
# Patient Demographic Sheet

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**Date:**_____ **Account Number:**_____
**(For office use only)**

**Name:**_____
**First MI Last**

**Date of Birth:**_____ **Social Security#**_____

**Address:**_____
**City State Zip Code**

**Home Ph#**_____**Cell#**_____**Wk#**_____

**Email Address:**_____

**Would you like to be enabled for our patient portal? Yes**_____ **No**_____

**Marital Status:** _____ **Race:**_____ **Ethnicity:**_____ **Language:**_____

**Employment Status: Full-time**_____ **Part-time**_____ **Retired**_____ **Unemployed**_____

**Local Pharmacy:**_____ **Ph #**_____

**Primary Care Physician:**_____ **Ph #**_____

**Referring Physician:**_____ **Ph #**_____

**Name of Insurance:**_____

**Secondary Insurance:**_____

**Policy Holder:**_____ **Insured DOB:**_____

**Emergency Contact:**_____ **Relationship to Patient:**_____

**Emergency Contact Ph #**_____

I authorize Star Nephrology, PLLC, to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Star Nephrology, PLLC. I Understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review. I authorize Star Nephrology to access past prescription information from external sources which may include my pharmacy, insurance company or previous physicians.

**Signature:** _____ **Date:**_____

## Authorization to Release Medical Information to Star Nephrology

**I**_____

**(Patient's legal name)**

**authorize**_____

**(Facilities or Physicians)**

the release of all medical information, for the purpose of treatment, by mail, fax, electronically or orally to:

**Star Nephrology, PLLC**
3400 Corinth Parkway, Suite 140
Corinth, Texas 76208
Ph: 940-312-7356 - Fax: 940-312-7357

This authorization is given freely with the understanding that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. A photocopy or fax of this authorization is acceptable as the original. I may revoke this authorization at any time in writing, except where the information has already been released. Star Nephrology, PLLC, its employees, officers and physicians are hereby released from any legal responsibility or liability for the receipt of the above information to the extent indicated and authorized herein. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.

**Patient Printed Name:**_____ **Date of Birth:**_____

**Patient/Legal Representative Signature:**_____

**Relationship to Patient:**_____ **Date:**_____

**Witness Signature:**_____ **Date:**_____


## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Star Nephrology, PLLC revers the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy either by mail or at the time of my next appointment in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at the time of my appointment.

**Patient's Printed Name:**_____ **Date of Birth:**_____

**Patient/Legal Representative Signature:** _____

**Relationship to Patient:**_____ **Date:**_____

**Witness:**_____ **Date:**_____

**I wish to be contacted in the following manner:**

**Home telephone:** _____ okay to leave message with detailed information
_____ Leave message with call-back number only

**Work telephone:** _____ okay to leave message with detailed information
_____ Leave message with call-back number only

**Cell phone:** _____ okay to leave message with detailed information
_____ Leave message or text with call-back number only

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Star Nephrology, PLLC, to share my protected health information with:

**Name:**_____ **Relationship:**_____**Ph#**_____

**Name:**_____ **Relationship:**_____**Ph#**_____


# Star Nephrology Financial Policy

Thank you for choosing Star Nephrology as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. **All patients must read and sign this form prior to receiving services. It is your responsibility to provide us with your most current insurance information.**

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company. • Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers or a referral has not been completed in compliance with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. • Co-payments, co-insurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our office within 30 days after receipt of the initial statement. The office number is 940-312-7356.
- Payment is due in full upon receipt of the statement. We accept cash, checks and credit cards. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any physician with Star Nephrology. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $40.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

By signing below I acknowledge that I have read and understand this Financial Policy.

**Patient /Legal Representative Signature_____ Date:_____**


## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been provided a copy of Star Nephrology, PLLC's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by **Star Nephrology, PLLC** and how I may obtain access to and control this information.

_____

**Signature of Patient or Legal Representative**

_____

**Print Name of Patient or Legal Representative**

_____

**Description of Legal Representative's Authority**

_____

**Date**