NORTHWEST NEPHROLOGY CLINIC
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Cell Phone #:	Home Phone #:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ Aetna	❑ Blue Cross	❑ Cigna

❑ UHC	❑ Care Improvement	❑	❑	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to **Northwest Nephrology Clinic**. I understand that I am financially responsible for any balance. I also authorize **Northwest Nephrology Clinic** or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

NORTHWEST NEPHROLOGY CLINIC

HYPERTENSION AND NEPHROLOGY

5255 Snapfinger Park Dr Ste 110
Decatur, GA 30035
Office 770-981-2211 Fax 770-981-0208

465 Winn Way Ste 201
Decatur, GA 30030
Office 404-355-1446 Fax 404-328-0226

Andrew A Dixon, M.D. Juan L. Pimentel, M.D.,FACP Arun Kumar, M.D. Aakash Amin, M.D.

Formulary Benefits Data Consent

Formulary Benefits Data is maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

This consent will enable Northwest Nephrology Clinic and it's clinical staff to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's plan allow electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

By signing below, ***I hereby give permission for the health care providers at Northwest Nephrology Clinic and its clinical staff to access my pharmacy benefits data , electronically, which includes information about other prescriptions prescribed by other providers using RxHub.***

Patient Name (Printed) **Date of Birth**

Patient Signature

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AUTHORIZATION FOR AND CONSENT TO RELEASE INFORMATION

I, the undersigned patient/guardian, hereby authorize _____to

Release information listed below from the records of_____.

The release of information to which I consent is for the purpose of_____

_____

For the following dates of hospitalization or outpatient services:_____

_____

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol abuse records, Venereal Disease and any other statutory protected diseases. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof.

_____ _____
Signature of Patient/Guardian Date of Signature

_____ _____
Relationship to Patient Signature of Witness

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HIPAA ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO DISCLOSE PHI

Date: _____

I, the undersigned acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for Northwest Nephrology Clinic, PC ("Group").

I hereby consent to the disclosure of information from and/or copies of all my medical records by Group, its staff and business associates (as that term defined under the Health Insurance Portability and Accountability Act of 1996, as amended) to any person, corporation, governmental agency or other entity performing services related to my treatment, billing and/or obtaining payment for my care, or for group's healthcare operations or otherwise in accordance with the Group's Notice of Privacy Practices. I also consent to the disclosure of my health information to the individuals listed below who are involved in my health care.

PLEASE LIST ANY PARTIES INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE TO WHOM WE MAY DISCLOSE YOUR HEALTHCARE INFORMATION RELATED TO THEIR PARTICIPATION IN YOUR CASE. (This includes family members such as your spouse, children, grandchildren, sister, brother, and my care takers who can have access to your records.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

__ If checked, this consent specifically allows the release of any information from or copies of my medical record concerning treatment for mental illnesses and psychiatric conditions, for drug or alcohol abuse, drug-related condition, alcoholism, as applicable.

I also consent to (a) the release of all or part of my medical record to Group for treatment purposes by any and all physicians, hospitals, and other health care providers; and (b) the release to Group of information from and/or copies of payment records pertaining to the medical services provided by group by any persons, corporation, or other entities that are legally responsible for the payment (all or in part) of the medical services provided to me.

I understand that I may revoke all or part of this consent at any time in writing, but if I do so it may adversely affect Group's ability to treat me appropriately or even to continue to provide my care. I hereby waive any requirement that this consent be addressed to any specific person or institution or dated within any particular time period before a disclosure of my medical records is made.

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- Cell phone confirmation
- Home phone confirmation
- Work phone confirmation
- Email confirmation
- U.S. Mail/Postcard
- Fax
- Any of the above

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE TO BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Email message
- U.S. Mail/Postcard
- Fax
- Any of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, OR NEW HEALTHCARE INFO VIA:

- Phone Message
- Email
- U.S. Mail/Postcard
- Any of the above

A photocopy of this consent shall have the same force and effect as the original

I have read the above acknowledgement and consent and I understand nature and purpose of this acknowledgement and consent.

_____ _____

Patient Name Please sign your name

_____ _____

Legal Representative Description of Authority

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Financial Policy

Thank you for choosing us as your healthcare provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

I authorize my insurance benefits be paid directly to **Northwest Nephrology Clinic**. I understand that I am financially responsible for any balance. I also authorize **Northwest Nephrology Clinic** or insurance company to release any information required to process my claims.

