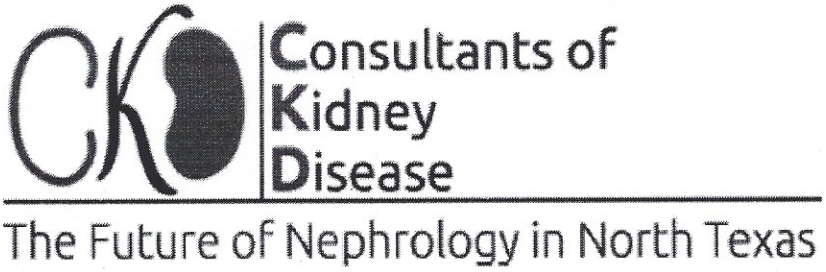


Syed Mujtaba Ali MD

Muzzaffar Hussain MD.

New Patient Form

Date: _____

Patient Demographics

Last Name: _____ First Name: _____ Middle Initial:

Date of Birth: _____ Age: ____ Sex: ____ Marital Status: _____ Driver's License #: _____

Address: _____

City: _____ State: _____ Zip code: _____ Primary Phone _____-_____-_____

Secondary Phone: _____-_____-_____ Social Security #: _____

Race: _____ Hispanic: Y or N Preferred Language: English Spanish Other: _____

Email address: _____

Emergency Contact

Last Name _____ First Name _____

Relationship: _____ Phone Number: _____

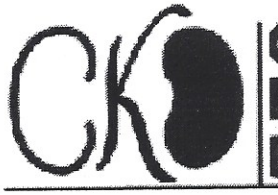
Employer information

Employed? Please circle one : Yes No Retired

Employer Name if employed: _____

Employer Address: _____

Work Phone #: _____-_____-_____ Occupation: _____



Consultants of Kidney Disease

The Future of Nephrology in North Texas

Syed Mujtaba Ali MD

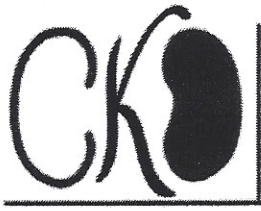
Muzzaffar Hussain MD.

CONSENT FOR TREATMENT /AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Consultants of Kidney Disease to administer such care and treatment for (patient) _____ as is medically necessary and as is set forth in the development plan of treatment. I also authorize Consultants of Kidney Disease to release any medical information acquired in the course of my examination or treatment, to any facility (including other physicians, laboratory, hospital or ancillary providers) to which I may need to be referred. I further authorize Consultants of Kidney Disease to release any medical information determined in the course of my examination or treatment required to process medical claims, to my insurance carrier.

Patient signature_____

Date of signature _____/_____/_____



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Consent to Obtain Prescription History

This consent form authorizes Consultants of Kidney Disease to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages. By signing this consent form you agree that Consultants of Kidney Disease can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes. Understanding all of the above, I hereby provide informed consent to Consultants of Kidney Disease to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed): _____

Patient Date of Birth: _____

Patient Signature: _____

Date of Signing Consent Form: _____

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Financial Policy Acknowledgement

As of 09/25/2017

Insurance Coverage: We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Copays: We have a contractual obligation (with your insurance company) to **collect** your copay at the time of service, and you have a contractual obligation (with your insurance company) to **pay** your copay at the time of service. **Copays are the patient's responsibility and are due at the time of service**. We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care you will be expected to pay this amount at the time of service. If you fail to pay your copay at the time of your appointment, we will charge an Administrative Fee of $5.00 per month for each month that your copay remains unpaid. Insurance will not cover the Administrative Fee, and you are personally financially responsible for payment.

Accepted Forms of Payment: We accept payment by cash, check, Visa, MasterCard, American Express and Discover.

Patient Outstanding Balances: If you have an outstanding balance with our company we will send a "Billing Statement" monthly to your home. We expect that you will pay your full balance upon receipt of our billing statement. If you are unable to pay the outstanding balance in full in a single payment, please contact our Billing Office. Our Billing Office is available Monday – Friday from 8:00am to 5:00pm. Please call us to discuss payment plans, patient financial evaluations and discounts available. Our direct phone number is 469-904-2020

Unpaid Accounts: In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee in order to continue receiving medical care from our physicians. Once your account has been sent to collections, you will need to make payment arrangements with the collection agency.

10611 Garland Rd, Suite 105, Dallas, TX 75218
Ph: 469-904-2020
Fax: 469-904-2028
Ckdtx.org

Other Possible Fees: **Missed Appointment Fee** - A missed appointment is a scheduled appointment that you miss without notifying us in advance. An appointment that is cancelled or rescheduled with less than 24 hours' notice is also considered a missed appointment. Our policy is that the first time you miss or cancel an appointment with less than 24 hours' notice, a letter will be sent to you. The 2nd time you miss or cancel an appointment with less than 24 hours' notice a $25.00 fee will be charged to your account. Insurance companies do not cover this charge, and you will be responsible for paying this fee prior to being seen again by our physicians.

Disclaimer: The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

Returned Check Fee – We charge $20.00 to patients whose checks are returned by our bank for non-sufficient funds. If a patient puts a stop payment on a check, the amount we will charge is $25.00. This is the amount our bank charges for these items.

I have read, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

Patient Name Printed: _____

Patient Signature: _____

Date: _____

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HIPPA Policy Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are giving us permission to share your PHI as you indicate below. I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether or not I sign this authorization. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if the Practice is soliciting my signature. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected. I understand that this authorization is voluntary and may be revoked at any time by signing the revocation form and returning it to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted up my previous authorization(s).

I, _____ hereby authorize Consultants of Kidney Disease and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

Patient Name: _____ **Date of Birth** _____

Patient Signature:_____**Date:**_____

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Ph: 469-480-4388
Fax: 469-480-4430
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