Northwest RENAL Clinic, Inc.

Patient Registration Form

Patient Name: (Last)_____ (First) _____ (MI) _____

Aliases: _____ **Date of Birth:** ___/____/____ **Email:** _____

Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Home phone: _____ **Work phone:** _____

Mobile Phone: _____ **Fax:** _____

Secondary contact / emergency contact: _____

Relationship to patient: _____ **Phone number:** _____

Preferred method of contact: ☐ Telephone – text yes/no ☐ Telephone – V/M yes/no ☐ Email
(Select all that apply)

Sex:	☐ Female | ☐ Male |☐ Nonbinary | ☐ Other | ☐ Unknown
Gender Identity:	☐ Choose not to disclose | ☐ Female | ☐ Male | ☐ Transgender Female ☐ Transgender Male | ☐ Not listed
Sexual Orientation:	☐ Choose not to disclose | ☐ Bisexual | ☐ Lesbian | ☐ Gay ☐ Not listed | ☐ Straight

Current Marital Status: ☐ Single | ☐ Married | ☐ Divorced | ☐ Widowed | ☐ Separated

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other or Undetermined

Preferred Language: _____

Primary Care Physician Name: _____**Phone:** _____

Referring Physician Name: _____**Phone:** _____

Preferred Pharmacy: _____

Preferred outpatient lab location: _____

ACKNOWLEDGMENT AND CONSENT

I understand that NW Renal Clinic, Inc. (NWRC) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by NWRC and may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that NWRC may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how NWRC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of NWRC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of NWRC's Notice of Privacy Practices in effect will be posted in waiting/reception area and available on the website at www.nwrc.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that NWRC is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

ASSIGNMENT OF BENEFITS

I agree to full responsibility for all expenses incurred by or on account for myself or for the above listed patient and hereby assign any and all insurance benefits and major medical and/or surgical benefits due to me to the full extent of my financial obligation to said physician. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is considered valid as an original. I understand that I am financially responsible for charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I agree that if costs or fees are incurred in connection with the collection of this account I will pay all such costs and fees, including collection costs, attorney fees and all court costs.

DATE _____ **SIGNATURE OF INSURED PERSON/RESPONSIBLE PARTY** _____

PHYSICIAN'S RESPONSIBILITY DISCLAIMER NON-REFERRED VISITS TO A SPECIALTY PHYSICIAN ARE YOUR RESPONSIBILTY

I understand that in order for my insurance to cover my care at Northwest Renal Clinic, a referral may be required from my Primary Care Physician. I also understand that if Northwest Renal Clinic does not receive the required authorization from my Primary Care Physician, I will be financially responsible for any and all charges incurred (including lab and X-ray services).

DATE _____ **SIGNATURE OF INSURED PERSON/RESPONSIBLE PARTY** _____

Northwest RENAL Clinic, Inc.

PERMISSION FOR PATIENT HEALTH INFORMATION (PHI) COMMUNICATIONS

I permit Northwest Renal Clinic, their physicians, medical specialists and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

(List family members/friends and state the person's relationship to the patient below)

NAME	DATE OF BIRTH	PHONE NUMBER	RELATIONSHIP

This authorization is limited to the following time frame:

- One year from Date Signed _____ Initial
- Does Not Expire _____ Initial

If, at any time, I do not want the verbal discussion to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Providers by contacting Northwest Renal Clinic to revoke this authorization.

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

INSTRUCTIONS: Bring in with your New Patient Paperwork OR print, sign and send to:

Northwest Renal Clinic
1130 NW 22nd Avenue, Suite 640
Portland, Oregon 97210
Phone: 503-229-7976, Fax: 503-274-4867