ADVANCED KIDNEY CARE OF HUDSON VALLEY, P.C

425 Robinson Avenue, Suite 1
Newburgh, NY 12550

2585 South Road, Suite 15A
Poughkeepsie, NY 12601

Phone (845) 454-1399/Fax (845) 397-1333

Paul Feldman, M.D. **Shawn Dhupar, M.D.** **Yong Wen, M.D.**
Meera Lobo, M.D. **Payam Shakouri, M.D.** **Chang Xu, M.D.**
Sharad Sathyan, M.D.

Please print clearly and complete all items that apply. Date: _________________________

Patient Information:

Last name: _______________________________ First name: _____________________________ Middle: _____________

Date of birth: _________________________ **Sex: Male or Female** SS#: ____________________________________

Address: ____

City: _____________________________________State: ____________________ Zip: ____________________

Cell phone #: _____________________________ Home phone #:____________________________

Emergency contact: Name & Phone: _______________________________ Relation: ______________________________

Referring Doctor: ______________________________ Primary Care Doctor: ________________________________

PHI- HIPPA Information: Enter any names you wish information to be released to family member or physician:

1. ____ TEL # _______________________________

2. ____ TEL # _______________________________

Do you want a copy of our HIPPA policy information? YES or NO

Insurance Information:

1) Primary Insurance: _________________________ ID# __________________________ Group#: ________________

Policy holder: __________________________________ Relationship: __________________________

Date of birth: ___________________________ SS#: _______________________________

2) Secondary Insurance: ___________________________ ID# __________________________ Group#: __________________

Policy holder: __________________________________ Relationship: __________________________

Date of birth: ___________________________ SS#: _______________________________

Information Release, Assignment of Benefits, Treatment Authorization

I understand that I am financially responsible for all charges for services and supplies, whether or not paid by said insurance. I authorize the release of any and all information necessary to process this claim and secure the payment. I permit a copy of this authorization to be used in place of the original. I certify that the information I have reported is correct. I hereby authorize payment to Physician for medical benefits on my behalf. I request that payment be made directly to Physician. Also, I authorize the performance of medically necessary diagnostic tests, treatment, and procedures upon myself/my child by Physician, and or his designee. I understand that I may access the HIPPA information on file with this office and I am aware of the possible uses and disclosures of my protected health information and my privacy rights.

Patient Signature: _________________________________ Date: ____________________