

Patient's Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_



**PATIENT INFORMATION SHEET**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex:  M  F Race:  African American  Caucasian  Hispanic Other \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino Language:  English  Other \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Telephone No. (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_ Marital Status:  M  S  D  W

Alternate/Emerg. Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Telephone No. \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Your email address \_\_\_\_\_ Preferred method of notification:  Mail  Phone

Do you have access to the internet?  Yes  No If Yes, have you visited our website at [www.delawarekidney.com](http://www.delawarekidney.com)?

<b>Primary Insurance Company:</b>	
ID#	Group #
Subscriber's Name:	Relationship to Patient
Subscriber's Employer:	Subscriber's DOB:
Subscriber's SS #	
<b>Secondary Insurance Company:</b>	
ID#	Group #
Subscriber:	Relationship to Patient
Subscriber's Employer:	Subscriber's DOB:
Subscriber's SS #:	
<b>Person Responsible For Payment, If Other Than Patient:</b>	
Name:	Telephone #
Address:	Relationship to Patient:
Social Security #:	Employer:

Patient's Name: \_\_\_\_\_



Date: \_\_\_/\_\_\_/\_\_\_

### Patient Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. The following is a statement of our payment policy. This payment policy applies to all services provided by Nephrology Associates, regardless of the location.

**Insurance Coverage** - We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility, and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

**Referrals** - If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician. A referral should be requested from your primary care physician's office at least 48-72 hours prior to your appointment.

**Copays** - We have a contractual obligation (with your insurance company) to collect your copay. We will collect it at the time of service. **Our office does not bill copays. Copays are the patient's responsibility and are due at the time of service.** We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service. We **cannot** waive copays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

**For our patients with no Medical Insurance Benefits**

If you do not have group or individual medical insurance, payment for all services is expected at the time of your visit. If you pay the charges in full on the day of service, we will offer a 5% prompt pay discount. Partial payments or payments made after the date of service are not subject to the prompt pay

discount. Please let us know if you are having difficulty paying your account. Nephrology Associates may be able to help by setting up a payment plan based on your financial needs. Our billing office is available Monday – Friday from 8:00 a.m. to 4:30 p.m. to assist you in satisfying your financial obligation. Please contact our billing department directly at **(302) 225-0462** to discuss payment plans, patient financial evaluations and discounts available.

**Accepted Forms of Payment** - We accept payment by cash, check, Visa and Mastercard.

**Unpaid Accounts** - In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

**Other Possible Fees** -

**Missed Appointment Fee** - A missed appointment is a scheduled appointment that you miss without notifying us in advance. A \$20 fee will be billed for patients who do not show for a scheduled appointment. Our practice requests that you provide us with at least a 24 hour notice to cancel your appointment to avoid this charge. Insurance companies do not cover this charge. **Disclaimer:** The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

**Returned Check Fee** - It is the policy of Nephrology Associates to charge \$20.00 to patients whose checks are returned by our bank for non-sufficient funds.

I have read and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print the Name of the Patient

**MEDICARE EXTENDED AUTHORIZATION – "SIGNATURE ON FILE":** I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to Nephrology Associates, P.A. for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**COMMERCIAL INSURANCE ASSIGNMENT OF BENEFITS:** I request that payment of authorized Commercial Insurance benefits, both primary and secondary, be made on my behalf to Nephrology Associates, P.A., for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the above-mentioned insurance carrier, any information needed to determine these benefits payable or benefits payable for related services.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Feroz Abubacker, M.D.  
 Piyaporn Apivatanagul, M.D.  
 Manmeet Brar, M.D.  
 Helen Chang\_DeGuzman, M.D.  
 Jeffrey S. Cicone, M.D.  
 Daniel N. Coar, M.D.  
 William J. Dahms, D.O.  
 Nealanjon Das, M.D.  
 Svastijaya Daviratanasilpa, M.D.  
 Manthodi K. Faisal, M.D.  
 Gertrude Findley-Christian, M.D.  
 Martin F. Gavin, D.O.  
 Stephanie Gilibert, M.D.  
 Rubeen K. Israni, M.D.  
 Carlos A. Machado M.D'



