Nephrology Associates of Lake County, LLC

_____ Dr. Meneses-Taylor ____ Dr. Rodriguez ____ Dr. Machado ____ Dr. Penix

Please Print

Patient Name_____ Date of Birth_____
Last First MI

Mailing Address_____ Phone_____

City_____ State_____ Zip_____

Northern Address(if applicable) _____

City_____ State_____ Zip_____

Social Security #_____ Sex_____ Marital Status M__ S__ W__ D__

Place of Employment_____ Phone_____

Name of Spouse/Significant Other_____

Social Security #_____ Date of Birth_____

Place of Employment_____

Name of Nearest Relative_____ Relationship_____

Address_____ Phone_____

Emergency Contact_____ Phone_____

Primary Insurance_____ Policy #_____

Secondary Insurance_____ Policy #_____

Preferred Pharmacy_____ Phone #_____

Person responsible for the bill_____

Who referred you to us_____

If the patient is not insured or the insurance has a co-pay, co-insurance or deductible, it is our policy that all office visits are to be paid at the time of service. Will payment be made by (circle one): Check, Cash or Credit Card (visa/mastercard)

I understand that I am financially responsible for all charges incurred that are not paid for, or supplemented by my insurance company(s).

_____ _____

Patient/Guardian Signature Date

New Beneficiary Signature Regulations in effect since April 1, 1982 allow physicians (or other suppliers, in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims on the beneficiary's behalf.

The beneficiary must sign a brief statement substantially as follows:

"I request that payment for authorized Medicare benefits and/or any other insurance benefits be made to me or on my behalf to the physician and/or supplier for any services furnished to me by the physician and/or supplier. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related service"

_____ _____

Patient/Guardian Signature Date