Khaled Nass, MD, F.A.S.N.
Sohail Saleem, MD, F.A.S.N.
Lalitha Bandi, MD
Miriam Gentin, MD
Deepak Aggarwal, MD
Sohail Ejaz, MD
Ernest Han, MD
Prashant Amin, MD

KIDNEY CARE CENTER OF GEORGIA

Dimpu Patel, MD
Montish Singla, MD, F.A.S.N
Sunitha Kalyanam, MD
Marlene Anderson-Reid, ANP-C
Elizabeth Grass, PA-C
Amanda Aguirre-Johnson, PA-C
Joanna Holder, PA-C
Bradee Aderholt, AGACNP-BC
Tonya Ramey, DNPAGANP-BC

www.kidneycarega.com
Office: 678-450-0202
Fax: 678-450-0080

PLEASE PRINT ON FORM **Demographic Sheet** PLEASE USE BLACK INK

Account # :_____
(Office Use)

Personal Information

Patient Name:_____ Date of Birth:_____/_____/_____

Birth Sex:_____ Social Security # :_____-_____-_____ Marital Status:_____

Race:_____ Primary Language Spoken:_____

Primary Phone Number:_____-_____-_____ *H / C / W (Please Circle One)*

Address:_____ State:_____Zip:_____

Primary Care Physician:_____ PCP Telephone: _____-_____-_____
_____ *(Doctor's First and Last Name Please)*

Insurance Information
Please Fill Out Completely

Primary Insurance:_____

Subscriber ID:_____ Group:_____

(If Insurance is through someone other than the Patient)

Subscriber Name:_____DOB:____/____/____SSN:_____-_____-_____

Secondary Insurance:_____

Subscriber ID:_____ Group:_____

(If Insurance is through someone other than the Patient)

Subscriber Name:_____DOB:____/____/____SSN:_____-_____-_____

I authorize Kidney Care Center of Georgia to release medical Information to my insurance companies about treatment and diagnosis necessary to process claims. I authorize assignment of benefits, including Medicare, to be paid on my behalf to Kidney Care Center of Georgia for services rendered. I recognize that my insurance policy is a contract between my insurance company and me and that I am ultimately responsible for paying the claim should my insurance company denies payment.
If not covered by insurance, I understand that payment is expected at the time service is rendered, unless I have made prior arrangements.
A photocopy of this shall be considered as valid as the original.

_____ _____/_____/_____
Patient / Representative Signature **Date**

Release of Information

This Form is only valid for 12 months after signed date

Kidney Care Center of Georgia

Kidney Care Center of Georgia is committed to protecting the Privacy of our Patients. Therefore, we will **not** give **Test Results, Medical Information, Financial Information,** or other **Private Health Information** to anyone ***other than*** the ***Patient, Guardian, or Referring Doctor,*** nor leave messages about test results on voicemail or an answering machine without your permission.

Please indicate your preferences below:

You may contact me at the **Phone Number(s) listed below with Test results**. I have **checked the number** I prefer you to call. *If no numbers are listed we will only call the home number listed in our records*. **Note: (Reminder calls about appointment will be left on answering machines or voicemail by our automated system)**

Yes No You may Leave a Message on my Answering Machine or Voicemail.

❑ **Home: _____/_____/_____** ❑ **Work: _____/_____/_____**

❑ **Cell: _____/_____/_____** ❑ **Other: _____/_____/_____**

Yes No You May Text me appointment Reminders at: _____/_____/_____

Yes No You may email me my appointment reminders at:_____@_____

Yes No You may Provide my/patient Private Health Information to the individuals indicated below.

*(Information will be provided **ONLY TO THOSE LISTED** on this page.)*

Please only list non-medical persons (Family Members or Friends). DO NOT list Medical Doctors on this Form

Emergency Contact	**Name** *example: John Doe*	**Relationship** *Husband*	**Phone Number** *(770) 123-0000*	**# Type** *Home, Cell, Work*	**Allow Access to *MyChart***
❑	1)		( ) -		❑
❑	2)		( ) -		❑
❑	3)		( ) -		❑

**** Under HIPAA regulations, we may provide private health information to other healthcare entities involved in your care and insurance companies for billing purposes without your written permission.***

By signing this form, I understand that the information provided above supersedes all previous notifications and will remain in force until I provide different written instructions.

Print **Patient Name**: _____ **Date:**_____/_____/_____

Patient or Guardian *Signature*: x_____

Relationship of Guardian (If applicable): _____

This Form is only valid for 12 Months after signed date

updated 1/01/2020

Kidney Care Center of Georgia
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The Following is a summary of our identification and payment policy.

