J. Mathews Joseph, MD
Anumeet Priyadarshi, MD

Middle Tennesee Nephrology

Welcome to Middle Tennessee Nephrology. You have six signature areas on the six pages below following this page. The titles are below:

1. **Patient – Provider Contract**
2. **New Patient Information**
3. **Authorization for Release of Medical Information**
4. **Acknowledgement of Receipt of Privacy Policy**
5. **Financial Policy**
6. **Assignment of Benefits & Permission for Treatment**

Thank you,

The Staff of Middle Tennessee Nephrology

270 East Main Street, Suite 200 | Gallatin, TN 37066 | Office 615.452.3250 | Fax 615.452.5186

J. Mathews Joseph, MD
Anumeet Priyadarshi, MD

Patient – Provider Contract

Middle Tennessee Nephrology will strive hard to be kind, courteous and respectful. Our intent is to serve our patients, in keeping with our mission statement. We want our patients to feel very comfortable and to be able to ask any questions regarding their care. Every question is important to us because it's important to you.

We would appreciate the opportunity to work with you to solve any problems you may have with Middle Tennessee Nephrology and encourage patients and their families to let us know if you are dissatisfied.

However, we can not and will not tolerate abuse and threatening language or behavior in any circumstances, and these will be grounds for immediate dismissal from our practice.

Name: _____

Signature: _____ **Date:** _____

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Middle Tennessee Nephrology, PLLC

615-452-3250 Fax: 615-452-5186

New Patient Information:

First: _____ **Middle:** _____ **Last** _____
Suffix: _____

SSN: _____ **DOB:** _____

Marital Status: (**Circle One**) Single/Married/Separated/Divorced/Widowed

Race: (**Circle One**) Black or African American/White/Hispanic/Other

Language: (Circle One) English/Spanish/Other

Street Address: _____

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

Home: (____) _____ - _____ **Work:** (____) _____ - _____ **Cell:** (____) _____-_____

Primary Contact: (Circle One) Home/Work/Cell **Emergency Contact:**

Secondary Contact: (Cirlce One) Hme/Work/Cell _____

Email: _____

PCP: _____ **Phone:** (____) _____ - _____

***Preferred Pharmacy:** _____

City/State: _____ **Pharm Phone:** (____) _____ - _____

****Please give receptionist your Insurance Cards for a copy to be made****

How did you hear about our clinic? Friend/Google/Facebook/Other

Name: _____ **Date:** _____

Signature: _____

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Authorization For Release of Medical Information:

Patient Identification:

Name: _____ **DOB:** _____

SSN: _____

Provider: (Who is releasing information):

Provider Name: _____

Phone: _____ **Fax:** _____

Disclose Information to (Where is information to be sent?):

Facility: Middle Tennessee Nephrology, PLLC

Address: 270 East Main St. Suite 200 Gallatin, TN 37066

Phone: 615-452-3250 **Fax:** 615-452-5186

Service Dates:

Dates of service from (date) _____ **to (date)** _____

Information to be disclosed:

□ **Standard Chart Copy (Includes Face Sheet, Reports, All test results)** □ **Entire Record**

□ **H&P** □ **Discharge Summary** □ **Lab** □ **Xray/Imaging** □ **Other** _____

I understand the information in my health record may include sensitive information. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorizarion. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed. I understand that any disclosure of information carries with it potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. We however, at MTN, strive to keep all patient information securely.

Name: _____ **Date:** _____

Signature of patient or responsible party: _____

Relationship to patient: _____

Expiration Date: _____

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Acknowledgement of Receipt of Privacy Policy

Privacy Policy Available Upon Request

I, _____ hereby acknowledge receipt of/ do not want, the Notice of Privacy Practices given to me by Middle Tennessee Nephrology.

Signature: _____

Date: _____

_____

For Clinical Use Only;

If not signed, document good faith efforts to obtain acknowledgement:

_____

_____

_____

Person seeking acknowledgement:

Name: _____ **Date:** _____

Signature: _____

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Middle Tennessee Nephrology

Financial Policy

Your insurance contract is an agreement between you, your insurance company, and in many instances, your employer. All charges incurred by you at Middle Tennessee Nephrology are your responsibility. Any disputes with the insurance company should be handled by you. You will be expected to pay your portion of the total charges at the time of service. If we do not participate with your insurance provider, you will be expected to pay all charges in full at the time of service. As a courtesy to you, we will file a claim with your insurance company unassigned so you will receive payment directly from your insurance company.

1. Payment is due when services are rendered. We accept cash, personal checks, and credit/debit cards. There will be a $35.00 charge assessed for all checks returned by your bank and not paid.

2. Payment plans on past due balances will be considered and approved if you can make monthly payments and pay off any outstanding balance in a timely fashion, (usually 1-2 years). Our billing manager will assist in setting up payment arrangements.

3. If you are insured, we will accept the co-payment or co-insurance, and file the insurance for you at no cost.

4. We consider an account delinquent if it has not been paid within 60 days. If we are unable to collect a bill owed by you, we will be forced to forward your account to the collection company of our choice after 90 days of no payment. You will be responsible for any costs we incur attempting to collect a debt owed by you. Unfortunately, patients who are referred to a collection agency are at risk of being formally discharged from our practice.

By signing below, I agree that I have read this information and understand it, and that I am financially responsible for all charges.

Name: _____ **Date:** _____

Signature: _____

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Anumeet Priyadarshi, MD

Middle Tennessee Nephrology

Assignment of Benefits

Non Medicare Patient

I hereby assign to Middle Tennessee Nephrology, any and all benefits from any insurance plans or any other protection maintained by the Patient and/or on the Patient's behalf or benefit, and authorize and direct such benefits to be paid directly to Middle Tennessee Nephrology for services provided to the patient by either Dr. J. Mathews Joseph or Dr. Anumeet Priyadarshi. I certify that the information given by me to Middle Tennessee Nephrology in applying for payment under my insurance plan or other protection is correct and complete. I authorize release of all records required to act on this release and assignment.

Medicare Patient

I request that payment of authorized Medicare benefits to be made to Middle Tennessee Nephrology for any services refurnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me to Middle Tennessee Nephrology in applying for payment under the Medicare program is correct and complete. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

By signing below, I agree to be financially responsible for all charges. I have read the information and understand it.

I further agree that in the event that my account is placed with an attorney for collection, I will be liable for the reasonable attorney's fees and any court costs incurred in attempt to settle my account.

Name: _____ **Date:** _____

Permission for Treatment

I hereby authorize Middle Tennessee Nephrology, PLLC to treat me for conditions requiring their services. I understand that all treatment plans will be explained in detail and I have the right to refuse any treatment. All medicine will be electronic prescribed unless I specifically deny this.

Name: _____ **Date:** _____

Signature: _____