PATIENT DEMOGRAPHICS		
First Name:	Last Name:	
Social Security # :	Date of Birth:	
Address:		
City:	State:	Zip:
Home Phone #:	Cell Phone #:	
Email address:		
Sex: ☐ Male ☐ Female	Race :	
Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widow(er)		

INSURANCE INFORMATION	
Primary Insurance:	Effective Date:
Name on card:	Policy #:
Secondary Insurance:	Effective Date:
Name on card:	Policy:
Primary Care Physician:	PCP Phone #:
Referring Physician:	Referring Provider #:

EMPLOYER INFORMATION		
Employer:	Work #:	
Business Address:		
City:	State:	Zip:
In case of an emergency, whom should we contact?	Relationship to patient:	**Emergency Contact Phone number:**

Authorization for Treatment

I authorize West Orange Nephrology, LLC to perform procedures and treatment including administration of medicine along with other surgical and medical procedures the may be necessary. I authorize the release of any medical information necessary to process a claim and hereby assign benefits payable to West Orange Nephrology, LLC in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to other specialty physicians. Furthermore, any services not covered by my insurance will become my responsibility to full payment services rendered by West Orange Nephrology, LLC.

_____ _____

Signature of Patient or Personal Representative **Date**

West Orange Nephrology, LLC

●301 S. West Crown Point Road, Suite 120, Winter Garden, FL 34787
● 828 Mercy Drive, Suite 3 Orlando, FL 32808
● 587 E. State Road 434, Suite 1011, Longwood FL 32750
● 7960 Forest City Road Suite 104 Orlando FL 32750
Phone: 407-297-8408 Fax: 407-297-8409

Dear Patient,

Please fill out the information below. The office of West Orange Nephrology will not call and leave a message unless you have authorized to do so. This includes reminders of appointments, lab results, chart information and ext. In the form below, state where, when, and who you are comfortable sharing information with. Also, if there is anyone specific in relation with you and you are not comfortable sharing your medical information, please let us know.

I authorize the office of West Orange Nephrology to call me at the following phone numbers:

Home: _____

Work: _____

Cell: _____

Other: _____

The best day to call me is (circle as many as apply) **Mon, Tues, Wed, Thurs, Fri**

The best time to call me is_____

If I am not available it is (circle one**) ok or not ok** to leave a message.

I authorize you to share my medical information with the following people (*we will not give out any information to anyone of your acquaintance, family, or relation without your personal consent)*

_____

_____

A D V A N C E D D I R E C T I V E	
Have you designated an advanced directive who would make decisions about your medical care?	☐ Yes ☐ No
Decision makers name:	
Decision makers phone :	Email:

Patient Name: _____ Date: _____

Signature of Patient or Personal Representative: _____

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Consent for Purposes of Treatment, Payment, and Healthcare Operations

I, _____ consent to the use or disclosure of my protected health information by West Orange Nephrology for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of WEST ORANGE NEPHROLOGY, LLC. I understand that diagnoses or treatment of me by West Orange Nephrologists may be conditioned upon my consent as evidence by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of his practice. WEST ORANGE NEPHROLOGY, LLC is not required to agree on the restrictions that I may request, the restriction is binding on WEST ORANGE NEPHROLOGY, LLC.

I have the right to revoke this consent in writing, at any time, except to the extent that WEST ORANGE NEPHROLOGY, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to review WEST ORANGE NEPHROLOGY LLC's Notice of Privacy Practices prior to signing this document. The WEST ORANGE NEPHROLOGY LLC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of WEST ORANGE NEPHROLOGY LLC. The Notice of Privacy Practices for WEST ORANGE NEPHROLOGY LLC is also provided 301 S. West Crown Point Road, Suite 120, Winter Garden, FL 34787. The Notice of Privacy Practices also describes my rights and the WEST ORANGE NEPHROLOGY LLC's duties with respect to my protected health information.

I understand that I need to call WEST ORANGE NEPHROLOGY LLC'S office 24 hours in advance to reschedule. We would like to accommodate other patients on our waiting list. WEST ORANGE NEPHRLOGY LLC's reserves the right to charge $50.00 for no show appointments and same day cancellations.

WEST ORANGE NEPHROLOGY LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

Thank-you for taking the time to fill this out.