Nephrology Associates, P.C.

Patient Information: Date: _____

Last Name: _____ First Name:_____ MI: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____ Work _____

Email Address: _____@_____

Date of Birth: _____ SS#: _____ Sex: M F _____

Race: ☐ White ☐ African American ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander

Language: _____ Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Work Status: _____ Name of Employer: _____

Primary Doctor Name & Phone _____

Referring Doctor Name & Phone _____

Pharmacy Name & Phone _____

Preferred method to receive results/messages: ___ Cell Phone ___ Home Phone ___ Email ___ Text Message

Allergies: (please indicate allergies to medications, dyes, foods, latex or other substances.)

_____

_____

Medications: (please include over the counter medications and supplements)

_____

_____

_____

Immunizations:

	Date
Flu Shot	_____
Pneumonia	_____
Chicken Pox Vaccine	_____
Hep B Vaccine	_____
Tetanus Shot	_____

Tests:

Bone Density Scan	_____
Colonoscopy	_____
Mammogram	_____
PSA Test	_____
Thyroid Test	_____
Tuberculosis Test	_____

Covid Vaccine: Johnson Moderna Pfizer

Dates: 1st _____ 2nd _____ 1st booster _____ 2nd booster _____

Patient Name: _____

Tobacco:

_____ Never Smoker Smokeless: _____ Current _____ Former

_____ Former Smoker: Year/Age Started _____ Year/Age Stopped _____

_____ Currently Smoker: Year/Age Started _____ How Much _____

Alcohol:

_____ Never Used Alcohol

_____ Formerly Used Alcohol: Year/Age Started _____ Year/Age Stopped _____

_____ Currently Use Alcohol: Year/Age Started _____ Type _____ How often/Drinks per week: _____

Recreational Drugs:

_____ Formerly Used Type: _____

_____ Currently Uses Type: _____

Exercise: ___Often ___Rarely ___ Never

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Spouse Name _____ DOB: _____ Employer _____

Sexual Activity: ___ Not Active ___ Active Partner: ___Male ___ Female

Occupation: _____ ___Full Time ___Part Time ___Retired ___Student

Power of Attorney or Living Will: ___ Yes ___No

Surgical History/Hospitalizations:

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐Scarlet Fever ☐ Polio

Family History

	Mother	Father	Other: _____	Other:_____
Cancer (type)	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Heart Disease (type)	_____	_____	_____	_____
Diabetes (type)	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____
Alzheimer's/dementia	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Drug/Alcohol Abuse	_____	_____	_____	_____

Patient Name: _____

Past Medical History:

____ Alcoholism
____ Alzheimer's Disease
____ Angina
____ Anemia
_____
____ Aneurysm
_____
____ Anxiety
____ Arteriosclerosis
____ Arthritis
Type _____
____ Asthma
____ Atrial Fibrillation/Flutter
____ Bleeding Disorder
____ Bronchitis
____ Cancer (indicate location)
_____
____ Hodgkin's Disease
Cardiac:
Type _____
____ Murmur
____ Carotid Artery Stenosis
____ Cataracts
____Chest Pain/Tightness
____ Crohn's Disease
____ COPD
____ Colitis
____ Colon
Type _____
____ Coronary Artery Disease
____ Deep Vein Thrombosis
____ Dementia
____ Depression
____ Dermatitis
____ Diabetes
Type: _____
____ Diverticulitis
____ Diverticulosis

____ Drug Addiction
____ Eating Disorder
Type _____
____ Eczema
____ Emphysema
____ Epilepsy/Seizure Disorder
____ Esophagitis
____ Gallstones
____ Gout
____ Headache
____ Hearing Loss
____ Heart Disease
Type _____
____ Arrhythmia
____ CHF
____ Heart Valve
____ Heart Attack
____ Hernia
Type _____

Herpes Type: ____
____ HIV Infection
____ Hepatitis A B C
____ High Blood Pressure
____ High Cholesterol
____ Hives ____
Immune Disorder
Type _____
____ Infectious Disease
____ Leukemia
____ Liver Disease
____ Cirrhosis
____ Lung Disease
____ Lupus
____ Lymphoma
Type_____
____Melanoma

