MARYLAND KIDNEY GROUP
Nephrology/Hypertension

Phone: 443.559.5063
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Jamie Romero, CRNP
Aiman Shammas, M.D., FASN
Dipti Patel, M.D.
Neal Shah, M.D.
Immanuellin Delfin, CRNP

REGISTRATION FORM

Last Name:	**Secondary Insurance Name:**
First Name, Middle Initial:	**Secondary ID#:**
Home Address: (P.O. Boxes not accepted)	**Secondary Group#:**
City, State, Zip:	**Secondary Policy Holder:**
Home Phone:	**Secondary Policy Holder SS#:**
Work Phone:	**Secondary Policy Holder DOB:**
Cell Phone:	**Relationship:** **Circle: Self or Spouse or Child or Other**
Social Security #: (required)	
Sex: Circle Male or Female	*****Primary Care Physician***:**
Email Address:	**Address:**
Date of Birth:	**City State, Zip:**
Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**	**Phone #:**
Primary Insurance Name:	*****Referring Physician***:**
Primary ID#:	**Phone #:**
Primary Group#:	**Emergency Contact Name and Number:**
Primary Policy Holder:	**Relationship:**
Primary Policy Holder SS#:	*****Primary Pharmacy***:**
Primary Policy Holder DOB:	**Location:**

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Patient Combined Consent Form for Insurance and Office Policies

I certify that the information I have provided regarding my insurance coverage is correct and I authorize the office of Maryland Kidney Group, P.A. to verify my insurance coverage and benefits allowed in accordance with my insurance plan's policies. I authorize those payments be made directly to Maryland Kidney Group, P.A. for all medical benefits which are payable under the terms of my insurance policy for the services provided. I agree to pay any co-payments, co-insurance, or deductible as required by my insurance plan for medical care provided to me or my dependent. I understand that I am responsible for knowing the terms and regulations of my insurance plan, and that specialist referrals are always my responsibility. I agree to accept full responsibility for payment if my insurance coverage is interrupted or terminated during my care.

Initial

I authorize Maryland Kidney Group, P.A. to submit a claim to my insurance company, health and welfare fund, Medicare or Medicaid (or Medical Assistance program) for medical service provided to me or my dependent. I authorize release of any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefit, including outside vendors that may be used on my behalf. I permit a copy of this authorization to be used in place of the original.
I agree to the above stated responsibility and consent:

Initial

Receipt of Notice of Privacy Practices Acknowledgement

I certify that I have been given access to a copy of Maryland Kidney Group, P.A. Notice of Privacy Practices.

Receipt of Office and Financial Policies

I understand and agree to pay the following fees if they should arise:

Initial

1. $45 less than 24-hour notice of cancellation, or no show appt for all office visits.
2. $45 bounce check fee
3. $25.00 per form Completion
4. There is a processing fee in the State of Maryland for all copies of medical records needed. $22.88 preparation fee, .76 per page

I have received a copy of Maryland Kidney Group, P.A. Office and Financial Policies and understand them as stated. I agree to abide by Maryland Kidney Group, P.A. Office, and financial policies.

Consent for Release of Medical Information

The office of Maryland Kidney Group, P.A. is authorized to discuss my medical information, including test results, medications, appointment times, and both insurance and billing information, with the following individuals only. I understand that without prior consent, and without exception, and for my protection, my medical information will not be shared otherwise.

Name	Relationship	Phone #

_____ _____

Name of Patient **Date**