Anna Office: 824 South Central Expressway, Suite 100, Anna, TX 75409
Sherman Office: 300 N Highland Ave, Suite 365, Sherman, TX 75092

Phone: 972-521-6000, Fax: 972-521-6012
www.kaotexas.com

Office use only
Date:
Verified By:

PATIENT INFORMATION

Name: ………………………………………………………………… SSN …………………………………… ☐ Male ☐ Female

Address: …………………………………………………………………………City: …………………………………… State: ……….. Zip: ………………

Age: …………… DOB: ………………………………………Phone: ………………………………………Alternate Phone: ……………………………………

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer Name: ………………………………… Address: ……………………………………………………………………………………………

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Self-Employed ☐ Student- Full-Time ☐ Student- Part-Time

Primary Care Physician: ……………………………………………………………………… Phone: ……………………………………………………

Referring Physician (if different from PCP): ……………………………………………………Phone: ……………………………………………………

EMERGENCY CONTACT 1: Name: …………………………… ……………………Phone: …………………………………Relationship: …………………

EMERGENCY CONTACT 2: Name: ……………………………………………… Phone: ………………………………… Relationship: …………………

INSURED PARTY

Name: …………………………………………………………… SSN …………………………… Relationship: ……………………………………

Address: ……………………………………………………………………… City: …………………………………… State: ……….. Zip: ………………

Age: …………… DOB: …………………………… Phone: …………………………………… Alternate Phone: ……………………………………

Employer Name: ……………………………………… Address: ……………………………………………………………………………………

Insurance Information (Copies of insurance card and Drivers License required)

Insurance 1: ………………………………………………………………………………………………………SSN# ……………………………………

Claims Mailing Address: ……………………………………………………………………………………… Phone: ……………………………………

Policy Number: …………………………………………… Group Number: ……………………………………………………

Insurance 2: ………………………………………………………………………………………………………SSN# ……………………………………

Claims Mailing Address: ……………………………………………………………………………………… Phone: ……………………………………

Policy Number: …………………………………………… Group Number: ……………………………………………………

Authorizations

For and In consideration of the services rendered by Kidney Associates of Texas, I agree to pay said provider of services for all services rendered. I understand that I am responsible for all health Insurance deductible, copayment, and coinsurance charges not covered by my Insurance policy and charges not covered as a result or any law settlements or Judgments obtained on my behalf. Additionally, I understand that I will be responsible for charges not covered by my Insurance policy to include, charges for services deemed experimental, investigational, and/or not medically necessary as determined by my insurance company. In consideration of services rendered, I hereby transfer and assign Kidney Associates of Texas all rights, titles, and interest in any payment due to me for services provided in the above mentioned policies of Insurance/settlements or judgments. I hereby consent to the release of information necessary to process claims with my insurance policy, I understand that the specific Information to be released may Include, but is not limited to history, diagnosis, treatment of drug or alcohol abuse, mental illness, or communicable diseases, including HIV and AIDS. I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information that has been made prior to the receipt of the revocation. I have read and understand this consent and I have signed it voluntarily and of my own free will.

Signed: ……………………………………………………………………………… Date: ……………………………………………

Patients Printed Name: ……

Witness Signature: ………………………………………………………………………… Date: ……………………………………………