BALBOA NEPHROLOGY MEDICAL GROUP, INC.

RECEIPT OF NOTICE OF PRIVACY POLICY AND PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED OR HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW A COPY OF BALBOA NEPHROLOGY MEDICAL GROUP'S:

NOTICE OF PRIVACY POLICY AND PRACTICES

I UNDERSTAND THAT AMENDMENTS TO THIS POLICY MAY OCCUR IN THE FUTURE AND THAT A CURRENT SUMMARY OF THIS OR THE AMENDED NOTICE WILL BE POSTED IN THE MEDICAL OFFICE FOR MY REVIEW. A COPY OF THE AMENDED NOTICE WILL BE MADE AVAILABLE TO ME ON REQUEST.

_____ _____

Print Name Date

_____ _____

Signature Telephone

_____

Date of Birth Physician

_____

Relationship to Patient (if other than patient)

BNMG
Balboa Nephrology Medical Group

Financial Policy

PATIENT NAME (PRINT) _____

PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand about medical insurance, eligibility, coverage, our office policy and medical services.

It must be understood that:

- **Our Business Office will bill your primary & secondary insurance carrier.**
- **If you do not have insurance, payment is due at the time of service.**
- **We render our services on the basis that insurance companies may or may not pay for all, or a portion of our charges.**
- **Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.**
- **Not all insurance companies/third party payors pay for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.**
- **All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received.**
- **Patients are personally responsible for Knowing and Understanding their own Insurance Policy, Eligibility and Coverage.**
- **Patients are responsible for payment of outstanding Deductibles and Co-insurance amounts at time of service. Co-payments will be collected at the time of service.**
- **Patients are financially responsible for payments of all non-authorized procedures and non-covered services.**
- **Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.**

The Patient or Patient's Legal Representative hereby acknowledges that he/she is Eligible for Health Insurance Benefits and Coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services, and agrees to pay all charges to the Physician accordingly.

_____ _____

Signature of Patient or Guardian **Date**

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ **If yes**, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ **DATE** _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

Your signature gives Balboa Nephrology Medical Group, INC permission to bill your insurance company for as long as you are a Patient in this office. To withdraw your permission, please submit your request in writing. Thank you.

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BNMG
Balboa Nephrology Medical Group

Consent to Review Medical Records by

California Institute of Renal Research (CIRR)

As a division of Balboa Nephrology Medical Group, CIRR has access to over 30 nephrologists, a large transplant program, and over 2,500 dialysis patients. This relationship, along with its principal investigators, staff, and research facilities, has made CIRR an established presence throughout San Diego County.

CIRR has become known as a leading research institute in the specialty areas of CKD (Chronic Kidney Disease), Dialysis, Vascular Access, and Renal Transplantation. CIRR has worked with many internationally known companies.

YES, I give my permission for CIRR to review my medical records so that I might possibly participate in a research study.

_____ _____
Signature Date

_____
Printed Name

NO, I do not want CIRR to have access to my medical records.

_____ _____
Signature Date

_____
Printed Name

Doctor: _____

Acumen Account #: _____