Kidney Care Center of Georgia

Account #:	Patient Name:	
Mailing Address:	Home Phone:	
Mailing Address:	Cell Phone:	
Email Address:	Race:	
Leave a Message:	Date of Birth:	Primary Language:
Social Security #:	Marital Status:	Patient Sex:
Emergency Contact Info:	Phone Number:	Relationship?
Employer Information		
Employer Name:		
Address:	Phone Number:	
Pharmacy Name:	Pharmacy Number:	
Pharmacy Address:		
Insurance Information		
Primary:	Phone Number:	
Primary Insurance Address:		
Subscriber Name:	Date of Birth:	
Subscriber ID:	Group Number:	
Subscriber SSN		
Secondary:	Phone Number:	
Secondary Insurance Address:		
Subscriber Name:	Date of Birth:	
Subscriber ID:	Group Number:	

I authorize **Kidney Care Center of Georgia** to release medical information to my insurance companies about treatment and diagnoses 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 deny 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 Signature Date

Kidney Care Center of Georgia

Release of Information

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 call. ***If no numbers are listed, we will only call the home number listed in our records. Note:*** *(reminder calls about appointments will be left on answering machines or voice mail by our automated system)*

☐ Home _____ ☐ Work _____

☐ Cell _____ ☐ Other _____

Yes No You may leave a message on my answering machine or voice mail

Yes No You may provide private health information about me (or the patient) as indicated below (information will be provided only to those listed):

Name	Relationship	Information to provide
_____		□ Medical □ Financial
_____		□ Medical □ Financial
_____		□ Medical □ Financial

Yes No You may text me appointment reminders at: _____

Yes No You may email me appointment reminders at: _____

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.

Patient or guardian signature _____ Date signed _____

Printed patient name _____

Relationship of guardian (if applicable) _____

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 your photo identification 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 your being seen by our physicians.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment of co-pays and outstanding charges is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable deductibles, coinsurances, and copayments for participating insurance companies. Kidney Care Center of Georgia accepts cash, personal check (in-state only), VISA, and 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:
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, coinsurances, 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, coinsurances, 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:
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.

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 requested 24-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. 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 costs of collections.

Patient Name:
_____

_____ _____
Signature of Insured or Authorized Representative Date

_____
Printed Name of Insured or Authorized Representative

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 requirement. 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 some lab services are billed separately and will be your responsibility.

2) Please check with your insurance company and advise us if your plan requires Pre-certification 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 us advised of any insurance or policy 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:
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, coinsurances, 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, coinsurances, 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:
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 have read and understand the Kidney Care Center of Georgia Insurance Policy. I understand that ALL applicable charges are my responsibility and payment is due in full at the time of service.

I have read and understand the Insurance Policy as stated above and agree to accept responsibility as described.

Patient Name: _____

_____ _____
Signature of Insured or Authorized Representative Date

_____
Printed Name of Insured or Authorized Representative

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

KIDNEY CARE CENTER OF GEORGIA

Ernest Han, MD
Prashant Amin, MD
Vesna Rizvanovic, PA-C
Marlene Anderson-Reid, ANP-C
Mishell Little, FNP-BC
Catherine Basel, NP-C

Nephrology New Patient Questionnaire

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

Primary Care Physician: _____ **Telephone:** _____

Address: _____

List Name of person completing form: _____

Signature: _____ **Today's Date:** _____

Medical History

Check any of the following conditions which you are currently being treated for or have had within the past and list the year diagnosed.

Medical Condition	Yes/No	Year Diagnosed
High Blood Pressure		
Diabetes		
Eye Problems from Diabetes		
Neuropathy from Diabetes (Nerve Damage due to Diabetes)		
Heart Attack		
Stents in Heart		
Pacemaker or irregular Heart Rhythm		
Congestive Heart Failure		
High Cholesterol		
Stroke		
Emphysema or Bronchitis		
Heart Burn (Acid Reflux)		
Bleeding from digestive tract		
Liver Disease		
Hepatitis B or C		
Enlarged Prostate		
Blood Clots		

Name: _____ Date of Birth: _____

Medical Condition	Yes/No	Year Diagnosed
Cancer (list type)		
Arthritis		
Gout		
Thyroid Disease		
Seizures		
Migraine Headaches		

List any other medical conditions you may have had in the past:

_____

_____

_____

List any surgeries you have had and the year performed:

_____

_____

_____

Are you currently or have you ever taken any of the following medications? If yes, how many tablets per day or week (on average) and for how long? Motrin, Ibuprofin, Advil, Aleve (Neprosyn, Naproxen), Mobic, Goody's Powders, BC Tablets/Powder, Celebrex, Vioxx, Bextra, Diclofenec, Voltaren:

_____

_____

_____

Family History

Check the below disease if your parents, siblings, or children have or have had any of the following conditions. Also, list which relative.

Medical Condition	Yes/No	Relative
Heart Disease		
Stroke		
Cancer (List Type)		
Diabetes		
Kidney Disease		
High Blood Pressure		

Please list any other conditions that are present in your parents, siblings, or children:

_____

_____

Name: _____ Date of Birth: _____

Allergies

List any allergies to medications that you have had and what the symptoms were that you experienced as a result of the medication: _____

_____

_____

Personal History

Check all that may apply to you:

_____ I current smoke cigarettes, cigars, or pipes/chew tobacco.

_____ I used to smoke cigarettes, cigars, or pipes/chew tobacco.

How many years did you smoke or chew tobacco? _____

_____ I drink alcohol on a daily/weekly/monthly basis. (Circle one if applicable)

_____ I rarely drink

_____ I used to drink alcohol on a regular basis. I quit _____ years ago.

Immunization History

Which vaccinations have you had?

Type	**Yes/No**	**Year**
Pneumonia Vaccine		
Hepatits B Series (series of 3 shots)		
Chicken Pox Vaccine		
Tetanus		
Flu Vaccine		

Review of Symptoms-Kidney Related

Check any of the below kidney related diseases or symptoms that you have had:

Symptom	**Yes/No**	**When Occurred**
Blood in urine		
Protein in urine		
Leg or feet swelling		
Kidney Stones, How many?		
Frequent Urination at night		
Repeated bladder or kidney infections		
Difficulty starting urine stream		
Kidney Cysts		
Blockages in kidney arteries		
Incomplete bladder emptying		
Kidney Failure; Dialysis Needed? Y or N		