____ Mental Illness
____ Migraine
____ Muscle Disorder
____ Night Sweats
____ Obesity
____ Osteoporosis
____ Palpitations
____ Pancreatitis
____ Parkinson's Disease
____ Peripheral Vascular Disease
____ Phlebitis
____ Pneumonia
____ Prostate Disease
Type_____
____ Psoriasis
____ Pulmonary Embolism
____ Shortness of Breath
____ Sickle Cell Anemia
____ Sinusitis
____ Stroke
Type: _____
____ Swollen Ankles
____ Thyroid Disease
Type _____
____ Tuberculosis
____ Tumors
____ Ulcer
Type _____
____ Urinary Issues:
_____
_____
____ Incontinence
____ BPH
____ Erectile Dysfunction
____ Venous Insufficiency
____ Vertigo
____ Weight Gain
____ Weight Loss

Patient Name: _____

Insurance Information

All information must be filled out entirely in order for your visit to be billed correctly to your insurance company. Without the correct information, we can't bill your insurance and you will be accountable for the bill. We need the primary insurance holder's information. Ex: If you are the patient and you are covered under your spouse's insurance we need your spouse's information, also same with parent/child coverage.
**Date of birth and Social Security number are mandatory for billing purposes.

Primary Insurance

Insurance Company _____Policy #_____

Policy Holder: check one Self _____ Spouse _____ Parent _____

If you are not the policy holder:

Policy holder's name: _____ Date of Birth: _____

Social Security #: _____ Phone Number: _____

Secondary Insurance

Insurance Company _____Policy #_____

Policy Holder: check one Self _____ Spouse _____ Parent _____

If you are not the policy holder:

Policy holder's name: _____ Date of Birth: _____

Social Security #: _____ Phone Number: _____

***RELEASE OF INFORMATION/EMERGENCY CONTACT*:** **____ No HIPPA release contacts.**
Please list any persons that we may release your personal health information:
Please include all names (spouse, children, and friends) as we are unable to release information if the name is not listed below:

Name_____ Phone ____-____-____

Relationship_____Address_____

Name_____ Phone ____-____-____

Relationship_____Address_____

Name_____ Phone ____-____-____

Relationship_____Address_____

Assignment of Benefits/Authorization for Release of Medical Records

Lifetime Medicare B and/or Independent Insurance Signature Authorization: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Independent insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/practitioner services to the physician/practitioner or directly to Nephrology Associates, PC. I also verify my name, address, and insurance information is correct as provided by me today. I understand I am financially responsible for all charges not covered by my insurance and guarantee payment of this account. I also authorize Nephrology Associates, P.C. to release any medical records to other providers participating in my care as well as allow this office to obtain records from my other physicians regarding my care, unless otherwise stated in writing by me. My signature below also signifies I have been given Nephrology Associates, PC Notice of Privacy Practices and authorize the release of information to the persons listed above.

_____ _____

Signature of patient/responsible party Date

FINANCIAL POLICIES

Thank you for selecting Nephrology Associates, P.C. for your care. We are committed to providing you with the best medical care possible. Please read below where we outline our payment policies. Your signature constitutes your agreement to abide by these policies.

CO-PAYMENTS:

- Your insurance contract requires that co-payments are due at the time of your visit. If for any reason you cannot pay your co-payment at the time of visit, your account will be charged a $10 processing fee.
- Specialist co-payments may be indicated on your card and may be more than your standard co-payment to your primary care provider.

HEALTH SAVINGS ACCOUNTS (HSA, HRA, FSA, etc.):

- These types of plans are commonly high deductible plans.
- As our patient, you are expected to pay for services when they are rendered.
- Our staff can provide you with your provider's approximate discounted fee for the services you receive.
- If after the insurance company processes your claim and you have a credit, we will issue a refund or if you have a balance, we will bill you for the difference.

PAYMENT ARRANGEMENTS:

- Under special circumstances, payment arrangements may be available to you when you meet with our billing specialist or practice manager.
- Monthly statements will be sent to you; however, it is your responsibility to know when your monthly payments are due. We will confirm this with you when we set up your payment plan.
- In the event that your unpaid charges are sent to a collection agency or attorney, you will be responsible for any fees or other legal cost of collection.
- If you have a financial hardship, you many request a budget payment plan with a deposit due at the time of service.
- All remaining balance is due upon receipt of our bill.

PAYMENT AT TIME OF SERVICE:

- Non-covered services, high deductibles and the absence of insurance will require payment at the time services are rendered.
- If you do not have a required physician referral at the time of your appointment, you are responsible for payment for all services rendered to you.
- If you have an insurance pan that our physicians do not participate with, you will be responsible for payment at the time of service.

INSURANCE CLAIMS:

- Our office will file insurance claims with your insurance company. While we file claims as a courtesy to you, you remain responsible for the payment for the services provided to you. Please direct any questions about your claims with your insurance company

METHODS OF PAYMENT:

- We accept the following methods of payment: cash; check; credit card (VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS)
- If your check is returned, you will be charged a $25 processing fee.

