MERCER KIDNEY INSTITUTE

PATIENT REGISTRATION FORM

(Please print clearly)

Last Name ______________________ MI ______ First Name ______________________

Date of Birth ________________

Home Address ____
Street *City* *State* *Zip*

Mailing Address if different ____
Street *City* *State* *Zip*

Home Phone ______________ Work Phone ______________ Other/Cell Phone ______________

Gender:	**Are you a veteran?**	**Preferred method of Contact**
☐ Male ☐ Female	☐ Yes ☐ No	**1. Home Phone or** **2. Cell Phone**
Marital Status:	**Race:**	**Primary Language:**
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner ☐ Other:_________	☐ White ☐ Black / African-American ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race ☐ Other: _______	☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other:___________

How did you hear about our office? ____

Can we call you to remind you of your appointments?
☐ Yes ☐ No

Employment Information:

Employer Name: ______________________________

Employer Address ____
Street *City* *State* *Zip*

Responsible person: (if different from patient)

Last Name ______________________ MI ______ First Name ______________________

Date of Birth ______________________ Telephone # ______________________

Address____
Street *City* *State* *Zip*

Relationship to patient____

Primary Language:__________________

Person to contact in case of emergency:

Name ______________________________ Telephone # ______________________

Relationship to patient ____

MEDICAL INSURANCE INFORMATION

Name of Insurance ____

Member ID number ______________________ Group # ______________________

Name of Subscriber ______________________________________

Employer ______________________________________

Relationship to Patient: □ Parent □ Spouse □ Partner □ Other

Address (if different from patient) ______________________________________
Street *City* *State* *Zip*

Authorization and Consent

1. I request care from Mercer Kidney Institute for treatment of my medical care. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:
Mercer Kidney Institute receives payment for patient care from insurance companies, Medicare, and/or other third party programs.

1. I agree to have my insurance company, Medicare, or other third party payment program make payments directly to Mercer Kidney Institute.
2. I agree to let my doctor(s) and/or Mercer Kidney submit claims and required treatment information to my insurance company, Medicare, or other third party payment program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company, Medicare, or third party payment program.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

Signature of the patient (or person authorized to sign for patient) ______________________________

Relationship to Patient ______________________________ Date ______________________

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Authorized Staff Signature **Date**

Special Note about Mental Health Benefits:

If you are using your health insurance benefits to pay for mental health treatment, and/or substance abuse treatment, your insurance company will need some information from your clinician(s). If you are going to receive mental health care as an outpatient, your insurance company may have limits on the number of visits for which it agrees to pay. We ask you to remain informed of your specific plan's mental health benefits. The information which insurance companies require from us for initial sessions is limited in its scope (i.e. diagnosis, type of treatment). However, if your treatment is to go beyond those initial sessions authorized by your insurance company, then additional information will need to be given to your insurer. This additional information allows your insurer to determine if the treatment is medically necessary.

Signature of the patient (or person authorized to sign for patient) ______________________________

Relationship to Patient ______________________________ Date ______________________

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Authorized Staff Signature **Date**