Patient Last Name:	**Emergency Contact Information**
Patient First Name:	Name:
Patient Middle Name:	Relationship:
Sex: M F Date of Birth: Age:	Home Phone:
Social Security Number:	Mobile Phone:
Address:	
City: State:	**Employer Information**
Zip Code:	Name:
Home Phone:	Phone:
Mobile Phone:	
Work Phone:	**Guarantor Information**
May we send text messages with an appointment reminder and/or follow up reminders? Yes No	Last Name: First Name:
Patient E-Mail:	Date of Birth:
Preferred Method of Contact:	Address:
Home Phone Work Phone Mobile Phone E-Mail Other (specify):	City: State: Zip Code:
Marital Status:	Phone:
Primary Language: English Spanish Other (specify):	**Pharmacy Information** Name: Location/City: Phone Number:
Race: White African American Asian American Indian Other (specify):	Preferred Laboratory: Imaging Facility:
Ethnicity: Not Hispanic/Latino Hispanic/Latino Cuban Dominican Mexican Puerto Rican South American Spaniard Central American	**Referral Information** Referred By: Primary Care Physician:

We will use the above preferred method of contact to contact you, and leave messages regarding treatment, payment or healthcare operations unless you request in writing that we do NOT do so and furnish an alternative

Responsible Party/Guarantor:

The responsible party/guarantor will get the bill and is responsible for payment- patients 18 or older will automatically be set up as their own guarantor unless authorized by signature below:

I authorize the above "Guarantor" to receive my medical bills:

_____

Signature Date

Primary Insurance Information

Insurance Plan Name: _____

ID/Certification Number: _____

Policy/Group Number: _____

Insurance Phone Number: _____

Address to Send Claims:

Policy Holder: _____

Patient's Relationship to Policy Holder: _____

Issue Date: _____

Copay Amount: _____

Patient Name:_____

Secondary Insurance Information

Insurance Plan Name: _____
ID/Certification Number: _____
Policy/Group Number: _____
Insurance Phone Number: _____
Address to Send Claims:
Policy Holder: _____
Patient's Relationship to Policy Holder: _____
Issue Date: _____
Copay Amount: _____

Do you have a health care power of attorney? YES/NO

If yes, who is your Heath Care Power of Attorney and how may we contact them?

Name: _____Relationship: _____
Phone: _____

FINANCIAL AND MANAGED CARE POLICY STATEMENT

The patient/responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign this Policy Statement prior to seeing your doctor.

1. Patients with an insurance co-payment are expected to make payment when checking in for their appointment.
2. Patients with insurance are expected to pay any personal balance that is due immediately after their insurance company(s) remit payment. If insurance does not remit payment within 45 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home on an outstanding bill with our office, that payment must be forwarded to us immediately.
3. Not all services are covered benefits of all insurance plans. The patient/responsible party maintains that responsibility of obtaining authorizations and verification of applicable coverage.
4. The patient is responsible for payment of any unpaid deductibles, co-insurance, or other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full or make payment arrangements at the time of service.
5. Patients are requested to provide staff with sufficient notice to complete any referral forms, pre-certifications, or other forms required by your insurance company to process payments for services. Retroactive referrals will be completed for emergency care only. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure proper referral for any services.
6. We do not bill third parties in legal situations or injuries (non-work related). We bill your health insurance. Any balance unpaid by your health insurance will be billed to the guarantor on the patient account.

We accept cash, personal checks, and credit cards (Visa, Mastercard, Discover, American Express). Returned checks and balances older than 45 days may be subject to additional collection fees. We encourage you to communicate with our billing staff any temporary financial problems may affect timely payment so that we can assist you in the management of your account. Thank you for understanding and cooperation with this policy.

1. **I have read and understand the Financial Policy stated above and agree to accept full responsibility as described above.**
2. **I agree that this authorization is valid regardless of when I receive services at this office, that the information on pages above is accurate, and that I am the patient or authorized to sign this document.**

_____

Patient/Responsible Party Signature Date

Patient Name:_____

Patient Rights and Responsibilities

Background

We seek to provide exceptional care and the best possible experience for every patient and family. We are committed to working with you to meet your health care needs and we encourage you to participate in discussions and decisions about your treatment.

