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: _____

Emergency Contact: _____ Rel: _____ Phone: _____

Primary Doctor Name & Phone _____

Referring Doctor Name & Phone _____

Pharmacy Name & Phone _____

Preferred method to receive results: ___ Cell Phone ___ Home Phone ___ Email

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

_____

_____

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

_____

_____

_____

Health Maintenance:

Test/Immunizaion	Most Recent Date Done
Bone Density Scan	_____
Chicken Pox	_____
Colonoscopy	_____
Flu Immunization	_____
Hepatitis B Vaccine	_____
Mammogram	_____
Pneumovax Immunizations	_____
PSA Test	_____
Tetanus	_____
TSH	_____
Tuberculosis Test	_____

Patient Name: _____

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

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:

Date	Procedure
_____	_____
_____	_____
_____	_____

Hospitalizations:

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Family History

	Family Member	Age Diagnosed
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:

____ AIDS
____ Abd Aortic Aneurysm
____ Alcoholism
____ Alzheimer's Disease
____ Anemia
____ Anemia of Chronic Disease
____ Anemia B12 Deficiency
____ Anemia, Iron Deficiency
____ Angina
____ Anorexia Nervosa
____ Anxiety
____ Arteriosclerosis
____ Arthritis
____ Arthritis, Osteo
____ Arthritis, Rheumatoid
____ Asthma
____ Atrial Fibrillation
____ Atrial Flutter
____ Benign Prostatic Hypertrophy
____ Bladder Infection
____ Bleeding Disorder
____ Bronchitis
____ Bulimia
____ Cancer (indicate location)
_____
_____
____ Cardiac Arrhythmia
____ Carotid Artery Stenosis
____ Cataracts
____ Cerebrovascular Accident
____Chest Pain/Tightness
____ COPD
____ Cirrhosis
____ Colitis
____ Colon Disorder
____ Colon Polyp
____ Congestive Heart Failure
____ Coronary Artery Disease
____ Crohn's Disease
____ Deep Vein Thrombosis
____ Dementia
____ Depression
____ Dermatitis
____ Diabetes, Gestational
____ Diabetes, Insulin Dependent
____ Diabetes, Non-Insulin Depend
____ Diabetes, Type 1
____ Diabetes, Type 2
____ Difficulty Urinating
____Diverticulitis
____ Diverticulosis
____ Drug Addiction
____ Eczema
____ Emphysema
____ Enlarged Prostate
____ Epilepsy
____ Erectile Dysfunction
____ Esophagitis
____ Gallstones
____ Gastroesophageal Reflux Dis
____ Gout
____ HIV Infection
____ Headache
____ Hearing Loss
____ Heart Attack
____ Heart Disease
____ Heart Failure
____ Heart Murmur
____ Heart Valve Problem
____ Heartburn
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Hernia, Adbominal
____ Hernia, Femoral
____ Hernia, Hiatal
____ Hernia, Inguinal
____ Hernia, Umbilical
____ Herpes Simplex
____ High Blood Pressure
____ High Cholesterol
____ Hives
____ Hodgkin's Disease
____ Hypercholesterolemia
____ Hypertension
____ Hyperthyroidism
____ Hypothyroidism
____ Immune Function Disorder
____ Incontinence
____ Infectious Disease
____ Leukemia
____ Liver Disease
____ Lung Disease
____ Lupus
____Melanoma
____ Mental Illness
____ Migraine
____ Mumps
____ Muscle Disorder
____ Myocardial Infarction
____ Night Sweats
____ Non-Hodgkin's Lymphoma
____ Obesity
____ Osteoporosis
____ Palpitations
____ Pancreatitis
____ Parkinson's Disease
____ Peptic Ulcer Disease
____ Peripheral Vascular Disease
____ Phlebitis
____ Pneumonia
____ Prostate Disease
____ Psoriasis
____ Pulmonary Embolism
____ Rheumatic Fever
____ Rubella
____ Scarlet Fever
____ Seizure Disorder
____ Shortness of Breath
____ Sickle Cell Anemia
____ Sinusitis
____ Stroke
____ Stroke, Premature
____ Swollen Ankles
____ Thyroid Disease
____ Transient Ischemic Attack
____ Trouble urinating
____ Tuberculosis
____ Tumors
____ Ulcer, Duodenal
____ Ulcer, Gastric
____ Ulcer, Peptic
____ Urethritis
____ 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*:**
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: _____