Arun Malhotra, M.D.  
 Collette J. Mehring, D.O.  
 G. Jeffrey Milan, M.D.  
 Wilson Nino, M.D.  
 Theodore F. Saad, M.D.  
 José M. Saez, D.O.  
 Sangeetha Satyan, M.D.  
 Shalini Sehgal, M.D.  
 Lindsey M. Slater, M.D.  
 Prayus T. Tailor, M.D.  
 Sarah S. Torregiani, M.D.  
 Jean Ann M. Yaccino, D.O.  
 Miroslaw P. Zdunek, M.D.

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS # \_\_\_\_\_ PHONE # \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

**I hereby authorize Nephrology Associates, PA to RELEASE / OBTAIN medical records TO /FROM:**

NAME OF PHYSICIAN, HOSPITAL, RELATIVE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

All Medical Records  
 Other (Please specify) \_\_\_\_\_

**PURPOSE:**

Medical Care Insurance Other \_\_\_\_\_

I specifically authorize the release of information relating to:  
 Substance abuse (including alcohol/drug abuse)  
 Mental health (including psychotherapy notes)  
 HIV related information (including AIDS related testing)

\_\_\_\_\_  
 SIGNATURE OF PATIENT OF LEGAL GUARDIAN / DATE

**I understand that my medical records may not be disclosed without my written permission; that this authorization will automatically expire one year (1 year) from the date signed; that I may revoke this consent at any time by notifying Nephrology Associates, PA.; that my private health insurance, once disclosed to others, may be disclosed to individuals or organizations not subject to HIPAA; that I may see and copy the information described on this form. I understand that, except in certain limited circumstances, NAPA may not condition my treatment on whether I sign an authorization form.**

**X** \_\_\_\_\_ **OR** \_\_\_\_\_  
 SIGNATURE OF PATIENT DATE LEGAL GUARDIAN/AUTHORIZED PERSON DATE

**PLEASE SEND / FAX RECORDS TO THE FOLLOWING OFFICE LOCATION:**

4923 Ogetown-Stanton Rd., Suite 200, Newark DE 19713 · (302)225-0451 · Fax (302) 225-0472  
 St. Francis MSB, 701 N. Clayton St., Suite 401, Wilmington, DE 19805 · (302) 421-9411 · Fax (302) 421-9460  
 1198 South Governors Avenue, Building B, Suite 100, Dover, DE 19904 · (302) 734-3227 · Fax 302-734-0391  
 201 West Liberty Way, Independence Commons, Milford, DE 19963 · (302) 424-3694 · Fax (302) 424-3697  
 34434 King Street Row, Suite 4, Lewes, DE 19958 · (302) 360-0142 · Fax (302) 360-0145  
 137 W.High Street, Suite 1A, Elkton, MD 21921 · (410) 620-9200 · Fax (410) 620-9207  
 51 Deak Drive, Smyrna DE · (302) 734-3227 · Fax (302) 734-0391

Patient's Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**MEDICAL HISTORY FORM**

**NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_ **Other Specialists:** \_\_\_\_\_

**CURRENT KIDNEY PROBLEM**

**Why are you being referred?** \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Is there a family history of this condition? \_\_\_\_\_

**CURRENT KIDNEY PROBLEM**

**OTHER MEDICAL PROBLEMS: Have you ever been treated for the following problems?**

YES	NO		Year Diagnosed
		Anemia	
		Asthma / COPD / Emphysema	
		Diabetes	
		Gout	
		Heart Disease – Congestive Heart Failure	
		Heart Disease – Heart Attack	
		High Cholesterol	
		High Blood Pressure	
		Arthritis – Rheumatoid / Osteoarthritis	
		Lupus	
		Peripheral Vascular Disease	
		Renal Failure (Acute / Chronic)	
		Polycystic Kidney Disease (PKD)	
		Kidney Stones	
		Thyroid Disease	
		Seizure Disorder	
		Stroke (TIA)	
		Prostate Disease	
		Hepatitis	
		HIV	
		Cancer	
		Other (Hospitalizations / Injuries)	

