New Patient Registration Form

PATIENT INFORMATION

Patient Name: _____ _____ _____ **DOB**: ____/____/_____
FIRST NAME MI LAST NAME MM DD YYYY

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

PREFERRED

Tel: _____ **HOME** ☐ **SSN**: _____ **Gender**: Male ___ Female ___

Tel: _____ **MOBILE** ☐ **Marital Status**: Single ___ Married ___ Divorced ___ Widowed___

Tel: _____ **WORK** ☐ **Employer**: _____ N/A:___

EMERGENCY CONTACT

Name: _____ **Relationship**: _____ **Tel**: _____

PHARMACY (PREFERRED)

Name: _____ **Address**: _____ **Tel**: _____

PHYSICIAN(S) INFORMATION

Name: _____ **Address**: _____ **Tel**: _____
REFERRING PHYSICIAN

Name: _____ **Address**: _____ **Tel**: _____
PRIMARY CARE PHYSICIAN

MEDICATIONS: LIST ALL MEDICATIONS AND THE RESPECTIVE DOSAGE

Age:_____ **Height**: _____feet _____inches **Weight**: _____lbs **Occupation**: _____ N/A:___

Name of Medication	Dosage
1.	
2.	
3.	
4.	
5.	
6.	

Name of Medication	Dosage
7.	
8.	
9.	
10.	
11.	
12.	

ALLERGIES

1.	3.	5.
2.	4.	6.

Nephrology Center OF MARYLAND

Review of Systems

Patient Name: _____ _____ _____ **DOB**: ____/____/_____
FIRST NAME MI LAST NAME MM DD YYYY

PLEASE CHECK ALL THAT APPLY:

Constitutional: ☐ Fever ☐ Chills ☐ Weight Gain ☐ Weight Loss ☐ Weakness

Eyes: ☐ Vision Impaired ☐ Cataracts ☐ Eye Pain ☐ Redness

ENT: ☐ Sore Throat ☐ Ear Pain ☐ Nose Bleed ☐ Sinus Problems

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Diaphoresis ☐ Edema

Respiratory: ☐ Shortness of Breath ☐ Cough ☐ Bloody Sputum ☐ Pain with Breathing

Gastrointestinal: ☐ Abdominal Pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

Genitourinary: ☐ Urinary Urgency ☐ Frequency ☐ Burning ☐ Difficulty Voiding ☐ Weak Stream

Musculoskeletal: ☐ History of Falls ☐ Arm of Leg Weakness ☐ Back Pain ☐ Join Pain

Integumentary: ☐ Rash ☐ Bruises or Lesions ☐ Itching

Neurologic: ☐ Headache ☐ Dizziness ☐ Seizures ☐ Numbness ☐ Slurred Speech ☐ Weakness

Psychiatric: ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Suicidal ☐ Homicidal

Endocrine: ☐ Heat Intolerance ☐ Cold Intolerance ☐ Hair Loss ☐ Tired ☐ Weight Gain

Hematologic: ☐ Bleeding Gums ☐ Anemia ☐ Easy Bruising

Allergic/Immunologic: ☐ Seasonal Allergies ☐ Reactions to Allergens

PLEASE LIST ANY OTHER SYMPTOMS NOT MENTIONED ABOVE:

1.	4.	7.
2.	5.	8.
3.	6.	9.

Authorization to Release Medical Information

PATIENT INFORMATION

Patient Name: _____ _____ _____ **DOB**: ____/____/_____
FIRST NAME MI LAST NAME MM DD YYYY

Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Tel: _____ **HOME** **SSN**: _____ **Gender**: Male ___ Female ___

PATIENT AUTHORIZATION

I, _____, hereby authorize the Nephrology Center of Maryland to receive any and all
PRINT FIRST and LAST NAME
medical information about me. Good health care is always a team effort, and I understand that the Nephrology Center of Maryland will obtain such information so that the respective Nephrologist(s) can take an active role to create a treatment plan and to facilitate the appropriate delivery of health care services with my coordination of care team.

_____ _____
NAME OF PATIENT (PLEASE PRINT) DATE

_____
SIGNATURE OF PATIENT

Agreement of Financial Responsibility

Thank you for choosing us as your preferred specialty care provider. We are committed to providing you with quality and affordable health care. We have adopted the respective policies because some of our patients have had questions regarding their financial responsibilities. Patient appointments will be rescheduled to a later date if patients are unable to pay the required payment of their account balance and/or their co-payment and/or deductible and/or any missed appointment charge(s).

I have read the respective financial policies, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Policy Effective Date: 10/17/2016
Policy Last Update: 3/2/2020

1) Financial Payment Policy
2) Missed Appointment/No Show Policy
3) Medical Forms Payment Policy

NAME OF PATIENT (PLEASE PRINT) DATE

SIGNATURE OF PATIENT

Financial Payment Policy

Patient Financial Payment Policy

We participate in most insurance plans, including Medicare. If a patient is not insured by a plan we do business with, payment in full is expected at each visit. If a patient is insured by a plan we do business with, but the patient does not have an up-to-date insurance card, payment in full for each visit is required until we can verify the patient's coverage. It is the patient's responsibility to know their insurance benefits. Patients can contact their insurance company with any questions they may have regarding their coverage.

