Transplant Institute of Research Medical Center
Daniel Murillo, M.D.
2340 E Meyer Blvd, Suite 646
Kansas City, MO 64132

Office Visit _____
Dr. Interview_____
PreTransplant Class_____
Active Transplant Update_____
Potential Donor For_____

REGISTRATION FORM: Kidney___ Pancreas___

PATIENT INFORMATION

HIPPA Brochure Given to Patient _____
Date_____ Insurance Policy Given to Patient_____

If this is your First Visit - Who Referred You to The Transplant Institute? _____

Patient's Legal Name:

First:_____ M.I.:____ Last:_____ Nickname:_____

Maiden Name or Other Names Known As:_____ Race:_____

Patient's SS#_____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____County_____

Home Phone: (____)_____Pager: (_____)_____Cell: (____)_____

Sex: M or F Marital Status: S M W D Spouse's Name: _____

Patient's E-mail Address: _____

Emergency Phone Number: (___)_____ Name & Relationship: _____

Emergency Contact Address:_____

Primary Care Doctor: _____ Phone #: (____)_____

Primary Care Doctor Address: _____

Does your insurance require **referrals** from your Primary Care Doctor? Yes_____ No _____

Nephrology (Kidney) Doctor: _____

Are you Employed? Yes___ Full-time___ Part-time___ No___ **Disabled**___ **What Date**_____

Occupation:_____

Employer: _____ How many years at this job?_____

Phone #: _____Employer's Address: _____

Retired(date):_____ **Indicate your former occupation, employer:**

_____

Continue Patient Name:_____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company: _____ Effective Date:_____

Certificate/ID#_____ Group/Policy #_____

Subscriber: Self__Spouse__Other__Subscriber Name:_____

Subscriber's Date of Birth: _____ Employer:_____

If this is a Group Health Plan sponsored by an employer, is the subscriber still working? _____

SECOND INSURANCE INFORMATION:

Name of Insurance Company:_____Effective Date:_____

Certificate/ID#_____ Group/Policy #_____

Subscriber: Self__Spouse__Other__Subscriber Name:_____

Subscriber's Date of Birth: _____Employer: _____

If this is a Group Health Plan sponsored by an employer, is the subscriber still working? _____

THIRD INSURANCE INFORMATION:

Name of Insurance Company:_____Effective Date:_____

Certificate/ID#_____ Group/Policy #_____

Subscriber: Self__Spouse__Other__Subscriber Name:_____

Subscriber's Date of Birth: _____ Employer _____

If this is a Group Health Plan sponsored by an employer, is the subscriber still working? _____

Are you on Social Security Disability? _____ If yes, from what date?_____

Why do you qualify for Medicare (check all that apply)?

[ ] Retirement (age 65 or over)
[ ] Disability Reason:_____
[ ] Work Related
[ ] Accident
[ ] Kidney Disease
[ ] Black Lung Program
[ ] VA Authorized
[ ] Government Grant

Dialysis Information: Start Date: _____Type: HEMO_____ PERITONEAL_____

Dialysis Center:_____

Have you had previous Kidney Transplant? _____ If yes, date:_____

(OVER)

NOTICE TO ALL PATIENTS:

AUTHORIZATION TO PAY BENEFITS TO RMC Transplant Physicians, L.L.C. and/or RESEARCH MEDICAL CENTER:

I hereby authorize payment directly to RMC Transplant Physicians, L.L.C. and/or Research Medical Center for the Surgical and/or Medical benefits, if any, for services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize RMC Transplant Physician, L.L.C. and/or Research Medical Center to release any information acquired in the course of my examination or treatment necessary to establish a health insurance claim for payment.

I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits, the benefits payable for related services, or other information as requested.

I understand that occasionally my insurance company will deny payment for services that my physician and/or I feel are necessary. I hereby agree to pay for such services in a prompt and timely manner.

If my insurance plan requires a referral form, I understand that it is my responsibility to obtain a referral prior to treatment or services rendered by RMC Transplant Physicians, L.L.C. and/or Research Medical Center. Failure to obtain a referral may result in denial of payment from the insurance company, in which case I will be responsible for payment.

I understand that if RMC Transplant Physicians, L.L.C. and/or Research Medical Center do not participate with the insurance plan in which I am enrolled that I will be responsible for payment.

If my insurance plan or coverage changes, I will notify the office within 5 working days of the change.

Signed: _____ Date: _____

Printed Name: _____

Insured Signature: (If different than patient) _____