I have read the above Nephrology Associates, PC Financial Policy and I understand what is expected at the time services are provided to me. I also authorized my insurance benefits to be paid directly to NEPHROLOGY ASSOCIATES, PC. I also further authorize the release of information required to process my insurance claim.

Printed Patient Name: _____ Date: _____

Patient Signature: _____

Witness: _____ Date: _____

American Sign Language

Point to your language. An interpreter will be called. The interpreter is provided at no cost to you.

Arabic

عربي

أشر إلى لغتك. وسيتم الاتصال بمترجم فوري. كما سيتم إحضار المترجم الفوري مجانًا.

Bengali

বাংলা

আপনার ভাষার দিকে নির্দেশ করুন। একজন দোভাষীকে ডাকা হবে।দোভাষী আপনি নিখরচায় পাবেন।

Burmese

မြန်မာ

သင့်ဘာသာစကားကို ညွှန်ပြပါ။ စကားပြန် ခေါ်ပေးပါမယ်။
သင့်အတွက် စကားပြန် အခမဲ့ ပေးပါမယ်။

Cantonese

廣東話

請指認您的語言，
以便為您提供免費的口譯服務。

Farsi

فارسي

زبان مورد نظر خود را مشخص کنید. یک مترجم برای شما درخواست خواهد شد. مترجم بصورت رایگان در اختیار شما قرار می گیرد.

French

Français

Indiquez votre langue et nous appellerons un interprète. Le service est gratuit.

Haitian Creole

Kreyòl

Lonje dwèt ou sou lang ou pale a epi n ap rele yon entèprèt pou ou. Nou ba ou sèvis entèprèt la gratis.

Hindi

हिंदी

अपनी भाषा को इंगित करें। जिसके अनुसार आपके लिए दुभाषिया बुलाया जाएगा। आपके लिए द्भाषिया की निशुल्क व्यवस्था की जाती है।

Hmong

Hmoob

Taw rau koj hom lus. Yuav hu rau ib tug neeg txhais lus. Yuav muaj neeg txhais lus yam uas koj tsis tau them dab tsi.

Italian

Italiano

Indicare la propia lingua. Un interprete sarà chiamato. Il servizio è gratuito.

Japanese

日本語

あなたの話す言語を指してください。
無料で通訳サービスを提供します。

Korean

한국어

귀하께서 사용하는 언어를 지정하시면 해당 언어 통역 서비스를 무료로 제공해 드립니다.

Mandarin

國語

請指認您的語言，
以便為您提供免費的口譯服務。

Nepali

नेपाली

आफ्नो भाषातर्फ औंल्याउनुहोस्। एक दोभाषेलाई बोलाइनेछ।
तपाईंको विना कुनै खर्चको, एकजना दोभाषे उपलब्ध गराइनेछ।

Polish

Polski

Proszę wskazać swój język i wezwiemy tłumacza. Usługa ta zapewniana jest bezpłatnie.

Portuguese

Português

Indique o seu idioma. Um intérprete será chamado. A interpretação é fornecida sem qualquer custo para você.

Punjabi

ਪੰਜਾਬੀ

ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ। ਜਿਸ ਮੁਤਾਬਕ ਇਕ ਦੁਭਾਸ਼ੀਆ ਬੁਲਾਇਆ ਜਾਵੇਗਾ। ਤੁਹਾਡੇ ਲਈ ਦੁਭਾਸ਼ੀਆ ਦੀ ਮੁਫਤ ਇੰਤਜ਼ਾਮ ਕੀਤਾ ਜਾਂਦਾ ਹੈ।

Romanian

Română

Indicați limba pe care o vorbiți. Vi se va face legătura cu un interpret caare vă este asigurat gratuit.

Russian

Русский

Укажите язык, на котором вы говорите. Вам вызовут переводчика. Услуги переводчика предоставляются бесплатно.

Somali

Af-Soomaali

Farta ku fiiqluqadaada… Waxa laguugu yeeri doonaa turjubaan. Turjubaanka wax lacagi kaaga bixi mayso.

Spanish

Español

Señale su idioma y llamaremos a un intérprete. El servicio es gratuito.

Tagalog

Tagalog

Ituro po ang inyong wika. Isang tagasalin ang ipagkakaloob nang libre sa inyo.

Vietnamese

Tiếng Việt

Hãy chỉ vào ngôn ngữ của quý vị. Một thông dịch viên sẽ được gọi đến, quý vị sẽ không phải trả tiền cho thông dịch viên.