Today's Date: ___________________

Patient Name: (last)____________________________ (first)_________________________(middle)____________

Date of Birth: _______________________ M____ F____ Patient's SS#: __________________________________

Patient's Address: _______________________________ City:_____________ State:________ Zip:__________

Home Phone:______________________________ Cell:______________________ Work:____________________

Email Address:_______________________________________________________________________________

Emergency Contact__________________________Phone_____________________Relationship___________

***Privacy and Security Release***

As a covered of the Health Insurance Portability and Accountability Act (HIPPA) Texas Kidney Institute, PA, and its business associates are protecting the privacy and security of your medical information. As such we do not release any information without your approval. This includes, but is not limited to medical and financial information. Please list any persons below, whom you are giving permission to have Texas Kidney Institute, PA, or its business associates, release information in regards to your care or billing.

___________________________ __________________________________ ( ) Medical ( ) Financial
Person's Name Relationship

***Primary Health Insurance*** **Does this insurance require pre-authorization? Yes______ No______**

Insurance________________________________________________Date Effective_________________________

Group#_____________________________________Ins ID____________________________________________

Policy Holder___________________________DOB_________________________SS#______________________

Insurance Claim Address and Phone#:_______________________________________________________________

***Secondary Health Insurance*** **Does this insurance require pre-authorization? Yes______ No______**

Insurance________________________________________________Date Effective_________________________

Group#_____________________________________Ins ID____________________________________________

Policy Holder___________________________DOB_________________________SS#______________________

Insurance Claim Address and Phone#:_______________________________________________________________

*I have received or read a copy of this office's Notice of Privacy Policy*

____________________________________________________________ ___________________________

**Patient Signature/Guarantor** **Date**

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