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

PATIENT REGISTRATION FORMS

PLEASE PROVIDE INSURANCE CARD(S) & DRIVERS LICENCE TO RECEPTIONIST FOR COPYING

PATIENT INFORMATION

Date Registered_____ Date Updated_____

Name:_____DOB: _____Age_____
First **MI** **last**

Home Address_____ City: _____State:_____ ZIP_____

Home Phone (____)_____ Work Phone (_____)_____Ext #_____

Employer_____

Social Security #_____ Marital Status: Married ☐ Widow ☐ Divorced ☐ Single ☐

Spouse's Name:_____ DOB_____ Social Security #_____

Employer_____ Work Phone #_____

Emergency Contact: _____Phone (_____)_____Relationship_____

Address:_____City:_____State:_____Zip:_____

Primary Care Physician:_____ Phone #:_____Fax:_____

Referred BY: _____ Phone:_____ Fax:_____

GUARANTOR INFORMATION (PERSON HOLDINGINSURANCECOVERAGE)

Name:_____DOB_____

Social Security#_____ Relationship to Patient_____

Local Address: _____ City:_____State:_____

Employer:_____ Phone #_____

If your insurance company requires you to use a particular laboratory, please indicate the name of the lab so that you do not incur extra charges,If you are not sure about this information please contact your company prior to allowing us to send you to any lab.

_____ _____

Name of Laboratory Patient Signature Date

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INSURANCE INFORMATION

PRIMARY INSURANCE

Guarantors Name:_____

Name of Insurance:_____

Address:_____

Phone #:(____)_____

Policy # :_____

Group # :_____Plan:_____

Secondary insurance

Guarantors Name:_____

Name of Insurance:_____

Address:_____

Phone #:(_____)_____

Policy # :_____

Group # ;_____Plan:_____

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 of benefit coverage to said insurance company (companies).

_____ _____
Patient Signature Date

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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
Name	Relation to patient	Phone
Name	Relation to patient	Phone

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

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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

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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:
_☐_ 1year 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 NOTCE:
This facsimile transmission and/or the documents accompanying it may contain confidential information belonging to the sender which is protected form 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.

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NO SHOW or LATE CANCELLATION FEE

Please be advised that **effective immediately**, you **will** be charged ***$50.00*** for a ***No show*** or ***missed appointments*** or a ***late cancellation fee***. $50 charge for New Patient missed appointment.

To avoid this fee, you must either **reschedule or cancel** your appointment **twenty four (24) hours in advance.**

I understand **that I will be charged for *No show* or *missed appointments* or a *late cancellation fee* in the amount of $50.00.**

This fee will be collected prior to being seen by the Doctor at your next scheduled appointment.

_____ _____

Print Name Signature

_____ _____

Personal Representative Signature

Date _____

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ATTENTION: PLEASE READ

COPY FEES & PROCDURES 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