ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: Nephrology Associates of WNY. If my account is turned over to a collection agency, I agree to pay the collection fee on the outstanding balance.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the sail insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____

Signature Date

NEPHROLOGY ASSOCIATES OF WNY, LLP

1306 Sweet Home Rd
Amherst, NY 14228
Phone (716) 838-3188
Fax (716) 838-1297

220 Redtail, Suite 2
Orchard Park, NY 14127
Phone (716) 712-0864
Fax (716) 712-0869

□ Alan S. Kuritzky, M.D. □ George N. Marinides, M.D. □ James E. Ryan, M.D.

□ Maria C. V. DelCastillo, M.D. □ Arundathi Namassivaya, M.D.

□ Kristin A. Matteson, D.O. □ Richard S. Steinacher, D.O.

□ Heather M. Wheat, M.D.

Dear _____:

Our goal at Nephrology Associates is to ensure the best possible care to you, our future patient. In order for us to serve you effectively and assist you in saving time, we ask that you follow the instructions listed below.

On the day of your scheduled appointment _____ at _____, Please bring the following items with you. If you cannot keep this appointment or if you have any questions, please call our office.

1. The enclosed patient information and medication sheet filled out and signed.
2. Your insurance cards & drivers license and/or photo I.D.
3. A valid referral, if your insurance carrier requires it to see a specialist
4. A list of any drug allergies
5. Please call your doctors office prior to your appointment and have them fax all pertinent labs (12months), any renal ultrasounds or CT's, and office notes stating why you are being referred. Fax to 838.1297 (Amherst office) or (Orchard Park office) 712-0869.
6. A 24 hour advance notice is appreciated to cancel your appointment
7. *If your insurance company requires a copay, it is due at time of service.*

PATIENT INFORMATION

Patient Name _____ Age_____ □Male □Female
Address_____City_____
State_____Zip_____
Home phone_____Cell_____
Date of Birth _____Social Security #_____

□ Single □Married □Widowed □Divorced □Separated

Employer _____
Work phone_____
Emergency Contact _____ Phone_____
Relationship _____ Cell # _____

Primary Care Physician_____
Address _____
Phone # _____
Referring physician (if different from PCP) _____
Phone # _____

Primary Health Insurance _____
Policy # _____ Group# _____
Primary Insurance holder name _____
Secondary Health Insurance _____
Policy # _____Group# _____
Insurance holder name _____

Patient Pharmacy Name _____
Address _____
Phone # _____

Please indicate how our office can contact you and/or your emergency contact:

□ Home phone □ Cell phone □ Work phone □ Mail

MEDICATION LIST

NAME _____ D.O.B. _____

TODAY'S DATE _____

PHARMACY NAME _____

ADDRESS _____ PHONE # _____

DRUG ALLERGIES _____

MEDICATION	DOSE	FREQUENCY	START DATE