Associated Nephrology Consultants, PA
REGISTRATION INFORMATION

Shannon E. Doyle, MD
David G. Husebye, MD
Alec D. Otteman, MD
Gary B. Schwochau, MD
Cara S. Walz, MD
David H. Warden, MD
Jennifer K. Nelson, PA-C
M. Kate Schmidt, NP

DATE:

Referring / Primary Care Provider ____________________ **Clinic Phone** ____________________

Pharmacy Name/ Location / Phone ____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #
HOME ADDRESS	CITY	STATE	ZIP	SEX: ❑ MALE ❑ FEMALE
DAY PHONE #	EVENING PHONE #	PREFERRED # FOR CALLS ❑ DAY ❑ EVENING	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED	

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:			OCCUPATION (Job Title)	EMPLOYMENT OR STUDENT STATUS: ❑ FULL-TIME ❑ NOT EMPLOYED ❑ RETIRED ❑ PART-TIME ❑ SELF EMPLOYED ❑ ACTIVE MILITARY
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS:	CITY	STATE	ZIP	

EMERGENCY INFORMATION

Emergency Contact	Relationship	Phone Number

RESPONSIBLE PARTY INFORMATION/INSURANCE POLICY HOLDER

RESPONSIBLE PARTY NAME LAST FIRST MI			DATE OF BIRTH	RESPONSIBLE PARTY HOME PHONE
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY SOCIAL SECURITY #
RESPONSIBLE PARTY EMPLOYER			OCCUPATION (Job Title)	RESPONSIBLE PARTY WORK PHONE
RESPONSIBLE PARTY EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ❑ SELF ❑ SPOUSE ❑ SON ❑ DAUGHTER

PRIMARY INSURANCE

EFFECTIVE DATE	GROUP NUMBER	ID NUMBER	
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP
SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

EFFECTIVE DATE	GROUP NUMBER	ID NUMBER	
INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP
SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

1. **Assignment of Benefits and Related Release of Information.** I request payment of authorized benefits directly to the provider for services furnished to me at this facility. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care reviews.
2. **Release of Information to Health Care Providers.** I consent to the release of my health records created, received and maintained by Associated Nephrology Consultants, PA for my treatment to other health care providers who are involved in my treatment. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.
3. **Important Information for Patients.** Initial Received

________ Notice of Privacy Practices (unless received during previous visit)

This consent will continue forever unless you cancel it by writing us at: Associated Nephrology Consultants, PA, 1997 Sloan Place, Ste 17, Maplewood, MN 55117; but if consent is cancelled, it will not change releases that have already been made.

Signature of Patient, or if Patient is unable to sign, a Representative of the Patient	Date
Relationship to Patient (if patient is unable to sign)	Reason Patient Unable to Sign

4. **Guarantee and Agreement to Pay**

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that 6% interest per year may be added if the account balance goes to a collection agency.

Patient, Legal Representative or Guarantor Signature	Date

☐ Directed by Patient to sign on their behalf (having read this document to them)