PATIENT INFORMATION FORM

Name: (Last, First, Middle)	Social Security No.	Marital Status	Date of Birth	Sex
Local Address	Email address			
City, State, Zip	Home Phone Number			
Primary Employer	Secondary Phone Number			
Address	Race	Ethnicity	Primary Language	
City, State, Zip	Alternate Contact Person's Name			
Work Phone	Alternate Contact Person's Phone Number			
Primary Care Physician	Referring Physician	Contact Name	Contact Phone	

RESPONSIBLE PARTY INFORMATION

Name: (Last, First, Middle)		Social Security #	Date of Birth	Sex
Local Address		Secondary Billing Address (if applicable)		
City, State, Zip		City, State, Zip		
Home Phone	Home/Cell phone	Relationship to Patient		

PRIMARY INSURANCE

Name of Insurance Company	Policy #	
Name of Insured	Group #	Effective Date
Address of Insurance Company	Copayment	Deductible
City, State, Zip	Relationship to patient	

SECONDARY INSURANCE (if applicable)

Name of Insurance Company		Policy #	
Name of Insured	SS#	Birthdate	Group #
Address of Insurance Company		Copayment	Deductible
City, State, Zip			
Relationship to patient		Effective Date	Expiration Date

Authorization: **I give consent to Nephrology Associates, its staff, physicians, and other practitioners to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well being.**

______________________________ ______________

Signature of Patient/Guardian: **Date:**

Patient Name: ______________________ Date of Birth: ______________________

PATIENT INFORMATION FORM

Patient Medical History Form

DATE: ____________________

Medical History: Have you ever been treated for any of the following medical conditions?

□ No changes
□ Arthritis
□ Diabetes
□ High blood pressure
□ Kidney disease
□ Osteoporosis

□ Cancer
□ Depression/anxiety
□ Heart problems
□ High cholesterol
□ Lung problems
□ Thyroid problems

Please list any additional medical conditions:
____
Have you ever been hospitalized overnight? □Yes □No
Have you ever had surgery? □ Yes □ No
____

Medications and Allergies: will be reviewed by clinic staff.
(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

Do you take any supplements (calcium/vitamin D/fish oil/multivitamin)? □Yes □ No

Family History: Please list any known medical problems for the relatives listed below:
(For example: diabetes, cancer, heart attacks, high blood pressure, kidney disease, etc.)
□ No changes
Mother:___________________________________
Father:____________________________________
Brothers/Sisters:___________________________
Children:_________________________________
Other:____________________________________

Social History:
Are you retired? □ Yes □ No
Work Type: ____________________________
Tobacco (chew/smoke): ____________per day
Alcohol (beer/wine, etc.):___________per day
Drugs (marijuana, etc.):___________________
Caffeine (coffee/tea/soda):__________per day
Any trouble sleeping? □ Yes □ No
Relationship Status: □ Married □ Single
□ Widowed □ Divorced/Separated

REVIEW OF SYSTEMS

Please circle any current symptoms below:

Constitutional:
Fatigue
Fever
Cardiovascular:
Chest Pain
Edema
Leg swelling
Heart palpitations
Neurological:
Dizziness
Focal weakness
Headache

HEENT:
Hearing loss
Visual loss
Gastrointestinal:
Abdominal pain
Diarrhea
Nausea
Vomiting
Psychiatric:
Depression
Anxiety

Respiratory:
Cough
Shortness of breath
Genitourinary:
Painful urination
Blood in urine
Urinary frequency
Urinary incontinence
Integumentary:
Itching
Rash
Skin Ulcers

Patient Name: ______________________________ Date of Birth: ________________________

PATIENT INFORMATION FORM

Patient Medical History Form

DATE: ____________________

Musculoskeletal:
Back pain
Body aches
Joint swelling

Hematologic:
Easy bleeding
Easy bruising

Immunologic:
Environmental allergies

Depression Screening

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things.	☐	☐	☐	☐
2.	Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3.	Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
4.	Feeling tired or having little energy.	☐	☐	☐	☐
5.	Poor appetite or overeating.	☐	☐	☐	☐
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9.	Thoughts that you would be better off dead, or of hurting yourself in some way.	☐	☐	☐	☐
10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	**Not difficult at all**	**Somew hat Difficult**	**Very Difficult**	**Extremely Difficult**
		☐	☐	☐	☐

Patient Name: ____________________ Date of Birth: ____________________

PATIENT INFORMATION FORM

Notice of Privacy Practices

Effective Date: January 1, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What's Protected Heath information (PHI)?

Protected Health Information (PHI) is information that Individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances;

For Treatment. We may use PH I to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring specialist's physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Patient Name: ______________________ Date of Birth: ____________________

PATIENT INFORMATION FORM

Notice of Privacy Practices
Continued

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care;(2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures that Require Us to Give You an Opportunity and Object and Opt Out

Individual ls Involved in Your Care or Payment for Your care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family provide a written request to this office listing the contact information of the Individual or entity who should receive your electronic PHI.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Patient Name: ______________________ Date of Birth: ______________________

PATIENT INFORMATION FORM

Notice of Privacy Practices
Continued

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the Information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) Is not Information that you would be permitted to Inspect and copy, or (2) Is accurate and complete. Lf we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should Indicate in what form you would like the accounting (for example, on pa per or by e-mail), the first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the Information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work.

ACKNOWLEDGEMENT OF RECEIPT

I, (Patient Name) ____,
have reviewed the Notice of Privacy Practices for Nephrology Associates.

