Northwest Louisiana Nephrology

Diseases of the Kidney, Dialysis and Transplantation

PATIENT REGISTRATION

Date:_____ Primary Care Physician:_____

Patient's Name: Last_____First_____MI____

Patient's Date of Birth:_____ Patient's Social Security Number:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Gender: ☐ Female ☐ Male

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ More than one race ☐ Undefined ☐ Refuse to report

Patient's Mailing Address:_____

City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

**********EMAIL:_____**********

Patient's Employer:_____ Patient's Work Phone:_____

Spouse's Name: Last_____First_____

Spouse's Date of Birth:_____ Spouse's Social Security Number:_____

In case of an Emergency, contact (not living with you):_____

Phone Number:_____ Relationship to Patient:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Primary Insurance:_____

Policy Number:_____ Group Number:_____

Name of Insured: Last_____First_____

Insured's Date of Birth:_____ Insured's Social Security Number:_____

Relationship to Insured:_____

****

Secondary Insurance:_____

Policy Number:_____ Group Number:_____

Name of Insured: Last_____First_____

Insured's Date of Birth:_____ Insured's Social Security Number:_____

Relationship to Insured:_____

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Patient Name:_____

Pharmacy (Local):_____

Address or Street where located:_____

Phone Number:_____

Pharmacy (Mail Order):_____

Phone Number:_____

Insurance (If different from your Primary Insurance) that your medication is filled to:
PLEASE PROVIDE A COPY OF YOUR MEDICATION INSURANCE CARD IF DIFFERENT FROM PRIMARY INSURANCE

Name of Insurance:_____

Policy Number:_____

NORTHWEST LOUISIANA NEPHROLOGY, L.L.C.
Designation of Personal Representative
(For Use and Disclosure of Health Information Only)

The Health Insurance Portability Act of 1996 (HIPAA) grants you the right to designate one or more individuals to act on your behalf regarding the protection of health information that pertains to you. This form indicates your desire to designate the listed individual(s) to be your personal representative for your health information. Your designation can be revoked at any time.

DESIGNATION

I, the undersigned, hereby designate the following person to act as my personal representative with respect to decisions regarding the use and/or disclosure of my health information.

_____ _____

Representative's Name (please print) Relationship to you

This person shall be given all of the privileges that would belong to me regarding my health information.

I understand that I may revoke this designation at any time by signing a revocation and delivering it to Northwest Louisiana Nephrology, L.L.C. I further understand that any revocation will not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on my previous designation.

_____ _____

Patient's Name (please print) Date

_____

Patient's Signature

_____

REVOCATION SECTION

I hereby revoke my designation of a personal representative.

_____ _____

Patient's Name (please print) Date

_____

Patient's Signature

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Stephen R. Patton, M.D.
Raja I. Zabaneh, M.D., FACP
Arnold E. Barz, M.D.
Zulqarnain A. Abro, M.D.
Cheng Chu, M.D.

Marwan O. Kaskas, M.D.
Sylvia D. Noble, M.D.
Michael D. Rokaw, M.D.
Sreedhara B. Alla, M.D.
Srinivasa R. Iskapalli, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

I acknowledge that I have received a copy of this medical practices' Notice of Health Information Practices of Northwest Louisiana Nephrology.

_____

Patient's Signature

_____

Date

If not signed by the patient, please indicate below the patient's name and your relationship to the patient:

_____

Patient's Name

_____

Relationship to Patient

1800 Buckner Street, Suite C-120
Shreveport, LA 71101
(318) 227-8899
FAX (318) 425-3793

2501 Greenwood Road
Shreveport, LA 71103
(318) 631-1584
FAX (318) 635-8322

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RECORDS RELEASE AUTHORIZATION

Patient Name: _____
Last First Mi

Address: _____
Street City State Zip

Phone: (____) _____ Date of Birth: _____ SSN: _____

I authorize _____

to release to _____

the following information:

- ☐ Entire Record
- ☐ Lab
- ☐ X-Rays
- ☐ Progress Notes
- ☐ Correspondence
- ☐ Records from other facilities
- ☐ Other _____

If you are not requesting the entire record, give specific date(s) needed: _____

This authorization will expire one (1) year form the date signed. I understand that I may revoke this consent at any time upon written request from patient or representative.

Signed: _____ Date: _____

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Billing Policy

I understand that it is my responsibility to provide the office of Northwest Louisiana Nephrology with current, accurate billing information at the time of check in and to notify Northwest Louisiana Nephrology of any changes in this information.

I understand that it is my responsibility to know my specialist co-pay and to pay it prior to services being rendered. I understand that this is a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

I understand that I am responsible for and will obtain the necessary prior authorizations prior to appointment(s).

I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts.

I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I authorize the release of all medical information to the insured's health insurance carrier that is:

1) acquired in the course of my examination or treatment and

2) which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Northwest Louisiana Nephrology or any of their authorized agents to assist me in obtaining payment from my health insurance companies.

I hereby authorize payment directly to Northwest Louisiana Nephrology, LLC for any services rendered to me by Northwest Louisiana Nephrology or any of their authorized agents.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all my insurance submissions. This request is effective until revoked in writing.

_____ _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE DATE

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ADVANCE DIRECTIVES

Advance Directives are legal documents designed to ensure that your decisions concerning your medical care, including the right to refuse treatment, are understood and followed by your health care providers if you become physically or mentally unable to make these decisions on your own.

Both state and federal law require health care institutions and physicians to respect the wishes of a patient over eighteen years of age concerning medical care, including the right to accept or refuse treatment and to discontinue treatment.

The law also allows you to designate an individual to make decisions about your medical care and treatment if you are physically or mentally unable to do so on your own.

This is an important matter, and you should talk to your spouse, family, close friends, your physician, and/or your attorney before deciding whether or not you want an advance directive.

Do you currently have an Advance Directive or a Living Will? _____ Yes _____ No

Do you have Durable Power of Attorney for Healthcare? _____ Yes _____ No

If yes, please indicate person to contact _____
Name

_____ _____
Patient Signature or Legal Guardian Date

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