South Florida Nephrology Consultants

Syed J. Hashmi, M.D. **Joanna M. Rodriguez, M.D.** **Nancy M. Tran M.D.**
Julio C. Vijil, M.D., M.P.H. **Neil J. Weiner, D.O.**
Board Certified, American Board of Internal Medicine
Board Certified, American Board of Nephrology

Beth L. Fromkin, M.D.
Board Certified, American Board of Nephrology

Patient Registration

Patient name _____ Male Female

SS#_____ Date of Birth_____ Married Single Other___

Address_____ Zip_____

Home Phone_____ Cell Phone_____

Patient e-mail address_____

Race: Asian African American Pacific Islander White Other Decline

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Primary Care Physician Name_____ Phone_____

Pharmacy_____ *Phone_____

Our office offers electronic prescribing, if available do you authorize E-prescribing? Yes No

Do you authorize the physician to view your Rx E-prescribing history? Yes No

Signature: _____ Date:_____

Emergency contact_____ Phone number_____

Relationship_____

How did you learn about South Fl. Nephrology Consultants: Friend/Family Internet Insurance

Doctor Referral _____

How will you be paying for today's bill? Self pay Insurance Worker's compensation claim

I will be paying the full bill/ co-pay today using: Cash Debit card Credit card Check

Insurance Information: Primary Policy Holder_____

Member ID_____ SS#_____ DOB_____

Relationship to subscriber: Self Spouse Child Other_____

Do you have insurance with more than one Health Plan? Yes No

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Financial Policy

Insurance: Insurance is a contract between you and your insurance. We are NOT a party to this contract, in most cases. We will bill primary and secondary contracted insurance companies only. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility.

Payment option if you have **NO** insurance or insurance company we **DO NOT** accept: You choose to pay by Cash, Credit, Debit card or Check the day services are rendered.

I hereby authorize direct payment of medical benefits to South Florida Nephrology Consultants for activities rendered by the physician. I understand that I am financially responsible for any balance not covered by insurance. I certify that I am responsible for health insurance co-pay and co-insurance. I certify that all information is correct and authorize South Florida Nephrology Consultants to release any information for either medical care or in processing application for financial benefits. By executing this agreement you are agreeing to pay for all services that are rendered.

Patients name (please print)_____

Responsible party (If not patient):_____

Signature_____ Date_____

Notice of Privacy Practices: I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under the federal and state law and outlining my rights regarding my health information.

Patient's name (please print) _____

Signature_____ Date_____

Medical record release:

I, _____, hereby authorize release of my medical record information to my primary care Physician or any other Physician upon request. I understand that this authorization may be revoked at any time.

Signature_____ Date_____