PATIENT INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security #:**
Address Two:	**Sex:** **Marital Status:**
City:	**Employer:**
State: **Zip:**	**Emergency Contact:**
Home Phone#:	**Emergency Phone#:**
Work Phone#:	**PCP Dr.:**
Cell Phone#:	**Referring Dr.:**
Email:	**Birth Place:**
Language:	**Ethnicity:**
Preferred Notification Method:	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	**Email:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**
Subscriber DOB:	**Subscriber DOB:**

Authorization To Pay Benefits To Physician: All of the above information is true and accurate to the best of my knowledge. I understand that regardless of my insurance coverage, I am responsible to ensure payment is made for services rendered. I authorize the release of medical or other information necessary to process health insurance claims including electronic submission. I also request payment of benefits to my Provider, Charleston Nephrology, LLC when he accepts assignment.

Authorization To Release Medical Information: I hereby authorize my Provider, Charleston Nephrology, LLC to release any information necessary for my course of treatment and to appeal any denied claims.

Payment Policy: Payment is due at time services are rendered unless prior arrangements are made. I understand it is the office policy to collect any outstanding balance before additional services are rendered. Accounts not paid may be referred to an outside collection agency and a collection fee may be added to your account.

Please sign below to verify that you have read, understand and accept the above terms.

_____ _____

Signed (patient or parent if minor) Date

PATIENT RECEIPT OF PRIVACY PRACTICES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Charleston Nephrology Associates, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Charleston Nephrology Associates, LLC Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have received the most recent Notice of Privacy Practices.

_____ _____

Patient Name Date

Charleston Nephrology Associates, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the address listed above, attention Privacy Officer.

With this consent, Charleston Nephrology Associates, LLC

- May call or mail to my home or other alternative locations and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out TPO. Such items include appointment informational cards, insurance items, patient statements or receipts, nutritional and educational information and newsletters, and anything pertaining to my clinical care, including laboratory results, prescription information and referral information.
- May take my photograph to place in my medical record for office use.
- Allow the following to ask questions regarding my healthcare.

_____ Relationship: _____ Phone Number: _____

_____ Relationship: _____ Phone Number: _____

_____ Relationship: _____ Phone Number: _____

If you have additional persons that can ask questions about your healthcare, please list on the back of the form.

I have the right to request that Charleston Nephrology Associates, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Patient Name Date

_____ _____

Witness Date

Financial Policy

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. To accomplish this in a cost-effective manner for all our patients, we ask that you read over our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.

3. This practice may charge a service fee for failure to pay a co-pay at the time of service.

4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

5. I agree to provide Charleston Nephrology Associates, LLC and/or its designated payment agent with my debit/credit card or ACH information.

6. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

7. If warranted, this practice may offer the option of paying my balance by automated payment plan.

8. I authorize Charleston Nephrology Associates, LLC and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures, labs or supplies, including (a) amounts agreed as part of a payment plan, (b) copayments, (c) coinsurance (after application of insurance proceeds), (d) amounts not covered by insurance and/or (e) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.

9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance.

10. Transaction receipts will be maintained in PM system and/or will be emailed to me if I provide and maintain a valid email address.

11. I authorize Charleston Nephrology Associates, LLC and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Patient Name: _____ Authorized Signature: _____ Date: _____

Please list all Physicians:

Primary Care Physician:_____Phone_____

Specialists:

_____Phone_____

_____Phone_____

_____Phone_____

_____Phone_____

_____Phone_____

Social History:

1. Do you work? Yes No

   If yes, where? _____ Part Time Full Time

2. Do you currently use tobacco? Yes No

3. Did you use tobacco in the past? Yes No

   If yes, what type and when did you stop? _____

4. Do you use alcohol? Yes No

5. Do you use drugs? Yes No

6. What was the highest level of education completed? _____

Family History:

1. Anyone in your family had kidney problems? Yes No _____

2. Anyone with kidney disease, such as protein or blood in urine or kidney failure? Yes No _____

3. Anyone on dialysis either in the past or currently? Yes No _____

4. Anyone with hypertension? Yes No _____

5. Anyone with diabetes mellitus? Yes No _____

REVIEW OF SYSTEMS: Please check ✓ all that apply.

