NEPHROMED ASSOCIATES, PA

Today's Date: _____ **Primary Care Physician: _____ PH #_____**

Patient's Name: _____ Date of Birth: _____SS#: _____

Sex: (Circle one) MALE Female Marital Status:_____ Race:_____ Language:_____

Physical Address: _____ City: _____ State:_____ Zip:_____

Mailing Address:_____City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell or Alternate Phone: _____

Please circle the one that applies to you: Employed, Retired, Disabled, Stay at home

Employer: _____ Work phone: _____

Email Address: _____

Preferred Method of Communication: Please circle one; Cell Phone Home Phone Work Phone Mail Email

Responsible Party: (Circle one) Patient Spouse Parent Other

Name: _____ Date of Birth:_____Phone #: _____

Address: _____ City: _____ State: _____ Zip:_____

Primary Insurance Information: ***<u>Please fill in the information below, even if you have given us a copy of your insurance card.</u>***

Insurance Company:_____

Policy Holder Name:_____ **<u>Policy Holder Date of Birth</u>**: _____
(If other than the patient) (If other than the patient)

Secondary Insurance Information:

Insurance Company: _____

Policy Holder Name: _____ **<u>Policy Holder Date of Birth:</u>** _____
(If other than the patient) (If other than the patient)

Emergency Contact:

Name: _____ Phone:_____ Relationship:_____

I authorize use of this form on all my insurance submissions and request payment of AUTHORIZED Medicare Benefits and / or Private insurance benefits be made to NEPHROMED Associates PA for services rendered to me.

I AUTHORIZE release of information to all my insurance companies.

I understand that I am responsible for my bills. I also understand if my insurance company requires a referral from my PCP, it is my responsibility to have my PCP contact my Insurance Company for the referral before my appointment with this office for the referral or the visit will be my responsibility.

SIGNATURE:_____ **DATE: _____**

NO SHOW, CANCELLATION POLICY

Our office has developed a NO SHOW, Cancellation Policy.

We ask that all appointments are confirmed.

We will call you prior to your appointment, if the phone call is not answered, we will leave a message on your voice mail. We require that you call us back to confirm your appointment. If we do not hear back from you to confirm your appointment within 24hours of the original phone call, we will cancel this appointment.

(Please understand that our schedule is full and we only do this to give another patient a needed appointment.)

As a NEW patient if I NO Show for my First appointment or CANCEL less than 24 hours prior to my appointment, I will not be rescheduled.

I also understand that the FIRST and SECOND NO SHOW or CANCELLATION less than 24 hours prior to the appointment will result in a $25.00 NO SHOW FEE that must be paid before I can schedule another appointment.

ALSO the THIRD Time that I NO SHOW or CANCEL less than 24 hours prior to the appointment, I will be DISCHARGED from the Practice.

By signing below, you are acknowledging that you have been made aware of this policy.

Signature:_____ **Date:**_____

Medication & Allergy List

Today's Date: _____ Patient Name: _____ Date of Birth: _____

DRUG ALLERGIES: LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC AND THE KIND OF SYMPTOMS YOU EXPERIENCED:

1._____SYMPTOM Experienced: _____

2._____ SYMPTOM Experienced: _____

3._____SYMPTOM Experienced: _____

4._____SYMPTOM Experienced: _____

Please list all medications you currently take;
Prescriptions and Over the counter (exp. Aleve, Advil, Tylenol, Vitamin D, Multi Vitamins)

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Medication:	Dosage:	How often do you take this Medication: Example: 1x day, 1x week, 1x month, as needed *AND THE NAME OF THE PHYSICIAN THAT PRESCRIBED*
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____ __	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____
11._____	_____	_____
12._____	_____	_____
13._____	_____	_____
14._____	_____	_____
15._____	_____	_____

NEPHROMED ASSOCIATES, PA

Medical History

Patient Name:_____ **Date of Birth: _____**

Family History:

Father's Age: _____ If deceased age at death: _____ Cause of Death: _____

Mother's Age: _____ If deceased age at death: _____ Cause of Death: _____

Total number of brothers and sisters you have had: _____ How Many still living: _____

Total number of Children:_____ How many still live at home:_____ How many still living:_____

Have any of your relatives ever had any of the following:

High Blood Pressure: _____ Relative: _____ Age at Diagnosis: _____

Diabetes: _____ Relative: _____ Age at Diagnosis: _____

Kidney Disease: _____ Relative: _____ Age at Diagnosis: _____

Kidney Stones: _____ Relative:_____ Age at Diagnosis: _____

Been on Dialysis: _____ Relative: _____ Age at Dialysis: _____

Kidney Transplant: _____ Relative: _____ Age at Transplant: _____

Cancer: _____ Relative: _____ Age at Diagnosis: _____

Patient Medical History:

Do you Smoke: _____ How many per day: _____ Do you Drink: _____ How much per day: _____

Do you use Illegal Drugs: _____

Have you ever been treated for High Blood Pressure: _____ At what age: _____

Have you ever been treated for Pre-Diabetes: _____ Diabetes: _____ At what age: _____

