SHOALS
Kidney and Hypertension
CENTER

N. RAO BOORGU, M.D., FACP
SUBIR K. PAUL, M.D.
RAJESH BOORGU, M.D., FASN
DWIGHT MATTHEW, M.D.

422 East Dr. Hicks Blvd. • Florence, Alabama 35630
Phone (256) 766-1401 • Fax: (256) 766-1402

CONSENT TO TREAT

I authorize N. Rao Boorgu, M.D., P.C. (Shoals Kidney and HTN Center) physicians and staff to provide medical services to me and authorize the disclosure of protected health information for purposed of payment, health care operations and treatment. this includes communication with my physician, pharmacist, and hospitals, by letter, phone or fax. I understand that I have a right to request that N. Rao Boorgu, M.D., P.C. (Shoals Kidney and HTN Center) restrict the use of disclosure of protected health information for treatment, payment and health care operations, and that N. Rao Boorgu, M.D., P.C. (Shoals Kidney and HTN Center) may refuse this request. I understand that unless N. Rao Boorgu, M.D., P.C. (Shoals Kidney and HTN Center) has taken action in reliance on such consent, that I may revoke this consent, by giving written notice.

❑ **Yes** ❑ **No**

Authorization To Leave Messages

I authorized N. Rao Boorgu, M.D., P. C. (Shoals Kidney and HTN Center) physicians and staff to leave messages regarding my medical condition, such as lab reports, other test results, and information about medications on my home answering machine. This authorization will be in effect until I give written notice to N. Rao Boorgu, M.D., P.C. (Shoals Kidney and HTN Center).

❑ **Yes** ❑ **No**

Authorization To Reveal Medical & Billing Information

I authorize N. Rao Boorgu, M.D., P. C. (Shoals Kidney and HTN Center) physicians and staff to reveal to the following individuals as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals that N. Rao Boorgu, M.D., P.C. (Shoals Kidney and HTN Center) will have no control over to whom these individuals may reveal this information. I may revoke this authorization by giving written notice to N. Rao Booru, M.D., P.C. (Shoals Kidney and HTN Center).

1). Name _____ Relationship _____ Phone # _____

2). Name _____ Relationship _____ Phone # _____

3). Name _____ Relationship _____ Phone # _____

E-Prescribe Consent: I authorize N. Rao Boorgu MDPC/SKHC to send my prescriptions electronically to my pharmacy of choice. I also consent for electronic Rx history with my drug plan.

TO OUR PATIENTS WITH COMMERCIAL INSURANCE

Insurance claims are completed without a charge as a courtesy to our patients. We allow 45 days for your insurance carrier to make payment. If payment is not received within this allowed time, we ask that payment be made by the patient. You are responsible for your bill being paid in full, unless other arrangements have been made with our credit department.

You are responsible directly to N. Rao Boorgu, M.D., P. C. (Shoals Kidney and HTN Center) for payment of your account within the time limits agreed upon, regardless of the status of your insurance claim. You will receive a statement each month from the clinic even though you may have an insurance claim pending.

The clinic cannot accept responsibility of collecting your insurance or negotiating a settlement on a disputed claim. We will be pleased to furnish account information to help you should a problem occur.

Should an insurance payment be received that is less than the physician's usual charge for the services provided, you will be responsible for the difference.

Authorization

I authorize N. Rao Boorgu, M.D., P. C. (Shoals Kidney and HTN Center) to submit claims, and as required, billing and medical information to my insurance company for the purpose of determining eligibility for, and payment of, charges rendered to me. I authorize payment for these medical services be sent directly to N. Rao Boorgu, M.D., P. C. (Shoals Kidney and HTN Center). I understand I am financially responsible for any co-payments, deductibles, and any services not covered by my insurance company.

This authorization shall remain in effect until revoked in writing by the patient.

❑ **Yes** ❑ **No**

_____ _____

Signature Date

NEW PATIENT INFORMATION

PERSONAL INFORMATION

PATIENT'S FULL NAME		HOME PHONE #		CELL PHONE #
SSN	DATE OF BIRTH	AGE	MARITAL STATUS (Circle One) S M W D SEP	MALE ❑ FEMALE ❑
STREET ADDRESS, CITY, STATE, ZIP CODE		EMAIL ADDRESS:		
MAILING ADDRESS, CITY, STATE, ZIP CODE				

EMPLOYER	OCCUPATION	WORK PHONE #
SPOUSE OR PARENT'S NAME	(SPOUSE OR PARENT'S) DATE OF BIRTH	(SPOUSE OR PARENT'S) SSN
SPOUSE OR PARENT'S EMPLOYER	(SPOUSE OR PARENT'S) OCCUPATION	(SPOUSE OR PARENT'S) WORK PHONE #
NAME OF FRIEND OR RELATIVE - NOT LIVIING WITH YOU	RELATION	PHONE #

HAS ANY MEMBER OF YOUR FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? YES NO

IF SO, INCLUDE FAMILY MEMBER AND NAME OF PHYSICIAN

REFERRED BY	ADDRESS	PHONE #

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY		POLICYHOLDER NAME AS APPEARS ON CARD	
EFF. DATE	GROUP #	INSURED D.O.B.	POLICY, CONTRACT, OR I.D. #
SECONDARY INSURANCE COMPANY		POLICYHOLDER NAME	
EFF. DATE	GROUP #	INSURED D.O.B.	POLICY, CONTRACT, OR I.D. #
OTHER INSURANCE COMPANY		POLICYHOLDER NAME	
EFF. DATE	GROUP #	INSURED D.O.B.	POLICY, CONTRACT, OR I.D. #

ATTENTION MEDICARE PATIENTS: EXTENDED PATIENT SIGNATURE AUTHORIZATION PROVIDER:
N. Rao Boorgu, M.D., P.C. 422 East Dr. Hicks Blvd. Florence, AL 35630 Group NPI: 1780641951 Tax I.D.: 63-0794660

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to **N. RAO BOORGU, M.D., P.C. / Shoals Kidney & Hypertension Center** for any services or items furnished to me by the physician(s) or supplier. I authorize any holder of medical information about me to release to health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS: I request that payment of authorized Medigap benefits be made either to me or on my behalf to **N. RAO BOORGU, M.D., P.C. / Shoals Kidney & Hypertension Center** for any services or items furnished to me by the physician(s) or supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

BENEFICIARY'S NAME	MEDICARE #	MEDIGAP #
SIGNATURE OF BENEFICIARY OR PERSON SIGNING FOR BENEFICIARY X		MEDIGAP #

PLEASE READ: All charges are due at the time of services; if a patient has an Insurance that requires pre-certification for hospital admissions or physician referral it is the patient's responsibility to notify our office ahead of time (48 hrs.) to assist in getting the approval of pre-cert. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office staff. If copay for primary insurance is not paid on same day as services are rendered, there will be a $15.00 handling fee charge added to your account. If your account is turned over to a collection agency for payment, patient will be responsible for paying any collection fees.

Signature X _____ Date_____