JACKSONVILLE NEPHROLOGY
Kidney Diseases and Hypertension

New Patient Form

PATIENT INFORMATION		
Name (First, Middle Initial, Last)	DOB	Birth Gender
Mailing Address	City, State, Zip	
Home Phone / Cell Phone		Preferred contact for appointment reminders? SELCECT
Employer Name		Work Phone
Primary Care Provider		☐ None
Preferred Language	Marital Status	
Ethnicity SELECT	Race	

PATIENT PORTAL
Our Patient Portal provides you access to your medical records 24/7. You can view results, request prescription refills, connect a health tracker device, pay a balance and schedule your next appointment. To activate, provide a non-work email address.
Non-work Email Address:

EMERGENCY CONTACT		
Best person to contact in case of emergency. No medical information released to this individual.		
Contact Name	Phone Number	Relationship to Patient

PREFERRED PHARMACY	
Pharmacy Name	Pharmacy Location

MEDICAL INSURANCE (Please present your ID and insurance card to the Front Desk)		
PRIMARY Insurance Carrier Name	Policy Number/Member ID	Group Number
Insured Name	Insured DOB	Patient Relationship to Insured ☐Self ☐Spouse ☐Dependent
Insurance Carrier Address		Phone
SECONDARY Insurance Carrier Name	Policy Number/Member ID	Group Number
Insured Name	Insured DOB	Patient Relationship to Insured ☐Self ☐Spouse ☐Dependent
Insurance Carrier Address		Phone

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TEXT MESSAGE ALERTS

I authorize Jacksonville Nephrology to send SMS text message alert reminders on my provided cell phone number. I understand that I may receive alerts regarding appointment reminders, check in completion, missed appointment notifications, account balance or other similar messages. By accepting these terms, I acknowledge ownership of the listed cell phone number and in the event that my cell phone number changes I will inform Jacksonville Nephrology immediately. Text message rates may apply.

Privacy disclaimer: ***Text messaging is provided as a service. Your information will not be shared or distributed in any way.***

Signature of Patient:_____Date:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with the federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA) of 1966, in order for your physician or the staff at Jacksonville Nephrology PA to give copies of and/or discuss your condition/exam/procedures/results with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. I authorize Jacksonville Nephrology PA to release any and all information (including verbal information, copies of results, appointment information) concerning my medical care to the following individual(s):

☐ You may release medical information as described above to my listed **Emergency Contact**.

☐ **I DO NOT** authorize Jacksonville Nephrology PA to release any information concerning my care to any individual.

Name:_____Relationship:_____Phone Number:_____

Name:_____Relationship:_____Phone Number:_____

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Right with detailed information about how Jacksonville Nephrology may use and disclose my protected health information. I understand Jacksonville Nephrology PA reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Jacksonville Nephrology PA any and all right, which I have against insurance companies or third party payers, for payment of charges for services provided by Jacksonville Nephrology PA to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible.

I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Jacksonville Nephrology PA***. It is our policy that any insurance copayments and deductibles or any balance of a bill owed by those without insurance is due at the time of service.*** Returned payments are subject to a $35 fee.

Signature of Patient:_____Date:_____