Referring and/or Primary Physician Name & Phone #____

Patient's Name____Birthdate____

Address____City___________________________Zip_____________________

Home Phone_________________________Cell Phone________________________Soc Sec #_______________________________

Sex:_______(M)_______(F) Marital Status: (M) Married (S) Single (W) Widowed (D) Divorced (O) Other

Employer_____________________________________Employer Address____

Occupation____________________________________Employer Phone____

Employment Status: (F) Full Time (P) Part Time (R) Retired (N) Not Employed

Student Status (F) Full Time (P) Part Time (N) Not

~SPOUSE OR LEGAL GUARDIAN OF PATIENT~

Name____ Sex: __________(M) __________(F)

Address____City__________________________State_____Zip_____________

Home Phone___________________________Birthdate___________________Soc Sec #___________________________________

Employer____Employer Address____

Occupation____Employer Phone____

PRIMARY INSURANCE

Insurance Co.____

Insurance Address____________________________________

Subscriber____

Relationship to Patient_________________________________

Subscriber Date of Birth_________________________________

Subscriber Soc Sec #____________________________________

Group #____

Subscriber Sex: ______(M) ______(F)

SECONDARY INSURANCE

Insurance Co.____

Insurance Address____

Subscriber____

Relationship to Patient______________________________________

Subscriber Date of Birth_____________________________________

Subscriber Soc Sec #_______________________________________

Group #____

Subscriber Sex: ______(M) ______(F)

Person to notify in case of emergency (someone not living with you)

Name____Relationship to patient____

Address____City_________________________State__________Zip___________

Home Phone______________________________Cell Phone________________________Work Phone________________________

RELEASE AND ASSIGNMENT: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE HEALTHCARE PROVIDER.. I ALSO AUTHORIZE ANY RELEASE OF INFORMATION BY MY PROVIDER AS REQUIRED BY THE INSURANCE COMPANY FOR THIS ACCOUNT TO BE PAID. RELEASE OF INFORMATION MAY INCLUDE: (1) ALCOHOL AND/OR DRUG ABUSE TREATMENT, (2) PSYCHIATRIC DIAGNOSIS, TREATMENT AND SUMMARIES, (3) TEST RESULTS FOR HUMAN IMMUNODEFICIENCY (HIV), SEXUALLY TRANSMITTED DISEASES (STD), AND THE TREATMENT THEREOF. I HEREBY RELEASE ASTIER ALEM AND EASTSIDE NEPHROLOGY FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM DISCLOSURE OF MY RECORDS AS PROVIDED BY THIS PARAGRAPH.

PAYMENT: I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE. I AGREE TO MAKE PAYMENT ARRANGEMENTS; PAY $5 OR 1% INTEREST PER MONTH (WHICHEVER IS GREATER) ON UNPAID BALANCES OVER 60 DAYS AND ALL THE REASONABLE EXPENSES SUCH AS ATTORNEY FEES AND COURT COSTS SHOULD THE ACCOUNT BE REFERRED FOR COLLECTIONS.

DATE__________________________________SIGNATURE____