KIDNEY & HYPERTENSION ASSOCIATES
Your Renal Care Specialists

Amite Bogalusa Covington Franklinton Hammond Kentwood Slidell

Administrative Office: 217 Cherokee Rose Lane Covington, Louisiana 70433 (985) 893-0911 (985) 875-7565 fax

David R. Powers, M.D.
Brandon K. Bean, M.D.

Brenda J. Ledet, ANP-C

DATE:

ACCT.#:

	Last Name	First Name	Middle/Maiden	Date of Birth
☐ Male ☐ Female	Address			Age
STATUS ☐ Single ☐ Married ☐ Other	City	State	Zip	Phone(Home)
	Social Security Number	Driver's Lic. No. LA	Work Related Injury ☐ YES ☐ NO	
RESPONSIBLE PARTY ☐ Self ☐ Parent ☐ Guardian	Name of Employer/School		If Student ☐ Full Time ☐ Part Time	
	Employers's Address		Phone (Work)	
INSURANCE INFORMATION	Primary Insurance		Secondary Insurance	
	Policy Contact No.	Group No.	Policy/Contract No.	Group No.
	Name and Social Security Number of Policy Holder		Date of Birth of Policy Holder	
	SEND CLAIMS TO:			

Emergency Phone # other than home	Name	Relationship
Family Physcian	Phone	Kidney & Hypertension Physcian
Referring Physician	Phone	

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

For medical services rendered to myself or dependents(s), I hereby authorize the following:

A) Release of any information to obtain examination, treatment, and/or payment.

B) Direct payment of KIDNEY & HYPERTENSION ASSOCIATES

C) Photocopies of this form to be as valid as the original.

D) I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kidney & Hypertension Associates for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any infromation needed to determine these benefits or the benefits payable for related services.

I UNDERSTAND THAT HAVING INSURANCE COVERAGE DOES NOT RELEASE ME OF THIS LIABILITY

Signature of Insured / Responsible Party	Date