Identification Requirements

This practice is committed to safeguarding your identity. Federal regulations now require us to verify your identity at each visit and ensure the identity of anyone presenting medical insurance identification. **To satisfy the federal requirements, we must have a copy of you photo ID on file. we will ask for your medical insurance identification at every visit.** When possible, we will take a digital photograph of you that is attached to your electronic file. This photograph allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent you being seen by our physicians.

Payment is expected at the time of service

Payment of copays and outstanding charges is required at the time of services are rendered unless other arrangements have been made in advance. Kidney Care Center of Georgia accepts **cash, personal check (in-state only), VISA, MasterCard, American Express and Discover.** There is a service charge for all returned checks. We do not accept post-dated checks. Checks are Electronically deposited by our office at the end of each day.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

Insurance

Plans in which we are contracted (In-Network):

You are responsible for all charges. We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments at the time of service. Applicable deductibles, coinsurance, and other financial responsibilities deemed appropriate by your carrier, will be billed to you. Charges billed to you are due at the time we send you a statement.

In the event you have a procedure(s) performed, we will file with your carrier and ALL applicable deductibles, coinsurance, and other financial responsibilities are your responsibility. If you have any questions about your financial responsibility, please speak with your provider or our financial counselors, prior to services being performed.

Plans in which we are NOT contracted (Not Accepted/Out of Network):

You are responsible for all charges at the time of service. Once paid, we will file your charges (upon request) to your carrier as a courtesy to you. You are responsible for any further information (follow-up) requested by your carrier.

Refunds:

Overpayments will be refunded upon request to the responsible party within 30 days.

Outstanding and Unpaid Balances:

I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for cost of collections.

Missed Appointments and Late Cancellations:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are to be requested 48-hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Kidney Care Center of Georgia Financial Policy.

Print Patient Name:_____

Signature of Patient or *Authorized Representative:* x_____ Date:
_____/_____/_____

Printed Name of Authorized Representative (If Different than Patient): _____

This Form is only valid for 12 Months after signed date

updated 1/01/2020

Kidney Care Center of Georgia

INSURANCE POLICY

In order to better serve the needs of our patients, we have enrolled in numerous managed care plans including HMO, PPO, and POS products.

Each Of these managed care plans have different requirements. We make every effort to keep our records updated on each plans individual requirements. However, we must ultimately depend on you, the insured to advise us on the requirements for your individual plan so that we may comply with your plans guidelines.

Providing quality medical care for our patients is our primary concern, and we are very willing to recommend physicians and/or facilities within your plans guidelines provided the care is medically necessary. Please familiarize yourself with the following information provided in your insurance.

1) If your insurance company requires that lab services be provided by a specific lab, **please advise us before your lab services are obtained**. Please also be advised that lab services are billed separately by the lab company and will be your responsibility.

2) Please Check with your insurance company and advise us ***if your plan requires precertification*** **before** a procedure is performed in the physician's office.

3) If your insurance company requires a referral from your primary care physician (PCP) before you can be seen, **you are responsible for confirming that the Dr's office has obtained that referral**. If you are seen without a referral and the insurance company denies payment, you will be responsible for the entire balance.

In the event that your coverage has changed, lapsed or expired on the date that services are rendered, all charges will be denied and ultimately become your responsibility. In order to avoid this, **Please Provide us with your most current insurance card each time you are seen in our office and keep up advised of ANY insurance changes as they occur.**

In order to provide our physicians care and follow the requirements of your insurance company, it is imperative that we have current information regarding your insurance coverage, type of plan (HMO,POS, PPO, etc.) and Primary Care Physician (PCP).

Plans in which we are contracted (In-Network):

You are responsible for all charges. We bill participating insurance companies as a courtesy to you. You are expected to pay your copayments at the time of service. Applicable deductibles, coinsurance, and other financial responsibilities deemed appropriate by your carrier, will be billed to you. Charges billed to you are due at the time we send you a statement.

In the event you have a procedure(s) performed, we will file with your carrier and ALL applicable deductibles, coinsurance, and other financial responsibilities are your responsibility. If you have any questions about your financial responsibility, please speak with your provider or our financial counselors, prior to services being performed.

Plans in which we are NOT contracted (Not Accepted/Out of Network):

You are responsible for all charges at the time of service. Once paid, we will file your charges (upon request) to your carrier as a courtesy to you. You are responsible for any further information (follow-up) requested by your carrier.

If you have any questions or need assistance, please know our staff is available to help you in any way that we can. By working together, we will help you receive the maximum benefits and provide the quality medical care that you deserve.

I understand that ALL applicable charges are my responsibility and payment is due in full at the time of Services.

I have Read and Understand the Kidney Care Center of Georgia Insurance Policy as stated above and agree to accept responsibility as described.

