NEW PATIENT INFORMATION:

LAST NAME_____FIRST NAME/INITIAL_____

SOCIAL SECURITY #_____DATE OF BIRTH_____

SEX_____MARITAL STATUS_____ RACE_____

ADDRESS_____CITY/STATE/ZIP_____

PRIMARY CARE DR_____PHARMACY_____

HOME PHONE #_____CELL PHONE #_____

EMERGENCY CONTACT:

NAME_____PHONE#_____

RELATIONSHIP_____

INSURANCE INFORMATION:

PRIMARY INS COPANY_____POLICY/GROUP #_____

PRIMARY INS POLICY HOLDER NAME/DOB_____

SECONDARY INS CO INFORMATION_____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY; OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DIRECTED, REALIZING THAT I AM RESPONSIBLE FOR PAYMENT OF ANY NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT WHICH IS NECESSARY TO PROCESS INSURANCE CLAIMS.

SIGNATURE_____

DATE_____

Carolina Nephrology, P.A.

Toll Free for All Offices 877-293-1973

R. David Kemp, M.D.
Ajay I. Shreenath, M.D.
Marisa M. Montgomery, FNP

1704 A Wayne Memorial Dr.
Goldsboro, NC 27534
(919) 580-1026
Fax # 580-1027

516 Beamon St.
Clinton, NC 28328
(877) 293-1973

201 N. Breazeale Ave.
Mt. Olive, NC 28365
(877) 293-1973

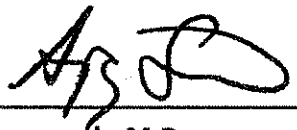
110 Eastwood Dr.
Wallace, NC 28466
(877) 293-1973

AGREEMENT TO BRING BOTTLES OF MEDICATION

TO APPOINTMENTS

Dr. Robert Kemp and Dr. Ajay Shreenath request that patients bring in ALL bottles of medications to include over-the-counter medication as well as medications prescribed by other physicians so that medication reconciliation will be accurate. A written list of medications will not be accepted. Starting November 01, 2015 if you do not have the actual bottles of medications you are taking, your appointment may be rescheduled.

Robert Kemp, M.D.



Ajay Shreenath, M.D.

_____

Patient's Signature

_____

Date

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ASSIGNMENT OF BENEFITS

I HEREBY CONSENT TO TREATMENT FOR MY MEDICAL PROBLEM BY CAROLINA NEPHROLOGY, P.A.

I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO CAROLINA NEPHROLOGY, P.A., FOR ANY SERVICES PROVIDED TO ME, AND I AUTHORIZE RELEASE OF ANY PERTINENT INFORMATION REQUIRED FOR PAYMENT, OR IN THE PURSUIT OF CONSULTATION. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE AND COPAYMENTS REQUIRED BY MY INSURANCE COMPANY(IES). I UNDERSTAND THAT THERE MAY BE SERVICES PROVIDED THAT ARE CONSIDERED A NON-COVERED, OR MEDICALLY UNNECESSARY, CHARGE BY MY INSURANCE COMPANY AND I HEREBY AGREE TO BE FINANCIALLY RESPONSIBLE FOR SAID CHARGES. I AUTHORIZE THE REFUND OF ANY OVERPAID INSURANCE BENEFITS. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING ANY RESONABLE LEGAL FEES.

SIGNATURE_____

DATE_____

Carolina Nephrology, P.A.

Toll Free for All Offices 877-293-1973

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I HEREBY GIVE CONSENT FOR THE FOLLOWING FAMILY MEMBER(S) TO RECEIVE INFORMATION REGARDING MY MEDICAL CONDITION:

NAME_____

NAME_____

NAME_____

NAME_____

SIGNATURE_____

DATE_____

Carolina Nephrology, P.A.

Toll Free for All Offices 877-293-1973

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REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE_____

TO_____
_____
_____
_____

I HERE BY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

CAROLINA NEPHROLOGY, P.A.
1704A WAYNE MEMORIAL DR
GOLDSBORO, N.C. 27534
FAX #(919) 580-1027

PATIENT'S NAME_____

ADDRESS_____

CITY/STATE/ZIP CODE_____

DATE OF BIRTH_____

THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED. PATIENT OR LEGAL GUARDIAN MAY CANCEL THIS AUTHORIZATION AT ANY TIME.

SIGNATURE_____