Co-payments and Deductibles

All co-payments and deductibles must be paid at the time-of-service. This arrangement is part of the patient's contract with their insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Patients are asked to help us uphold the law by paying their co-payment at each visit. Co-payments and deductibles are due at the time-of-service or the patient's appointment will need to be rescheduled.

Non-covered Services

It is important for patients to understand that some and perhaps all of the services they receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. Patients are responsible for services not covered by their insurance company.

Proof of Insurance

We must obtain a copy of every patient's driver's license and current valid insurance card to provide proof of insurance. If a patient does not provide us with their correct insurance information in a timely manner, they may be responsible for the balance of a claim.

Claims Submission

We will submit patients' claims and assist patients in any way we reasonably can to help get their claims paid. A patient's insurance company may need the patient to supply certain information directly to them. The balance of a claim is the patient's responsibility whether or not their insurance company pays their claim. The patient's insurance benefit is a contract between the patient and their insurance company; we are not party to that contract.

Coverage Changes

Patients are asked to notify our office of any change with their insurance coverage before their scheduled visit, so we can update the change in our systems and submit the claim to the appropriate insurance company. If a patient's insurance company does not pay their claim within 45-days, the balance will automatically be billed to the patient.

Account Balances

We require that patients with account balances pay a minimum payment on their account balance prior to receiving further services by our practice. Payment plans will be required for patients having account balances over $100.00.

Account Balances	Required Payment
Between $0.01 and $30.00	Paid in full
Between $30.01 and $199.99	Minimum payment of $30.00
$200.00 and greater	Minimum payment of $50.00

MedStar Good Samaritan Hospital | 5601 Loch Raven Boulevard, Suite 3 North, Baltimore, MD 21239 | Tel: 443.444.3775 | Fax: 443.444.4678
2309 Bel Air Road Professional Building | 2309 Bel Air Road, Suite C, Fallston, MD 21047 | Tel: 443.981.3130 | Fax: 443.981.3136

Missed Appointment/No Show Policy
Medical Forms Payment Policy

Missed Appointment/No Show Policy

We request that all patients arrive fifteen (15) minutes before their scheduled appointment so that our administrative team will have the opportunity to facilitate their information with our clinical team and billing department. When we schedule a patient's appointment, we reserve a time for their specific medical care. Our practice requests that patients provide our office with at least twenty-four (24) hours' notice before their scheduled appointment. When a patient misses an appointment without cancelling twenty-four (24) hours in advance, another patient who could have been seen is delayed unnecessarily and is prevented from receiving medical care.

Definition of Missed Appointment/No Show

The Nephrology Center of Maryland defines a missed appointment/no show as an appointment where a patient does not show and does not provide the practice with at least twenty-four (24) hours' notice before their scheduled appointment.

Definition of Late Arrival

The Nephrology Center of Maryland defines a late arrival as ten (10) or more minutes after a patient's scheduled appointment. In the event a patient arrives ten (10) or more minutes after their scheduled appointment, the appointment may be rescheduled to a later date/time. A patient is requested to arrive fifteen (15) minutes before their scheduled appointment; and therefore, a late arrival is as a result of a patient being twenty-five (25) or more minutes late.

Missed Appointment Charge

A missed appointment fee of thirty-five dollars ($35.00) will be billed to patients who do not notify our office with at least twenty-four (24) hours' notice before their scheduled appointment and to patients who do not show for a scheduled appointment. Insurance companies do not cover this charge. Missed appointment fees must be paid prior to scheduling another appointment.

Medical Forms Payment Policy

The Nephrology Center of Maryland has adopted a policy to charge for completing various medical forms because of the additional administrative and clinical time needed to complete such forms. We reserve the right to charge a small fee due to the increasing demand that requires practices to extend additional financial resources.

Medical Forms Charge

There is a minimum fee of twenty-dollars ($20.00) for the completion of various medical forms. Insurance companies do not cover this fee.

Thank you for choosing us as your preferred specialty care provider. We are committed to providing you with quality and affordable health care. We have adopted the respective policies because some of our patients have had questions regarding their financial responsibilities. Patient appointments will be rescheduled to a later date if patients are unable to pay the required payment of their account balance and/or their co-payment and/or deductible and/or any missed appointment charge(s).

MedStar Good Samaritan Hospital | 5601 Loch Raven Boulevard, Suite 3 North, Baltimore, MD 21239 | Tel: 443.444.3775 | Fax: 443.444.4678
2309 Bel Air Road Professional Building | 2309 Bel Air Road, Suite C, Fallston, MD 21047 | Tel: 443.981.3130 | Fax: 443.981.3136