Print Patient Name:_____

Signature of Patient or *Authorized Representative:* *x*_____ Date:
_____/_____/_____

Printed Name of Authorized Representative (If Different than Patient): _____

This Form is only valid for 12 Months after signed date

updated 1/01/2020

Kidney Care Center of Georgia

PF-200 **Acknowledgment of Receipt of Notice of Privacy Practices**

(HIPAA)

Kidney Care Center of Georgia Reserve the right to modify the privacy practices outlined in the notice.

Signature

I have viewed and/or received a copy of the Notice of Privacy Practices for **Kidney Care Center of Georgia**.

Print Patient Name:_____ **Date:** _____/_____/_____

Signature of Patient or *Authorized Representative*: x_____

*Printed Name of Authorized Representative (if Different than Patient):*_____

*Relationship of Authorized Representative (If Different than Patient):*_____

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updated 1/01/2020

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Nephrology New Patient Questionnaire

Patient Name: _____ Date of Birth: _____/_____/_____

Pharmacy:_____ Pharmacy Phone: _____-_____-_____

Pharmacy Address:_____ State: _____ Zip: _____

Medical History

Please Check Any of the Following Conditions that you are currently being treated for or have had within the past 10 years and the year you were first diagnosed/treated.

❑ High Blood Pressure	Year: _____	❑ Congestive Heart Failure	Year: _____	❑ Bleeding from Digestive Tract	Year: _____	❑ Thyroid Disease	Year: _____
❑ Diabetes	Year: _____	❑ High Cholesterol	Year: _____	❑ Liver Disease	Year: _____	❑ Gout	Year: _____
❑ Eye Problems from Diabetes	Year: _____	❑ Heartburn (Acid Reflux)	Year: _____	❑ Hepatitis B or C	Year: _____	❑ Migraine Headaches	Year: _____
❑ Heart Attack	Year: _____	❑ Emphysema	Year: _____	❑ Enlarged Prostate	Year: _____	❑ Seizures	Year: _____
❑ Stents in Heart	Year: _____	❑ Chronic Bronchitis	Year: _____	❑ Blood Clots	Year: _____	❑ Cancer*	Year: _____
❑ Pacemaker	Year: _____	❑ Stroke	Year: _____	❑ Arthritis	Year: _____	*List Types Below	

List Cancer Types and any other Medical Conditions you may have had in the past:_____

_____

_____

List Any Surgeries you have had and the year it was performed:_____

_____

_____

Family History

Check the below disease if your Parents, Siblings, or Children have or have had any of the following conditions:

Medical Condition	Father	Mother	Siblings	Children	None
Kidney Disease	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑
Gout	❑	❑	❑	❑	❑
ADPKD-Polycystic Kidney Disease	❑	❑	❑	❑	❑
Dementia	❑	❑	❑	❑	❑

Immunization History

Have you had these Vaccinations?

❑ **Flu Vaccine *Within the Past Year***

❑ **Pneumonia Vaccine *Within the Past 5 Years***

Are you currently or have you ever taken any of the following Medications on a Daily/Weekly Basis?

Please Check which ones:

❑ **Advil / Ibuprofen**
❑ **Celebrex**
❑ **Motrin**
❑ **Aleve**
❑ **Diclofenac**
❑ **Naproxen / Naprosyn**
❑ **BC Tablets/Powder**
❑ **Goody's Powders**
❑ **Vioxx**
❑ **Bextra**
❑ **Mobic**
❑ **Voltaren**

Review of Symptoms Related to your Kidneys

Check any of these Kidney Related Symptoms that you are Currently experiencing:

- ❑ **Swelling in Hands / Legs / Feet**
- ❑ **Frequent Urination**
- ❑ **Painful Urination**
- ❑ **Difficulty Starting Urine Stream**
- ❑ **Incomplete Bladder Emptying**
- ❑ **Nose Bleeds**
- ❑ **Shortness Of Breath**
- ❑ **Cough / Wheezing**
- ❑ **Headache / Dizziness**

Personal History

Check all that Apply to You:

Tobacco Use (Smoke/Chew)	❑ **Former** When did you Quit? _____	❑ **Current** How often?_____	❑ **Never**
Alcohol Use	❑ **Former**	❑ **Currently** Rarely / 1-2 Drinks per Day / 3 or more Drinks per Day	❑ **Never**
Recreational Drug Use	❑ **Former**	❑ **Current**	❑ **Never**

Allergies

Please List any Allergies to Medications that you have and what Symptoms you had.

Medication	Symptoms

List any Additional Medications and reactions below if needed: _____

_____

_____

_____

Medications

Please List the Medications you are Currently Taking Below:

Medication (Example: *Hydralazine*)	**Dosage** (Example: *25mg*)	**Frequency** (Example: *Take 1 Tablet 3 Times a Day*)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

***If your medications exceed this page please bring medications to your apt or bring a typed listed to your appointment.**