Nephrology Associates of Dayton Inc. *Patient Information*

Dr. Klein Dr. Oxman Dr. Doerr Dr. Kaufhold Dr. Jackson Dr. Eze Dr. Ammula Dr. Lovekar Dr. Patel

PATIENT INFORMATION – PLEASE FILL OUT ALL INFORMATION COMPLETELY

Patient Name (First Middle Last)			**Home Phone ( )**
Home Address			**Cell Phone ( )**
City **State** **Zip**			**Work Phone ( )**
DOB _____/_____/_____	**SSN - -**	**Race**	**Marital Status**
Employer			**Business Phone ( )**
Spouse's Name			**Spouse's Employer**
Spouse's DOB _____/_____/_____			**Spouse's SS # - -**
Emergency Contact Other than Home Number: Name:			**Phone Number ( )**
Family Physician			**Phone number ( )**
Referring Physician			**Phone Number ( )**

INSURANCE INFORMATION – MUST BE FILLED OUT COMPLETELY

Primary Insurance	**Effective Date**
Policy Holders Name	**ID #** **Group #**
Secondary Insurance	**Effective Date**
Policy Holders Name	**ID #** **Group #**
Tertiary Insurance	**Effective Date**
Policy Holders Name	**ID #** **Group #**

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY Nephrology Associates of Dayton, Inc.

I understand that payment of charges is due at the time of service unless other definite arrangements have been made prior to treatment. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO Nephrology Associates of Dayton, Inc. SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

_____ _____

SIGNATURE DATE

***** FOR FUTURE USE ONLY *****

I AGREE THAT THE ABOVE INFORMATION IS CURRENT AND ACCURATE, AND THAT I HAVE REVIEWED IT COMPLETELY!

_____ INITIAL	_____ DATE	_____ INITIAL	_____ DATE	_____ INITIAL	_____ DATE
_____ INITIAL	_____ DATE	_____ INITIAL	_____ DATE	_____ INITIAL	_____ DATE
_____ INITIAL	_____ DATE	_____ INITIAL	_____ DATE	_____ INITIAL	_____ DATE

OVER

Nephrology Associates of Dayton, Inc.
Payment and Dismissal Policy

Thank you for choosing us as your specialty care provider. We are committed to providing you with the highest quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed these policies. Please read this carefully, ask us any questions you may have, sign and date in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans including Medicare and Medicaid. Please check with your insurance company if you are unsure if we are providers under your plan. Knowing your insurance benefits is your responsibility.
2. **Co-payment.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. A $15.00 fee will be assessed to your account if we have to bill you for your copay, unless prior arrangements have been made with the billing department.
3. **Proof of Insurance.** You must complete our patient information form before seeing the doctor. You must also provide us with your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all charges incurred.
4. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claim paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Failure to do so will result in you being 100% responsible for charges incurred. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Coverage Changes.** If your insurance changes, please notify us immediately so we can make appropriate changes to help you receive your maximum benefits.
6. **Referrals.** It is your responsibility to know if you need a referral from your primary care physician to see a specialist. You must obtain and bring the referral with you to your visit or make arrangements with your primary care physician to have it faxed to our office. If your visit is denied due to lack of referral, you will be responsible for charges incurred.
7. **Dismissal from practice.** There are several reasons we may dismiss you as a patient from our practice.
   - A) **Non-payment.** If your account is over 90 days past due, you will receive a final statement giving you 15 days to pay your account or to arrange payment. Failure to do so will result in your account being turned over to a collection agency and possible dismissal from the practice.
   - B) **Non-compliancy**. If you fail to comply with a recommended plan of care, including subsequent appointments.
   - C) **Abuse.** If you, a family member or other display any verbal abuse, disruptive or violent behavior towards any staff member or physician.

If you are dismissed from the practice, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis. You will NOT be dismissed based on ethnicity, gender, religion or age. Our practice is committed to providing the best treatment to our patients. Thank you for reviewing our payment policy. If you have any questions, do not hesitate to ask one of our staff.

I have read and understand the payment and dismissal policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**