DESERT KIDNEY CARE

Rodolfo R. Batarsé, M.D., F.A.S.N.
71-511 Highway 111, Suite H, Rancho Mirage, CA 92270-4465

PATIENT REGISTRATION FORM

TODAY'S DATE_____ New Patient _____ Update _____

PATIENT NAME: _____
Last First MI

Patient's Home Telephone Number: _____ Patient's Cell Number _____

Patient Date of Birth: _____ Social Security Number _____
Month/Day/Year

Permanent Address: _____
Street City State Zip

Mailing Address (if different): _____
Street City State Zip

Marital Status: (please circle one) Single Married Divorced Widow/Widower

Spouse Name: _____ Spouse Telephone _____

Emergency Contact _____ Contact's Telephone Number _____

Race: _____ Ethnicity: _____Hispanic/Latino _____Not Hispanic/Latino

(Race Choices: White Black Asian Alaska Native American Indian Native Hawaiian Pacific Islander Other - Please CHOOSE One)

Language: _____ **Patient's email address:** _____

Primary Care Physician: _____ Referring Physician_____

Employer:_____ Occupation_____

_____ Employer Telephone _____
Employer address

YOUR PHARMACY NAME_____ **LOCATION CITY AND STREET**_____

INSURANCE

1)Primary Insurance: _____Subscriber ID# _____

Group #_____ Subscriber Name _____

Claims Mailing Address: _____

2)Secondary Insurance: _____Subscriber ID# _____

Group #_____ Subscriber Name _____

Claims Mailing Address: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Desert Kidney Care/Rodolfo R. Batarsé, MD. I also authorize Desert Kidney Care/Rodolfo R. Batarsé, MD to release any information required to process my claims.

_____ _____
Patient's Signature Date

Desert Kidney Care

Medication List

DATE_____

PATIENT NAME _____

Date of Birth_____

MEDICATION	Strength	DIRECTIONS FOR USE	Prescribing Physician	Start Date	Condition/Reason

DESERT KIDNEY CAR*E*

Rodolfo R. Batarsé, M.D., F.A.S.N.

71-511 Highway 111, Suite H

Rancho Mirage, CA 92270

Notice of Privacy Practices

Acknowledgement of Receipt

I acknowledge that I have been given the opportunity to read the Practice's Notice of Privacy Practices.

_____ _____

Patient's Printed Name Patient's Signature

_____

Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

□ **Home Telephone** _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

□ **Work Telephone**_____
- □ O.K. to leave message with detailed information

□ Leave message with call-back number only

□ **Written Communication**
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number

□ **Other** _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Key: T=Treatment Records, P=Payment Information, O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax, P=Phone, E=Email, M=Mail, O=Other

Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: RODOLFO R BATARSE MD MEDICAL CORPORATION
DESERT KIDNEY CARE

Patient's Name: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐ ☐ ☐ ☐

Expiration Date: _____

I, _____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

_____ _____

Cardholder's Signature Date