DELMARVA KIDNEY & HYPERTENSION SPECIALISTS LLC

Patient Insurance Information

Patient Name _____ DOB _____
First, Middle Last

Address _____

City _____State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Marital Status: S M W D Sex M F Maiden Name _____ Spouse Name_____

Soc. Sec# _____ Ethnicity_____Race_____Ethnicity_____

Email_____Pharmacy(Name/Location)_____

Patient's Employer Information

Are you currently ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Student ☐Other

Employer/Company Name _____ Phone _____

Employer address _____

Guarantor Information (person responsible for account)

Guarantor Name _____ Relationship to Patient

Soc. Sec# _____ Date of Birth _____

Guarantor Address _____

Home Phone _____ Work _____ Cell _____

Guarantor's Employer _____ Employers Phone _____

Employer's Address _____

Healthcare Contact Information

Primary Care Physician _____ Phone _____
Referring Physician _____ Phone _____
Pharmacy Name _____ Phone _____
Nursing Home Name _____ Phone _____

Emergency Contacts

Name Relationship Phone Number

_____

_____

What is your race? (Circle one) American Indiana or Alaska Native ☐ Asian ☐ Black or African American ☐
Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race ☐ Decline to Answer ☐
What is your ethnicity? (Circle One) Hispanic or Latino☐Not Hispanic or Latino ☐ Decline to answer ☐
What is your primary language? (fill in blank) _____

Insurance Information

Do you have Medicare Part B? ☐yes ☐no If yes your Medicare # _____

Do you have Medicaid? ☐yes ☐no If yes your Medicaid # _____

Does your Insurance Company require referrals for Office Visits? ☐yes ☐no

Primary Insurance Company _____ Effective Date of Coverage _____

Member ID# _____ Group# _____

What is your office co-pay amount $ _____ What is your annual deductible amount $_____

IF YOU ARE NOT THE POLICY HOLDER PLEASE ANSWER THE FOLLOWING:

Policy Holder's Name _____

Policy Holder's Birth Date _____ Policy Holder's Relationship to Patient_____

Policy's Holders Soc. Sec.# _____

Member ID# _____ Group# _____

Policy Holder's Employer _____

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Additional Insurance Coverage

Do you have additional coverage ☐yes ☐no **If yes, please complete**

Secondary Insurance Company _____

Policy Holder's Name _____

Policy Holder's Birth Date _____ Policy Holder's Relationship to Patient_____

Policy's Holders Soc. Sec.# _____

Member ID# _____ Group# _____

Policy Holder's Employer _____

** If Medicare is your primary insurance, is the second policy a Medicare Supplement policy ☐yes ☐no

Authorization and Assignment

I authorize Delmarva Kidney & Hypertension Specialists to release information and submit insurance claim forms on my behalf for all services furnished on inpatient or outpatient basis.

I understand that the failure to notify Delmarva Kidney & Hypertension Specialists of pre-certification requirements that result in the denial of charges by the insurance company will be the patient's full responsibility. The patient will also accept financial responsibility for denials of claims if the patient fails to notify Delmarva Kidney & Hypertension Specialists of insurance changes in coverage.

I understand that if my health benefit plan participates in a(n) utilization management/review program, health maintenance organization (HMO), preferred provider network (PPO), point-of-service program (POS) or any other type of managed care or pre-paid health plan arrangement, I may be required to obtain prior authorizations, pre certifications, or referrals from my primary care physician (PCP) before any services are provided by Delmarva Kidney & Hypertension Specialists. I also acknowledge that, if applicable, my failure to obtain any required prior authorizations, pre-certifications or referrals may result in my receiving less or no benefits under my health benefit plan. I understand that I will be responsible for payment of any outstanding balances or amount that are not otherwise covered by my health benefit plan due to my failure to meet any of my health benefit plan requirements.

I request that all payments of benefits be made directly to Delmarva Kidney & Hypertension Specialists. I will be responsible for all deductibles, co-insurance and non-covered services.

This authorization will remain in effect until revoked in writing. A photo copy of my signature shall be valid as the original.

I understand and agree that I am responsible for the payment of any charges which are incurred for the services provided by Delmarva Kidney & Hypertension Specialists, LLC. Patients who fail to present for a scheduled appointment without contacting the Practice to cancel within 24 hours will be charged a **$20.00 fee. ____ Initial**. If I fail to pay any balance due in a timely fashion and it becomes necessary for Delmarva Kidney & Hypertension Specialists, LLC to retain an attorney to assist in the collection of my account, I do hereby agree to be responsible for all reasonable attorneys' fees incurred by Delmarva Kidney & Hypertension Specialists, LLC. All of the information which I have provided is true and accurate. I agree to notify Delmarva Kidney & Hypertension Specialists, LLC of any changes in my health status or in any of the information listed herein.

I have read the above foregoing and fully understand the terms thereof.

_____ _____

Patient/Responsible Party Signature Date

OR

_____ _____

Responsible Party Signature (if minor) Date

Relationship to patient _____