Kidney Care Specialists, LLC
Valley Kidney
1230 South Cedar Crest Blvd., Suite 301• Allentown, PA 18103

PATIENT DEMOGRAPHIC SHEET

Referring Doctor: _____ Phone: _____

Family Doctor: _____ Phone: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Emergency Phone #: _____

Date of Birth: _____ Social Security #: _____

Sex: ❑ M ❑ F Marital Status: ❑ S ❑ M ❑ D ❑ W Spouse's Name: _____

Email Address: _____

Emergency Contact

Name: _____ Phone: _____

Primary Insurance

Company Name: _____

ID Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Secondary Insurance

Company Name: _____

ID Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's DOB: _____

MEDICARE AND MEDICAID AUTHORIZATION AND ASSIGNMENT

I request payment of authorized Medicare/insurance benefits be made on my behalf to Kidney Care Specialists, LLC for any medical services furnished to me. I authorize Kidney Care Specialists, LLC to release my medical information necessary to determine benefit coverage to the Centers of Medicare and Medicaid Services and/or its agents.

Signature: _____ Date: _____

ALL PATIENTS TREATMENT AUTHORIZATION AND ASSIGNMENT

My signature authorizes the physicians of Kidney Care Specialists, LLC to provide medical treatment to me and submit claims to my insurance for treatment on my behalf. I understand that I am financially responsible for the medical care provided to me, and any balances not covered by insurance are due in full to Kidney Care Specialists, LLC.

Signature: _____ Date: _____

COMPLETE BOTH SIDES

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I _____ authorize Kidney Care Specialists, LLC to leave personal, medical information about myself at the following numbers. I understand that this option is voluntary and by checking "DECLINE", Kidney Care Specialists, LLC will only give personal, medical information to myself or my chosen personal representative.

- ❑ Cell Phone: (number) _____
- ❑ Home answering machine: (number) _____
- ❑ At work: (number) _____
- ❑ Personal Representative: (See Privacy Rule Form)
- ❑ Decline all of the above options

Signature: _____ Date: _____

TELEPHONE CONSUMER PROTECTION ACT (TCPA)

You agree, in order for us to service your account or to collect monies you may owe, Kidney Care Specialists, and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

☐ I/We have read this disclosure and agree that Kidney Care Specialists, its employers and/or agents may contact me/us as described above.

Signature: _____ Date: _____