NEPHROLOGY PHYSICIANS OF HOUSTON

NPH

NEPHROLOGY • DIALYSIS • HYPERTENSION • TRANSPLANTATION

(Certified Diplomate of the American Board of Internal Medicine and Nephrology)

(**Board Certified Specialist in Hypertension)

Rafael C. Esquenazi, MD**, FACP, FASN
Mary A. Washington, MD, FACP
Ather R. Khokhar, MD

PATIENT INFORMATION

PATIENT'S NAME	MARITAL STATUS (S M W DIV SEP)	DATE OF BIRTH	SOCIAL SECURITY NO.

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE NO.

PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

IN CASE OF ENERGENCY, CONTACT:	DRIVERS LIC. NO.

SPOUSE'S NAME	CREDIT CARD TYPE NO.

SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.

EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

WHO REFERRED YOU TO THIS PRACTICE?	FAMILY PHYSICIAN (PEDIATRICIAN/ OB/GYN/ INTERNIST)

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE, ZIP	HOME PHONE NO.

COMPANY NAME & ADDRESS NAME OF POLICYHOLDER	CERTIFICATE NO. GROUP NO.	

COMPANY NAME & ADDRESS NAME OF POLICYHOLDER	POLICY NO.	

COMPANY NAME & ADDRESS NAME OF POLICYHOLDER	POLICY NO.	

MEDICARE	MEDICARE NO.	MEDICAID	PROGRAM NO.	COUNTY NO.	ACCOUNT NO.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

ASSIGNMENT AND RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM.

DATE _____ SIGNATURE _____

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THE PATIENT IS RESPONSIBLE FOR ALL CHARGES RESULTING FROM PROFESSIONAL SERVICES RENDERED BY DOCTOR REGARDLESS OF INSURANCE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

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