervision, and authorize him to release any medical or incidental information that may be necessary for either medical care or benefit coverage to said insurance company (companies).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Kidney & Hypertension Specialists of Central Florida, PA**  
**Adnan Ahmed MD FACP**  
**Board Certified Internal Medicine and Nephrology**

**RELEASE OF CONFIDENTIAL INFORMATION**

This is to inform you that, for your protection, it is our office policy not to release any information regarding your medical history to anyone without your permission. This includes spouses and parents of minor children, regardless of who is responsible for the payment.

If it is your desire that we be able to discuss your medical case with someone other than yourself please indicate in the appropriate box below. Please list the names of those individuals in the space provided.

\_\_\_\_\_ I **do NOT** wish you to discuss my medical case with anyone besides myself.

\_\_\_\_\_ **You have** my permission to discuss my medical case with the following individual (s)

Name	Relation to patient	Phone
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Name	Relation to patient	Phone
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Name	Relation to patient	Phone
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Please **Initial** next to all the methods you would prefer to receive information about your appointments, Labs, procedures, account balances, or any health information. Please keep in mind that you are authorizing us to release information about your medical condition during this process.

_____ Answering Machine (home)	_____ Voice Mail (work/cell)
_____ Message with workplace personnel	_____ Message with family member (s)
_____ Email Address	

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

**Kidney & Hypertension Specialists of Central Florida, PA  
Adnan Ahmed MD FACP  
Board Certified Internal Medicine and Nephrology**

**Acknowledgement of Receipt of Notice of Privacy Practices**

**I acknowledge that I have received and understand Kidney & Hypertension Specialists of Central Florida, PA's Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that Kidney & Hypertension Specialists of Central Florida, PA may update its Notice of Privacy Practices at any time and that I may receive an updated copy of Kidney & Hypertension Specialists of Central Florida, PA's Notice of Privacy Practices by submitting a request in writing for a current copy of Kidney & Hypertension Specialists of Central Florida, PA's Notice of Privacy Practices.**

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If completed by patient's personal representative, please print name and sign below.

\_\_\_\_\_  
Printed Patient Personal Representative Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient Personal Representative Signature

\_\_\_\_\_  
Date

**For Kidney & Hypertension Specialists of Central Florida, PA Official Use Only**

Complete this form if unable to obtain signature of patient or patient's personal representative.

Kidney & Hypertension Specialists of Central Florida, PA made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reasons documented below:

- Patient or patient's personal representative refused to sign
- Patient or patient's personal representative unable to sign
- Other \_\_\_\_\_

\_\_\_\_\_  
Employee Name (printed)

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Kidney & Hypertension Specialists of Central Florida, PA  
Adnan Ahmed MD FACP  
Board Certified Internal Medicine and Nephrology

I Authorize Kidney & Hypertension Specialists of Central Florida P.A. **and its agents/employees to (Please initial), \_\_\_\_\_ RELEASE or \_\_\_\_\_ OBTAIN** information and copies of records pertaining to my medical care and treatment. **By state law you must be advised that the information you authorize for release may include information that could be considered information about communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome).** In addition, it may include information about mental health, or drug, substance or alcohol abuse.

**Release to:**

Kidney & Hypertension Specialists  
of Central Florida PA  
306 Mohawk Road  
Clermont FL 34715  
P 352-394-1361  
F 352-394-1362

**Release from:**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City State Zip**

**Information to be released:**

\_\_\_\_\_ 1 year of most recent pertinent information (Notes, Labs, Imaging, Special Tests)

**Purpose for which request is being made. Please check one of the following:**

\_\_\_ Physician \_\_\_ Medical Claims Processing \_\_\_ Self \_\_\_ Attorney \_\_\_ Other

**My Rights:**

I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

**This authorization will expire in 12 months or on \_\_\_\_\_.**

\_\_\_\_\_  
Signature of Patient/Patient's Authorized Representative

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
Date

**CONFIDENTIALITY NOTICE:**

This facsimile transmission and/or the documents accompanying it may contain confidential information belonging to the sender which is protected from unauthorized use.

Alcohol, drug abuse and psychiatric information, if present, was disclosed from records whose confidentiality is protected by Federal regulations (42CRF, Part II) prohibits making any further disclosure of it without the specific written authorization of the patient, or as otherwise permitted by such regulations.

HIV testing, ARC and or AIDS diagnosis information, if present, has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without a specific written consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for the release of medical or other such information is NOT sufficient for this Purpose.

This information is intended for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this transmission in error, immediately notify us by telephone to arrange for return of the document.



**Kidney & Hypertension Specialists of Central Florida, PA**  
**Adnan Ahmed MD FACP**  
**Board Certified Internal Medicine and Nephrology**

**ATTENTION: PLEASE READ**

**COPY FEES & PROCEDURES FOR REQUESTING MEDICAL RECORDS**

- If we are faxing to another physician, the first copy is complimentary. Otherwise there is a charge.
- Copy fee charges are \$1.00 per page. Payment is due at the time of pick-up. No records will be released without payment. This includes records for attorneys and life insurance companies etc.
- Proper Identification **MUST** be shown in order to receive medical records, ie. Driver's license.
- Authorization **MUST** be signed, dated and filled out. This includes spouses and family members.
- You will be contacted by phone within (7) seven business days for pick up.
- There is no charge for records being faxed or mailed to another healthcare facility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Pick Up Date

\_\_\_\_\_  
Fee Amount

\_\_\_\_\_  
Initial