Have you ever taken (circle): Lithium      Fleets Phosphosoda      Gentamycin      Tobramycin      Cisplatinum

Have you had previous exposure to **gadolinium** (a contrast agent) during an MRI?    Yes\_\_\_    No\_\_\_

**Allergies:**    Do you have any allergies to medications? Yes \_\_\_\_\_ No \_\_\_\_\_ (if yes, please list below)

If yes	Name of Drug	Type of Reaction

**Do you have any other allergies?**

Patient's Name: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**FAMILY HISTORY:** (Example – diabetes, hypertension, heart disease, kidney disease, etc.)

	<u>Alive (Y –or- N)</u>	<u>Age –or- Age at Death</u>	<u>Medical Problem</u>
Mother			
Father			
Siblings			
Children			

**SOCIAL HISTORY:**

**Occupation:**

**Marital Status:** Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_

**Industrial Exposures (i.e. dust, fumes, solvents, chemicals, etc):**

**Cigarettes:**

Do you smoke cigarettes, cigars or a pipe? Yes \_\_\_\_\_ / No \_\_\_\_\_

How many did you or do you smoke per day (packs)? \_\_\_\_\_

For how many years? \_\_\_\_\_ When did you quit? \_\_\_\_\_

**Alcohol:**

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ # of drinks per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Drugs:**

Do you use illegal / street drugs? Yes \_\_\_\_\_ No \_\_\_\_\_ What? \_\_\_\_\_ For how many years? \_\_\_\_\_

**SURGICAL HISTORY**

	Year	Surgeon		Year	Surgeon
Hysterectomy/Ovary Removal			Cancer Surgery		
Hernia Repair			Joint Surgery		
Tonsillectomy			Back Surgery		
Appendectomy			Gall Bladder		
Heart – Coronary Bypass			Kidney		
Heart / Valve			Bladder		
Heart - AICD / Pacemaker			Transplant		
Heart – Angioplasty or Stent			Vascular		

OTHER Surgery:

**Other Medical History (including Immunizations)**

	Date	Provider		Date	Provider
Colonoscopy			Pneumonia Vaccine		
Flu Vaccine			Hepatitis Vaccine		



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**GENERAL MEDICAL HISTORY REVIEW**

**Do you have chronic difficulty with:**

		Y	N			Y	N			Y	N	
<b>GENERAL</b>	Appetite loss			<b>CARDIOVASCULAR</b>	Chest pain			<b>MUSCULO-SKELETAL</b>	Painful urination			
	Chills				Leg pain/swelling				Urinating at night			
	Fatigue				Palpitations				Joint pain			
	Fever				Shortness of breath				Muscle aches			
	Weight gain				<b>GASTROINTESTINAL</b>	Constipation			<b>NEUROLOGICAL</b>	Loss of consciousness		
	Weight loss					Diarrhea				Numbness		
<b>SKIN</b>	Itchy skin			Heartburn				Seizures				
	Skin rash			Jaundice				Weakness in extremities				
<b>HEENT</b>	Blurred vision			<b>GASTROINTESTINAL</b>		Liver disease			<b>PSYCHIATRIC</b>	Anxiety		
	Dental/Mouth problems					Nausea				Confusion		
	Double vision				Painful swallowing			Depression				
	Headache				Rectal bleeding			Mood changes				
	Hearing loss				Vomiting			<b>ENDOCRINE</b>	Cold flashes			
	Nose Bleeds/Sinusitis				Vomiting blood				Excessive sweating			
	Ringling in the ears				<b>GENITOURINARY</b>	Blood in urine				Hot flashes		
<b>RESPIRATORY</b>	Chronic cough			Cloudy urine				<b>HEMATOLOGY</b>	Easy bruising			
	Coughing up blood			Excessively foamy urine					Excessive bleeding			
	Difficulty breathing			Foul smelling urine								
	Wheezing			Frequent urination								

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_