

**Yuma Nephrology, P.C.  
REGISTRATION FORM  
(Please Print)**

Today's Date:	PCP:
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**PATIENT INFORMATION**

Patient's Last Name	First Name	M. I.	Mr. <input type="checkbox"/>	Miss <input type="checkbox"/>	Marital Status (Circle One)
			Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>	Single / Mar / Div / Sep / Wid

Is this your legal name?	If not, what is your legal name?	Former Name	Birth Date:	Age:	Sex (Circle One):
Yes / No					Male / Female

Street Address:	Social Security No.	Home Phone No. ( )
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P.O. Box:	City:	State:	Zip Code:
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Occupation:	Employer:	Employer Phone No. ( )
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Choose clinic because/Referred to Clinic By (Please check one box)	Dr. <input type="checkbox"/>	Insurance Plan <input type="checkbox"/>	Hospital <input type="checkbox"/>
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Communication Preference: E-mail/MyCare/Mail	Preferred Language:	Interpreter Needed:	Ethnicity:	Religion:
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Preferred Pharmacy:
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**INSURANCE INFORMATION  
(Please give your insurance card to the receptionist)**

Person Responsible for Bill:	Birth Date:	Address (if different):	Home Phone No:
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Is this person a patient here? Yes / No	Occupation:	Employer:	Employer Address:	Employer Phone No.
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Is this patient covered by insurance? Yes / No	Subscriber's Name:	Subscriber's SS No.	Birth Date:
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Group No.	Policy No.	Co-Payment:
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Patient relationship to subscriber (circle one):	Self / Spouse / Child / Other
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Name of secondary insurance (if applicable):	Subscriber's Name:	Group No.	Policy No.
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Patient Relationship to Subscriber:	Self / Spouse / Child / Other
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**IN CASE OF EMERGENCY**

Name of Local Friend or Relative:	Relationship to Patient:	Home Phone No.	Work Phone No.
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Cardiovascular Center of Yuma or insurance company to release any information required to process my claims.

Patient / Guardian Signature:	Date:
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**CONSENT TO TREATMENT**

I authorize and consent to allow Yuma Nephrology, P.C. licensed healthcare providers to examine my person, perform any medical diagnostic studies, and give any medical treatment with quality medical care..... Initial here: \_\_\_\_\_

If a minor (under 18 years):

\_\_\_\_\_

**Consent for treatment (signature)**

**Relation to patient**

*I certify that the information I have reported with regard to my insurance and personal is correct.*

\_\_\_\_\_

**Signature of Patient or Guardian**

**Date**



# Yuma Nephrology, P.C.

Board Certified in Nephrology and Internal Medicine

Kamal Ahmed, M.D., FACP

Trinidad Lim, M.D.

Annie Hyon, D.O.

Nephrology and Hypertension

## *Authorization for Treatment & Payment of Medical Benefits Patient Financial Responsibility Form*

Thank you for choosing our practice, Yuma Nephrology, P.C., as your Nephrologists. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies.

## *Authorization for Treatment & Payment of Medical Benefits*

I give permission to the practice, Yuma Nephrology, P.C., to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, Yuma Nephrology, P.C.

## *Patient Financial Responsibilities*

I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.

You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated. f

I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards. f

I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):

- Charge for returned checks.
- Charge for the copying and distribution of patient medical records.
- Charge for forms completion.
- Charge for missed appointments.

## *Patient Authorizations*

By my signature below, I hereby authorize the practice, Yuma Nephrology, P.C., to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services. By my signature below, I hereby authorize assignment of financial benefits directly to the practice, Yuma Nephrology, P.C.

**I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s). I have read, understand, and agree to the provisions of this Authorization for Payment of Medical Benefits and Patient Financial Responsibility Form:**

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**Signature of Patient or Guardian**

**Date**

*Yuma Nephrology, P.C.*

***Acknowledgement of Receipt of Notice of Privacy Practices and  
Notice of Health Information Practice***

*\*You may refuse to sign this acknowledgement\**

I, \_\_\_\_\_, have received a copy of the office's Notice of Privacy Practice. I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in the Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refuse to sign
- Communications barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- other (please Specify)

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