Mercer Renal Associates, PA

Last Name: (please write above the line) **First Name:** **MI:**

Mailing Address: (please write above the line) **City & State:** **Zip:**

Date of Birth: (please write above the line) **Social Security #:** **Gender:**

Home Number: (____) _______-___________
___ OK to leave message with detailed information
___ Leave message with call back numbers only

Work Number: (____) _______-___________
____OK to leave message with detailed information
____ Leave message with call back numbers only

Cell Phone: (____) _______-___________
___ OK to leave message with detailed information
___ Leave message with call back numbers only

E-mail: ______________________________________
____ OK to e-mail health information
____ NOT ok to e-mail health information

Race: (please write above the line) **Ethnicity:** **Preferred Language**:

Marital Status: Single/Married/Widowed **Employed:** None/Retired/Full-time/Part-time

Name of Employer: (please write above the line) **City & State:** Zip:

Emergency Contact Name: (please write above the line) **Number:** **Relationship:**

Primary Care Physician (first and last name): (please write above the line) **Phone:**

Pharmacy: (please write above the line) **Phone:**

Care Team: (please list any other doctors you see)

Do you have any allergies? Yes or No

Do you require a referral: Yes or No

*Co-pays and balances are due at the time of service. We will bill only two contracted insurance companies, however you are ultimately responsible for all charges whether the insurance company paid for your claim or not. We accept checks, cash, and most credit cards. I hereby authorize SOMD Foot and Ankle and staff to disclose my individually identifiable health information to the insurance carrier(s). SOMD Foot and Ankle will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient, Guardian and/or Insured Signature: (please write above the line) **Date:**

Mercer Renal Associates, PA

Authorization of Payment (ALL insurances)

I request that payment of Insurance benefits be made to Mercer Renal Associates, P.A. for any services provided to me by that physician. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services (CMS)/other insurance and its agents any information needed to determine these benefits of the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If “other health insurance” is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductable, coinsurance, and non-covered services. Coinsurance and the deductable are based upon the charge determination of the carrier.

Signature: (please write above the line) **Date:**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
(Please look on clip board or in binder for copy of HIPAA)

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories or physical therapy centers that you have been referred to, by Southern Maryland Foot & Ankle, to aide in your coordination of care. We will not release your information to any third parties.

Patient Name: **Date:**

Relationship to patient (if not self):

<u>Mercer Renal Associates, PA</u>

Medicare Secondary Payor Questionnaire

1. Are you receiving Black Lung Benefits? Yes No
2. Are the services to be paid by a government research program? Yes No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)? Yes NO
4. Was the illness/injury due to a work related accident/condition? Yes *(if yes please fill in below portion)* No *Date of injury/illness* _______________ *Policy or Identification #:* _______________ *Workers' Comp Plan Name*_______________ *Employer Name:*_______________
   *Plan Address:*_______________ *Employee Name:* _______________
   _______________ _______________
   _______________ _______________
5. Was the illness/injury due to a non-work-related accident? Yes No *(if yes please fill in below portion) Date of accident:*_______________

   Is no-fault insurance available? Yes No (if yes please fill in below portion)
   No-Fault Insurance plan name: _______________
   No –fault policy owner name: _______________ *Plan Address:* _______________
   Policy Owner Address: _______________
   Insurance Claim # _______________
6. Are you entitled to Medicare based on your age? Yes No
7. Are you entitled to Medicare based on a disability? Yes No
8. Are you entitled to Medicare based on End Stage Renal Disease (ESRD)? Yes No
9. Are you currently employed? Yes*(if yes please fill in below portion)* No
   Employer Name: _______________ *Address:*
   ____

10.Do you have a spouse who is currently working? Yes*(if yes please fill in below portion)* No
*Employer Name:*_______________ *Employer Address:* _______________

11.Do you have a group health plan (GHP) coverage based on your own current employer? Yes No 12.Do you have a group health plan (GHP) coverage based on your spouse's current employment? Yes No