Have you ever been treated for Kidney Disease: _____ ____ At what age: _____

Have you ever had Kidney Stones: _____ At what age: _____

Have you ever been on Dialysis: _____ At what age:_____

Have you ever had a Kidney Transplant: _____ At what age: _____

What Operations / Procedures have you had? ***Please list approximate dates of operations:***

_____ _____

_____ _____

_____ _____

_____ _____

Have you had any serious illness or injuries? **Please list approximate dates:**

_____ _____

_____ _____

Have you had a Colonoscopy? YES or NO IF YES, When :_____

Have you had a MAMMOGRAM? YES or NO or NA IF Yes, When :_____

Have you had a PSA? YES or NO or NA IF Yes, When: _____

Nephromed Associates, PA

General Consent for Care and Treatment / Consentimiento general para el cuidado y tratamiento

You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo and suggested treatment or procedure after knowing the risks and hazards involved. At this point, no specific treatment plan has been recommended. This consent form is simply to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and or procedure for any conditions.

Usted tiene el derecho a ser informado sobre su condición y el procedimiento quirúrgico, médico o de diagnóstico recomendado a utilizar de modo que usted puede tomar la decisión si o no sufrir y tratamiento sugerido o procedimiento después de conocer los riesgos y peligros involucrados. En este momento, ningún plan de tratamiento específico se ha recomendado. Este consentimiento es simplemente para obtener su permiso para realizar la evaluación necesaria para identificar el tratamiento apropiado o el procedimiento para cualquier condición.

This consent provides us with permission to perform reasonable and medical examinations, testing, and treatment. By signing, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or another office under common ownership. The consent will remain effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risk, and benefits of any test ordered. If you have any concerns regarding any test or treatment recommended we encourage you to ask questions.

Esta autorización nos da permiso para realizar exámenes médicos y razonables, pruebas y tratamiento. Al firmar, estás indicando que usted tiene la intención de que este consentimiento continúa incluso después de que se ha realizado un diagnóstico específico y tratamiento recomendado; y usted da su consentimiento al tratamiento en esta oficina u otra bajo propiedad común. El consentimiento se mantendrá efectivo hasta que sea revocada por escrito. Usted tiene el derecho a suspender servicios en cualquier momento. Usted tiene el derecho a discutir el plan de tratamiento con su médico sobre el propósito, riesgos y beneficios de cualquier prueba que se ordenó. Si usted tiene alguna preocupación con respecto a cualquier prueba o tratamiento recomendado le animamos a hacer preguntas.

I voluntarily request a physician, midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), other healthcare providers, designees as necessary, to perform reasonable and necessary medical, testing, treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test or procedures.

Solicito voluntariamente un médico, proveedor de grado medio (enfermera, asistente médico o especialista en enfermería clínica), otros profesionales de la salud, designados según sea necesario, para realizar tratamiento médico, prueba, razonable y necesario para la condición que me ha traído a buscar atención en esta práctica. Entiendo que si se recomienda pruebas adicionales, invasiva o intervencionista, le pedirá que lea y firme formularios de consentimiento adicional antes de la prueba o procedimientos.

*** I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**
*** Certifico que he leído y comprender a las declaraciones anteriores totalmente y completamente y voluntariamente el consentimiento a su contenido.**

Signature: _____ Date: _____

Nephromed Associates, PA

HIPAA RELEASE of INFORMATION

HIPAA dictates that our office must do everything possible to protect your medical information. For this Reason please indicate below who we may leave messages with or talk to regarding appointments, prescriptions, test results, surgery dates, and any other medical need we may have. Please list the phone number below where you can most likely be reached during our business day.

HIPAA exige que la Oficina debe hacer todo lo posible proteger su información médica. Para ello sírvase indicar a continuación que podemos dejar mensajes con o hablar sobre citas, recetas, resultados de pruebas, las fechas de la cirugía y cualquier otra necesidad médica que tengamos. Enumere el número de teléfono abajo donde más probable es que usted puede llegar durante el día.

***PHONE#: _____**

*** Is it ok to leave a message? _____ Yes _____ NO**
¿Está bien dejar un mensaje? _____Si _____NO

I will allow medical information and test results including abnormal results and appointment information to be released to the following people:

Permitir que la información médica y me resultados incluyendo resultados anormales y la información de la cita que se lanzarán a las siguientes personas:

NAME/NOMBRE Relationship/RELACION Phone/TELEFONO

_____
_____
_____
_____

***_____ I do not want Medical information, test results, released to anyone BUT myself.**
This Form will be valid until revoked by me in writing.

***_____No quiero información médica, resultados, a nadie más que yo.**
Este formulario es válido hasta revocado por mí en la escritura.

HIPAA ACKNOWLEDGEMENT FORM

I hereby acknowledge by signature below that I have been given a copy of the HIPAA Privacy Policy for review. I also acknowledge that I have read and been given an opportunity to ask any questions related to my privacy rights. This form is to be retained in my Medical Chart until revoked by me in writing.