You have rights and responsibilities as a patient of our practice. We encourage you to ask questions about these rights and responsibilities.

Patient Rights

You have the right to:

Receive information about your care and treatment in a way that is easy to understand

- Receive clear answers to your questions

Be treated with dignity and respect

- Be protected from harassment or discrimination based on race, color, national origin, sexual orientation, gender identity, disability, age, sex, and religion.

Help make decisions about your care

- Be involved in decisions regarding medical care you receive
- Participate in discussions of medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Accept, refuse, or stop any treatment that is prescribed for you, and to be informed of the potential consequences of the decision.
- Receive a response by the on-call physician for urgent or emergent conditions, after business hours.

Privacy and Confidentiality

- Privacy and confidentiality of your personal medical records. These rights and privacy practices are explained in our Notice of Privacy Practices. A copy of the Notice of Privacy Practices is given to you upon admission, is posted in this facility, and is available upon request at any time.

Clear information about practice policies

- Be informed of all practice rules and regulations governing your conduct as a patient.
- Information about the cost of care and estimates of your out of pocket expenses.

Patient Name:_____

Make a compliant, and receive a response

- Make a complaint yourself, anonymously, or through a representative of your choice without the fear or concern that services will be affected.
- Your complaint can be written or verbal

Patient Responsibilities

You have the responsibility to:

Speak up about your care

- Tell the staff if you don't understand your treatment plan/instructions
- Tell the staff if something doesn't feel or look right
- Inform the staff if you have had health problems since we saw you last
- Actively participate in your care

Comply with the agreed upon treatment

- Cooperate, to the best of your ability, with your diet, medication, and treatment plans

Be considerate of other patients and staff, and follow the practice rules

- Treat fellow patients, physicians, and staff with respect and dignity
- Behave appropriately. This means refraining from inappropriate, discriminatory, harassing, or abusive language and behavior
- Follow the rules of the practice that have been developed to provide protections, safety, and quality care to all patients

Provide updated information to staff

- Report changes in address and phone numbers
- Give complete information about insurance coverage
- Meet out of pocket responsibilities at the time of service
- Be on time for appointments or cancel 24 hours in advance

Making a Complaint

if you have a complaint or concern about our services, facilities, or staff, we want to hear from you.

Please inform any staff member of your concern. You may submit your concern verbally or through written communication.

Response to a complaint or concern will take place within 3 business days

Patient Name:_____

Acknowledgement of Receipt of Patient Rights and Responsibilities

I have been made aware of my rights and responsibilities as a patient of the practice, and I have been made aware of how to submit a complaint/concern.

DATE	
PATIENT NAME (PRINTED)	

SIGNATURE OF PATIENT	
CAREGIVER/RELATIONSHIP	

If patient is unable to document signature, two persons must be witnesses

WITNESS	
WITNESS	

Patient Name:_____

Atlanta Nephrology Associates

5667 Peachtree Dunwoody Rd. Suite 260

Atlanta, GA 30342

Patient Authorization for Use and Disclosure of Protected Health Information

The information of this form is used to facilitate our communications to you as we strive to provide you with excellent service.

Patient Information:

Name: _____

DOB: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give permission for Atlanta Nephrology Associates and Dr. _____ and his/her staff to disclose my personal information to the following individuals(s).

Name:_____ **Relation to patient:**_____

Telephone #_____

Name:_____ **Relation to Patient:**_____

Telephone #_____

Name:_____ **Relation to Patient:**_____

Telephone#_____

Check Information to be disclosed:

__ **All Medicals Records** __ **Lab Results** __ **All Billing/Account Information**

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature:_____ **Date:**_____

Patient Name:_____

MEDICATION LIST

Patient Name:

_____

Date of Birth:

_____

Preferred Pharmacy Name and Address:

_____

Are you allergic to any medications? **YES** **NO**

If yes, please list medication name and reaction.

