Nephrology Associates of Montgomery County

Stephen G. Vaccarezza, M.D.
Jeffrey A. Perlmutter, M.D.

Montrose Professional Park
6240 Montrose Road
Rockville, Maryland 20852

Patient Name_____
(FIRST) (MIDDLE) (LAST)

Home Address_____
(STREET)

_____
(CITY) (STATE) (ZIP)

Telephone_____
(HOME) (CELL) (WORK)

Email address_____Pharmacy:_____Location:_____

Date of Birth: _____

Ethnicity: Hispanic/Latino___ Not Hispanic or Latino_____ Declined_____

Language Spoken: _____Gender: M_____F_____

Who Referred you to this office?_____

Patient's Employer_____

Occupation_____

Are you Single _____ Married _____ Divorced _____Widowed_____

If married please complete the following:

Spouse's Name: _____Occupation_____

Spouse's Employer's Name:_____

Spouse's Work Phone_____

Is your visit a result of: Auto Accident ? ____Yes ___No Date_____
Job Injury ____Yes ___No Date_____

In case of an emergency, whom should we contact?

Name_____Relationship_____

Daytime#_____Cellphone_____Night_____

Do you have a living Will? _____Yes _____No

PATIENT AUTHORIZATION

I request that payment of authorized benefits from my insurance company be made, on my behalf, to Drs. Vaccarezza and Perlmutter for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Date Patient Signature

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name_____

I hereby acknowledge that I received a Notice of Privacy Practices form from Nephrology Associates of Montgomery County.

_____ _____

Date Patient Signature

Nephrology Associates of Montgomery County has my permission to discuss my protected health information (PHI) with any healthcare professionals involved in my treatment and the following individuals: PLEASE DO NOT LIST YOUR OTHER PHYSICIANS. This would be family members/friends. If their name is not listed, we cannot speak with them. This is particularly important if you were to be hospitalized.

_____ _____

_____ _____

Nephrology Associates may contact me at:

_____Home _____Phone #

_____Work _____Phone#

_____Other _____Phone #

_____E-mail _____E-mail Address

_____ _____

SIGNATURE DATE

_____****Patient has reviewed by not signed acknowledgement

I understand That Drs. Perlmutter and Vaccarezza may be using telehealth services with me to provide treatment. By signing below, I give permission for the doctor to use telehealth for my visits. I understand that I am responsible for ensuring privacy at my location.

_____ _____

Patient Signature Date:

INSURANCE INFORMATON

PRIMARY INSURANCE CO._____

ID/MEMBER NUMBER_____

GROUP NUMBER_____

CLAIMS MAILING ADDRESS_____

_____

PHONE NUMBER _____

SECONDARY INSURANCE CO_____

ID/MEMBER NUMBER_____

GROUP NUMBER_____

CLAIMS MAILING ADDRESS_____

_____

PHONE NUMBER_____

YOUR COPAYS ARE DUE AT THE TIME OF YOUR OFFICE VISIT. IF YOU ARE HAVING A TELEHEALTH VISIT, YOU ARE RESPONSIBLE FOR EITHER CALLING OUR OFFICE AFTER YOUR VISIT TO MAKE A CREDIT/DEBIT CARD PAYMENT OR SENDING A CHECK TO OUR OFFICE IN A TIMELY MANNER.