Por la presente reconozco por firma a continuación que le he dado una copia de la política de privacidad de HIPAA para revisión. También reconozco que he leído y ha dado una oportunidad de hacer preguntas relacionadas con mis derechos de privacidad. Esta forma es que se retenga en mi expediente médico hasta revocado por mí en la escritura.

Signature:_____ Date:_____

HIPAA Information

(Please keep this copy for your records.)

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your Privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available or posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. **WWW.HHS.GOV**

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks, and / or on password protected electronic devices and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that suck records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments, we may do this by telephone, E-mail, U.S. mail, or by any means convenient for the practice and / or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the Office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

NEPHROMED ASSOCIATES, PA

HIPAA Information

(Please keep this copy for your records.)

La Health Insurance Portability y Accountability Act (HIPPA) ofrece garantías para proteger su privacidad. Implementación de requerimientos de HIPPA comenzó oficialmente el 14 de abril de 2003. Muchas de las políticas han sido nuestra práctica durante años. Esta forma es una versión "amigable". Un texto más completo es publicada o disponible en la oficina.

Lo que trata sobre: específicamente, hay reglas y restricciones sobre quién puede ver o ser notificado de su información de salud protegida (PHI). Estas restricciones no incluyen el intercambio normal de información necesaria para proveer servicios de oficina. HIPPA proporciona ciertos derechos y protecciones como el paciente. Nos equilibramos estas necesidades con nuestro objetivo de brindarle atención y servicio profesional de calidad. Información adicional está disponible del Departamento de salud y servicios humanos de los Estados Unidos.**WWW.HHS.GOV**

Hemos adoptado las siguientes políticas:

1. Información para el paciente se mantendrá confidencial excepto que sea necesario para prestar servicios o para asegurar que todas las cuestiones administrativas relacionadas con su cuidado sean atendidas adecuadamente. Esto incluye específicamente el intercambio de información con otros profesionales de la salud, laboratorios, seguros de salud pagan como es necesario y apropiado para su cuidado. Paciente archivos pueden almacenarse en estantes de abrir el archivo, y/o dispositivos electrónicos protegidos por contraseña y no contendrá cualquier codificación que identifica la condición del paciente o la información que ya no es una cuestión de expediente público. Pueden dejar el curso normal de brindar medios de atención que chupan los registros, al menos temporalmente, en áreas administrativas tales como la recepción, sala de examen, etcetera. Los registros no estarán disponibles para personas que no sean personal de la oficina. Usted está de acuerdo a los procedimientos normales utilizados en la oficina para el manejo de gráficos, registros de pacientes, PHI y otros documentos o información.

2. Es la política de esta oficina para recordar a los pacientes de sus citas, podemos hacer esto por teléfono, correo electrónico, correo, o por cualquier medio conveniente para la práctica y/o como solicitada por usted. Podemos enviarle otras comunicaciones que le informa de los cambios en la política de oficina y las nuevas tecnologías que pueden encontrar valiosos o informativos.

3. La práctica utiliza un número de proveedores en la realización de negocios. Estos proveedores pueden tener acceso a la PHI pero deben estar de acuerdo en acatar las normas de confidencialidad de HIPPA.

4. Usted entiende y acepta las inspecciones de la oficina y revisión de documentos que pueden incluir PHI por agencias del gobierno o seguro pagadores en el normal desempeño de sus funciones.

5. Usted acepta llevar inquietudes o quejas sobre privacidad para la atención de la oficina del administrador o el médico.

6. No se utilizará su información confidencial para fines de marketing o publicidad de productos, bienes o servicios.

7. Nos comprometemos a ofrecer a los pacientes con acceso a sus registros de acuerdo con leyes estatales y federales.

8. Podemos cambiar, agregar, eliminar o modificar cualquiera de estas disposiciones para servir mejor a las necesidades de la práctica y el paciente.

9. Usted tiene el derecho a solicitar restricciones en el uso de su información protegida de la salud y a solicitud de cambios en ciertas políticas utilizadas dentro de la oficina con respecto a su PHI. Sin embargo, no estamos obligados a modificar las políticas internas para cumplir con su petición.

NEPHROMED ASSOCIATES, PA
4002 S LOOP 256, SUITE F,
PALESTINE, TEXAS 75801
PHONE: 903-729-1071 FAX: 9037291078

REQUEST FOR RELEASE OF MEDICAL RECORDS

Name: _____

Date of Birth: _____

Telephone Number: _____

Address: _____

_____

I hereby authorize _____

To release my Medical records or copies of such
(LAST HISTORY & PHYSICAL, LAST LAB, LAST CHEST XRAY and LAST KIDNEY US)
and request this records be sent to:

DR. ADEBAYO ADEWALE
NEPHROMED ASSOCIATES PA
4002 S LOOP 256, SUITE F
PALESTINE, TEXAS 75801

These records can be faxed to our secure fax machine at 903-729-1078 or emailed to our secure email: Adewale@nephromedassociates.com.

Signature: _____ Date: _____