_____

_____

Medications you are currently taking (prescription and over the counter):

Medication	Dosage	Times per day

Would you like to be registered for our "My Chart" online health records portal? Yes__No __

If yes, please provide your e-mail address: _____

Preferred Laboratory: LabCorp_____ Quest _____ Other (please specify) _____

Patient Signature: _____ Date: _____

Patient Name:_____

MEDICAL HISTORY

Please circle any conditions that you have ever been diagnosed with

Acute Kidney Injury

Anemia

Atrial Fibrillation (A-fib)

Cancer (Please specify) _____

Congestive Heart Failure (CHF)

Chronic Kidney Disease (Stage _____)

Clotting Disorder

COPD

Coronary Artery Disease

Diabetes Mellitus

Diabetic Nephropathy

End Stage Renal Disease (ESRD)

GERD

Gout

Hematuria (Blood in urine)

Hepatitis B

Hepatitis C

HIV/AIDS

Hyperkalemia (High potassium)

Hyperlipidemia

Hyperparathyroidism

Hypertension (High blood pressure)

Hyponatremia (Low sodium)

Hypothyroidism

Kidney Stones

Lupus

Myocardial Infarction (Heart attack)

Nephrotic Syndrome

Osteoarthritis

Osteoporosis

Polycystic Kidney Disease

Proteinuria (Protein in urine)

Pyelonephritis

Renal Cyst

Sleep Apnea

Stroke

TIA

UTI (Urinary tract infection)

Other (Please Specify)

_____

_____

_____

_____

Patient Name:_____

Surgical History

Please Select and Describe Any Past Surgeries

□ Abdomen Surgery: Year _____ Description_____

□ Bladder Surgery: Year _____ Description_____

□ CABG: Year _____ Description_____

□ Cardiac Stent: Year _____ Description_____

□ Cystectomy: Year _____ Description_____

□ Dialysis Access: Year _____ Description_____

□ Gallbladder: Year _____ Description_____

□ Hysterectomy: Year _____Description_____

□ Kidney Biopsy: Year _____ Description_____

□ Kidney Removal: Year _____ Description_____

□ Kidney Stone Surgery: Year ____ Description_____

□ Kidney Transplant: Year _____ Description_____

□ Lithotripsy: Year _____ Description_____

□ Parathyroid Surgery: Year _____ Description_____

□ Thyroid Surgery: Year _____ Description_____

□ Any Additional Surgeries Not Listed Above: _____

_____

_____

Patient Name:_____

Family History

Please Select Any Condition A Member of Your Has Been Diagnosed With

□ Anemia

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Autoimmune Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Cancer

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Diabetes

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Hypertension (high blood pressure)

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Kidney Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Stroke

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Heart Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Dementia

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ___

□ Gout

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF ____

□ Autosomal Dominant Polycystic Kidney Disease

Mother ___ Father ___ Sister ___ Brother ___ Maternal GM ___ Maternal GF ___ Paternal GM ___ Paternal GF _____

Patient Name:_____

Social History

Tobacco Use:

Current User ____ Former User ____ Never Used ____

Length of Use? _____ Amount of Use _____

Length of Use Prior to Quitting? _____ Date of Quitting? _____

Smokeless tobacco Use:

Current User ____ Former User ____ Never Used ____

Length of Use? _____ Amount of Use _____

Length of Use Prior to Quitting? _____ Date of Quitting? _____

Alcohol Use:

Current User ____ Former User ____ Never Used ____

If you are a current used, how many drinks do you consume?

Occasional/Social 1-2 drinks per day 3+ drinks per day

If you are a former user, how many years did you consume alcohol? _____ Date of quitting?_____

Substance Use:

Current User ____ Former User ____ Never Used ____

If you are a current or former user, please indicate the drug or drugs used:

Marijuana ____ Amphetamines ____ LSD ____ Heroin ____ Ecstasy ____ Other: (please specify)

_____

If you are a former user, how many years did you use? _____ Date of quitting? _____

Living Arrangement:

Alone ____ Family Member ____ Spouse In-Home ____ Significant Other ____ Caregiver ____
Assisted Living ____

Marital Status:

Single _____ Married ____ Separated ____ Divorced ____ Widowed ____

Number of Children ____

Employment Status:

Employed ____ Unemployed ____ Retired ____ Student ____ Current Occupation: _____