

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?

Primary Insurance Company:	
ID#	Group #
Subscriber's Name:	Relationship to Patient
Subscriber's Employer:	Subscriber's DOB:
Subscriber's SS #	
Secondary Insurance Company:	
ID#	Group #
Subscriber:	Relationship to Patient
Subscriber's Employer:	Subscriber's DOB:
Subscriber's SS #:	
Person Responsible For Payment, If Other Than Patient:	
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.
 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 _____

<p>I specifically authorize the release of information relating to:</p> <ul style="list-style-type: none"> Substance abuse (including alcohol/drug abuse) Mental health (including psychotherapy notes) HIV related information (including AIDS related testing) <p><input checked="" type="checkbox"/> _____</p> <p>SIGNATURE OF PATIENT OF LEGAL GUARDIAN / DATE</p>
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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 Ogletown-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, 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 Cisplatinium

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

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____