Understanding your bill
When you receive your bill, you will have the name of the physician whom treated you. Bills for physician services are separate from bills you will receive for any services performed outside our office. Quest Diagnostics and LabCorp are separate entities from Northwest Nephrology Clinic.

Regarding Insurance
WE DO REQUIRE YOUR CO-PAYMENT, DEDUCTIBLES AND ANY CO-INSURANCES BE PAID AT THE TIME SERVICES ARE RENDERED. IF YOU ARE UNABLE TO PAY AT THE TIME SERVICES ARE RENDERED, YOU MAYBE REQUIRED TO RESCHEDULE YOUR APPOINTMENT IF OTHER ARRANGEMENTS HAVE NOT BEEN MADE WITH THE BILLING DEPARTMENT. It is your responsibility to provide us with complete and accurate insurance information. If you are a member of a managed healthcare system or an HMO (Health Maintenance Organization), such as Aetna, Blue Cross Blue Shield HMO or POS, Cigna, or Coventry, etc., a referral is required from your primary care physician before we can see you. **IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL FROM THE PHYSICIAN or PRACTICE LISTED ON YOUR INSURANCE CARD.**

Uninsured Patients
Full payment is due at the time services are rendered. We accept your personal check, VISA, MC, and American Express. If your physician orders labs work for you, you will receive a separate bill from the lab for those charges. If you are unable to pay the full amount of your bill, please ask to speak to someone in our billing department in order to make payment arrangements.

Other Policies
For any checks returned unpaid, your account will be charged a 35.00 service fee. We do not balance bill for any copays. Copays are paid at the time services are rendered. **If you are unable to keep your appointment, please notify the office within 24 hours. If you do not call to reschedule within that time, your account will be accessed a 30.00 fee which must be paid in addition to any other co- pays or co-insurance before seeing your physician.**

Billing Inquiries
When you have a question regarding your bill, you may call 770-981-2211 and ask to speak with a representative in the billing department.

I have read and agree to this financial policy. I understand that failure to follow this policy may result in delay of medical services.

_____ _____

DATE **PATIENT SIGNATURE**

Northwest Nephrology Clinic

Medical History Form

Name: _____ Date of Birth: _____

Allergies: _____

Pharmacy: _____

Medications: (please specify name, strength and dose):

_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History: (include dates diagnosed)

□ High Blood Pressure	□ Cancer (type) _____
□ Heart Disease	□ COPD
□ Pacemaker/Defibrillator	□ Kidney Stones
□ Congestive Heart Failure	□ Kidney Disease
□ Palpitations	□ Hepatitis _____
□ Stroke	□ Gall Bladder Disease
□ Seizures	□ Arthritis (Osteoarthritis or Rheumatoid)
□ Asthma	□ Gout
□ Thyroid Disease	□ Depression
□ Headaches	□ Bipolar Disorder
□ Sinus Problems	□ Anxiety
□ Glaucoma	□ Breast Disease _____
□ Hearing Loss	□ Prostate Disease _____
□ Lupus	□ Erectile Dysfunction
□ Anemia	□ Diabetes □ Insulin dependent
□ Gastrointestinal Bleeding	□ Skin Disease
□ GERD	□ Blood Clots

List any surgeries or hospitalizations and the dates:

_____
_____
_____

Family History:

		Living	Age (or age at death)	Medical History
Father	□ Yes	□ No	_____	_____
Mother	□ Yes	□ No	_____	_____
Sisters	□ Yes	□ No	_____	_____
Brothers	□ Yes	□ No	_____	_____

Name_____ Date of Birth _____

Personal Health History

History of tobacco use _____How many _____packs/day # of years _____
Year quit _____
History of alcohol use _____ How much _____drinks/week # of years _____
Year quit _____
History of drug abuse _____

Social History

Work**:** □ Employed □ Unemployed □ Retired □ Disabled

Occupation: _____

Marital Status: □ Married □ Single □ Divorced □ Widow □ Domestic Partner

Children (age):

Sons:
_____

Daughters:
_____

Hobbies:
_____
_____

Sports:
_____
_____

Religion Preference:
_____