General Health:
☐ Appetite Loss ☐ Fever or Chills ☐ Weight Gain or Weight Loss

Skin:
☐ Bruising ☐Itching ☐Rash ☐Lesions

HEENT:
☐ Blurred Vision ☐Double Vision ☐Hearing Loss ☐Nasal Congestion ☐Nose Bleed ☐Oral Ulcers ☐ Runny Nose
☐ Ringing in the Ears ☐Seasonal Allergies ☐Sinusitis ☐Sleep Apnea ☐Snoring ☐Sore Throat ☐ Visual Loss
☐Visual Disturbances

Neck:
☐ Neck Mass or Neck Pain

Respiratory:
☐Bloody sputum ☐Cough ☐Difficulty breathing ☐Wake up gasping for air ☐Wheezing

Cardiovascular:
☐Abnormal Blood Pressure ☐Chest Pain ☐Fainting ☐Irregular Heart Beat ☐Murmur ☐Swelling of Extremities

Gastrointestinal:
☐Abdominal Pain ☐Black tarry stool ☐Bloating ☐Bloody Stool ☐Constipation ☐Diarrhea ☐Jaundice
☐Nausea/Vomiting ☐Poor appetite ☐Poor taste

Genitourinary:
☐Blood in urine ☐Change in urinary stream ☐Frequency ☐Hesitancy ☐Painful urination ☐Urgency ☐Proteinuria
☐Decreased/increased urine output ☐Urinating at night

Musculoskeletal:
☐Joint Pain ☐Joint Redness ☐Joint Stiffness ☐Joint Swelling ☐Muscle Pain

Neurological:
☐Decreased Memory ☐Dizziness/Fainting ☐Numbness ☐Seizures ☐Tremors ☐Trouble Walking ☐Headaches
☐Weakness/Fatigue ☐Lightheadedness

Psychiatric:
☐Anxiety ☐Depression

Endocrine:
☐Cold Intolerance ☐Heat Intolerance ☐Excessive Thirst ☐Uncontrolled blood sugars

Hematology:
☐Abnormal Bleeding ☐Anemia ☐Enlarged Lymph Nodes ☐Blood transfusions

_____ _____ _____

Patients Signature Provider Signature Date

PAST MEDICAL HISTORY: Have you had any of the following during the past six (6) months?

Constitutional:
☐Weight Gain ☐Fever Chills

Skin:
☐Rash

Eyes:
☐Damage from Diabetes ☐Damage from High Blood Pressure

Pulmonary:
☐Cough ☐History of Asthma/COPD ☐Sleep Apnea ☐Do you use CPAP _____

Cardiovascular:
☐High Blood Pressure ☐History of Heart Attack ☐Previous Heart Surgery ☐Poor Circulation ☐Congestive Heart Failure

Gastrointestinal:
☐History Gastrointestinal bleeding ☐History recurrent Nausea/vomiting ☐Prior colonoscopy
How long ago? _____ Was it normal? ____

Musculoskeletal:
☐ Gout Arthritis ☐Do you take anything for pain beside Tylenol? _____

Genitourinary:
☐Kidney problems ☐Kidney Stones ☐Bladder Problems ☐Frequent Urinary Tract Infections ☐Blood in Urine ☐Protein in Urine

Endocrine:
☐History of diabetes (sugar)

Blood or Cancer:
☐History of Anemia ☐Do you take blood thinner?

Past Surgical History: Please list any past surgeries.

_____

_____

_____

_____

_____

_____

Allergies: Please list below as well the reaction

_____

_____

Current Medications: Please list below and bring all medications to your appointment. Be sure to include over the encounter medications, mineral and herbal supplements.

Please check the medications you are presently taking or have taken in the past.

	Ibuprofen (Motrin, Advil, Excedrin, Midol)		Sulindac (Clinoril)
	Naproxed (Naprosyn, Aleve)		Tolmetin (Tolectin)
	Idomethacin (Indocin)		Goody Powders and BC Powders
	Diclofenac (Voltaren, Cataflam)		Aspirin (Once daily is acceptable)
	Diflunisal (Dolobid)		Meloxicam (Mobic)
	Etodolac (Lodine)		Fenoprofen
	Flurbiprofen (Ansaid)		Meclofenamate
	Ketoprofen (Toradol)		Celecoxib (Celebrex)
	Nabumetone (Relafen)		Rofecoxib (Vioxx)
	Oxaprozin (Daypro)		Valdecoxib (Bextra)
	Piroxicam (Feldene)		

Tylenol and Extra Strength Tylenol are the medications of choice for pain management.