Eastside Premier Nephrology & Hypertension

Dr. Ekundayo A. Falase, MD, FACP - Dr. Sitharam C. Nandigam, MD –
Dr. Yilikal T. Kassa, MD- Dr. Nardos Belayneh

Patient Information Sheet

ALL INFORMATION IS REQUIRED

Name:_____ Date of Birth:_____/_____/_____

Guardian:_____ Social Security #:_____-_____-_____

Address:_____

City:_____ State:_____ Zip:_____

Contact Information:

Home:_____ Cell:_____

Work:_____ Email:_____

Preferred Contact Method (circle one): Home Work Cell Email

Sex:_____ Race:_____ Ethnicity: Hispanic? Yes No

Marital Status:_____ Preferred Language:_____

Referring Physician: _____ Phone: _____

Primary Care Physician:_____ Phone: _____

Pharmacy Name/City _____ Phone _____

Nearest Relative NOT Living with Patient: Name:_____

Phone:_____Relationship: _____

Emergency Contact: Name: _____

Phone:_____ Relationship:_____

Employment Information (circle one):
Retired Full Time Part Time Not Employed Disabled Student

Insurance:
Primary:_____ Secondary:_____

Please Provide Staff with your Insurance Cards

Authorization to Release Information via Phone or second Party:

I hereby Authorize Eastside Premier Nephrology and/or it's agents to:

****Leave messages on my answering machine and/or call recording device:**

Yes No

****I authorize the following family members to retrieve my medical information:**

_____ _____

Eastside Premier Nephrology & Hypertension

Patient Release, Authorization, Responsibility and Assignment

1. ***Consent for Medical Treatment:***

The undersigned hereby authorizes the attending physicians to furnish the necessary treatments, x-rays, ultrasounds, drugs and supplies, and diagnostic procedures ordered and/or performed by the attending physicians. I acknowledge that no assurance has been made to me as to the results of the treatment.

2. ***Authorization for the Release of Medical Information:***

Authorization is hereby granted to Eastside Premier Nephrology & Hypertension and treating physicians to release my insurance company or companies, their agents, or other third party payers confidential information (including copies of records) as may be required or necessary for the completion of claim processing relative to my treatment at the center.

3. ***Assignment of Insurance Benefits and Guarantee of Payment:***

The undersigned herby assigns and authorizes payments directly to Eastside Premier Nephrology the insurance benefits otherwise payable to the undersigned. The undersigned remains financially responsible for any and all charges covered and/or not covered by this assignment of benefits and personally guarantees payment of all amounts not paid by the insurance. I, the undersigned, herby instruct and direct my insurance company to pay Eastside Premier Nephrology and mail it to Eastside Premier Nephrology. If my current policy prohibits direct assignment to Eastside Premier Nephrology, I hereby instruct and direct my insurance company to make the benefit payable to me and to mail the check to me in care of Eastside Premier Nephrology. I hereby grant power of attorney to Eastside Premier Nephrology to endorse any and all checks made payable to me for medical benefits provided by Eastside Premier Nephrology. I authorize Eastside Premier Nephrology to initiate a complaint on my behalf to the insurance commissioner for any reason.

4. ***Past Due Accounts:***

If your account becomes 60 days past due you will receive a final notice, then you account will be sent to a collection agency and a 29% fee will be added. You will be responsible for any collection charges incurred by the collection agency for your account.

5. ***Additional Charges:***

If, for any reason, my check to this office is returned I will pay a $35.00 returned check charge.

A photocopy of these assignments shall be valid as the original.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Signature of Witness Date

Eastside Premier Nephrology & Hypertension

Dr. Ekundayo A. Falase, MD FACP, Dr. Sitharam C. Nandigam, MD
Dr. Yilkal T. Kassa MD & Dr. Nardos K. Belayneh, MD
1612 Milstead Rd, Suite A Conyers GA 30012

Patient Acknowledgment of Receipt of Notices & Policies

Patient Name:_____

- Please carefully read the attached Notices and Policies documents.
- Initial below that they have been provided to you and that you understand the contents.
- Please see the office staff if you have questions regarding the contents of the documents.

_____ 1. Appointments, Medications, and Insurance Policies

_____ 2. Notice of Patient Rights and Responsibilities

I have a Living Will or Durable Power of Attorney, otherwise known as Advance Directives: **_____Yes _____No**

If Yes, I will provide Eastside Premier Nephrology & Hypertension a copy for their records.

If No, I would like information on Advance Directives or I would like to speak to someone about Advance Directives: **_____Yes _____No**

_____ 3. Notice of Privacy Practices

_____ 4. Information About Your Medical Record

Patient Signature _____ Date _____