____ ________________________
Patient/Guardian Signature Date

Patient Name: ______________________________ Date of Birth: ________________________

PATIENT INFORMATION FORM

Patient Authorization for Disclosure of Protected Health Information

Notice to Patients: In compliance with HIPAA regulations, this letter authorizes Nephrology Associates to release medical records concerning you to the entity specified below. We must have this form to authorize our release of your protected health information to entities other than covered providers (for example, insurance companies, attorneys, education programs, etc.)

Patient Name: ______________________________

Purpose of Request: I authorize Nephrology Associates to disclose or provide protected health information, about me, to: (please list person or persons below, example family or friends by first name last name and relationship)

____

Description of Information to be Disclosed: I authorize Nephrology Associates to disclose the following protected health information about me to the person identified above (please provide a written description of the information to be disclosed).

____

Purpose of Disclosure (please list the purpose of the disclosure).

____

Expirations or termination of authorization - This authorization will expire one year (365 days) from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. (Please list earlier expiration, if less than one year)
Right to Revoke or Terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person, or by mailing a request to

Nephrology Associates
251 N. Lyerly
Chattanooga, TN. 37404
ATTN: Clinical Manager

Redisclosure - We have no control over the person(s) you have listed to receive your protected health information.

Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Nephrology Associates.

______________________________ ______________________________
Patient/Guardian Signature Date

Patient Name: ______________________________ Date of Birth: ______________________________

PATIENT INFORMATION FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
MEDICAL RECORD RELEASE

NOTICE TO PATIENTS: In compliance with HIPAA Regulations, this letter authorizes Nephrology Associates, to obtain medical records concerning you from other providers.

Patient Name: ______________________________

Purpose of Request: - I request and authorize the disclosure or release of my protected health information (as identified below) to the following provider:

NEPHROLOGY ASSOCIATES **(To be filled out by the provider)**

Name of Provider ______________________________

Address ______________________________

City, State, Zip ______________________________

Phone ____________________ Fax ____________________

Description of Information to be disclosed - I authorize the disclosure of the following protected health information about me to the person(s) identified above.

☐ Complete Medical Record Or ☐ Only the following information (listed below)

____

Purpose of Disclosure - This protected health information Is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

____

Expiration or termination of authorization - This authorization will expire one year (365 days) from the date of my signature below:

______________________________ ____________________
Patient/Guardian Signature Date

Patient Name: ____________________ Date of Birth: ____________________

PATIENT INFORMATION FORM

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 services being rendered. 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.

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.

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.

For our patients with no Medical Insurance Benefits – If you do not have group or individual medical insurance, payment or arrangement for all services is expected at the time of your visits. If you pay the charges in full on the day of service, we will offer a prompt pay discount.

Account Balances – 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 423-702-7903 to discuss payment plans, patient financial evaluations and discounts available.

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.

Returned Check Fee – It is the policy of Nephrology Associates to charge $35 to patients who checks are returned by our bank for non-sufficient funds or Account Closed. After two check returns, no checks will be accepted from that point on the account.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made on my behalf to Nephrology Associates for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to my insurance carrier, any information needed to determine these benefits or benefits payable for related services.

______________________________ ______________________
Patient/Guardian Signature Date

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

Patient Name: ______________________ Date of Birth: ______________________

PATIENT INFORMATION FORM

Consent to Voicemail/Text for appointment reminders and other Healthcare Communications:

Patients in our practice may be contacted via voicemail and/or Text to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email at which I may be contacted, I consent to receiving appointment reminders and other healthcare communication information at that email or voicemail from the Practice.

______ (Patient Initials) ○ I consent to receive Voicemail from the practice to receive communications as stated above. I understand that this request to receive voicemail will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

______ (Patient Initials) ○ I consent to receive Texts from the practice to receive communications as stated above. I understand that this request to receive Text will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

Cell Phone Number: ______________________________

______ (Patient Initials) ○ I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recording. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Revocation

I hereby revoke my request for future communications via email and/or voicemail.

____ (Patient initials) ○ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via voicemail messages.

____ (Patient initials) ○ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via Text messages.

____ (Patient initials) ○ I DO NOT consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. quality improvement activities).

NOTE: This revocation only applies to communications from this Practice.

Patient Name: ______________________________

Patient/Patient Representative signature: ______________________________

Date: ____________________ Time: ____________________

Patient Name: ____________________ Date of Birth: ____________________

PATIENT INFORMATION FORM

Southeast Renal Research Institute (SERRI)

Southeast Renal Research Institute (SERRI) is the Research Department of Nephrology Associates. We study new medications and devices to help improve and slow the progression of kidney disease and associated conditions.

Would you be interested in participating in a clinical trial? _____ **Yes** _____ **No**

If yes, do you have any of the following?

- Hypertension (High Blood Pressure) _____ **Yes** _____ **No**
- Diabetes _____ **Yes** _____ **No**
- Anemia _____ **Yes** _____ **No**
- Lupus or Other Autoimmune conditions? _____ **Yes** _____ **No**

Please provide us with the best method to reach you. We will review your record to see if you are eligible for a clinical trial here at SERRI.

Name (please print): ______________________________

Date of Birth: ______________________________

Phone: ______________________________

Email address: ______________________________

SERRI Contact Information:

45 East Main Street, Suite A / Chattanooga, TN / 37408

Phone: 423.826.8003 / Fax: 423.648.7697

Email: research@nephassociates.com

SERRI.net