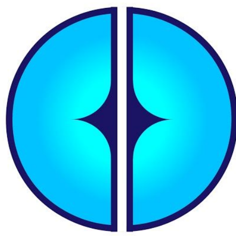

NEPHROLOGY
OF GEORGIA

NEW PATIENT INFORMATION SHEET

Date: _________________________ E mail: ______________________________________

Patient's Name: ____

Last First Middle Initial

Address (Number and Street): ____

City: ____________________________________ State: _______________ Zip: _____________

Phone Numbers: Cell ___________________________ Home: _________________________________

Date of Birth: ___________________________ Marital Status: ________________________________

Employer: ________________________________ SS #: ____________________________________

RESPONSIBLE PARTY/GUARANTOR INFORMATION (if different from above)

Name: ____
Relationship to patient: ____
Date of Birth: ____
Address (if different than above): ____
City: ______________________________ State: ____________________ Zip: ____________________

EMERGENCY CONTACT PERSON

Name: _____________________________________ Relationship:______________________________
Phone Numbers: Home: ____________________________ Work: ______________________________
Cell: ____

PRIMARY INSURANCE INFORMATION

Insurance Name: _______________________________________ Plan Type: _____________________
Insurance ID #: _____________________________ Patient Relationship to Insured: ________________
Policy Holder Name: ____
Policy Holder DOB: __________________ Policy Holder SS #: __________________________________
Policy Holder Address: ____

SECONDARY INSURANCE INFORMATION

Insurance Name: _______________________________________ Plan Type: _____________________
Insurance ID #: _____________________________ Patient Relationship to Insured: ________________
Policy Holder Name: ____
Policy Holder DOB: __________________ Policy Holder SS #: __________________________________
Policy Holder Address: ____

PHARMACY (name, number, address)

Please Answer the Following Questions:

1. What is the reason for your visit?

____

____

____

2..Are you allergic to any medication? If yes, please list:

____

____

____

3. Are you currently under the care of a doctor for any reason? If yes, please explain:

____

____

____

4. Have you been hospitalized in the past five years for more than two days? If yes, please explain:

____

____

____

5. Please circle any of the following you have (had):

- ❏ High blood pressure
- ❏ High cholesterol
- ❏ Stroke
- ❏ Depression
- ❏ Diabetes
- ❏ Asthma
- ❏ Neuropathy
- ❏ Arthritis
- ❏ Leg swelling
- ❏ COPD
- ❏ Anemia
- ❏ Spine disease
- ❏ Kidney stones
- ❏ GERD
- ❏ Ulcers
- ❏ Osteoporosis
- ❏ Heart disease
- ❏ Sleep apnea
- ❏ GI bleeding
- ❏ Frequent UTI
- ❏ Heart failure
- ❏ Allergies
- ❏ Hepatitis
- ❏ Irregular heart
- ❏ Heart valve problem
- ❏ Gout
- ❏ Gallbladder
- ❏ Seizures
- ❏ Heart murmur
- ❏ Vascular disease
- ❏ Cancer
- ❏ Thyroid

6. Any other serious illness?

____

____

____

Review of Systems (Please indicate any personal history within the last three months):

General
- ❑ Chills
- ❑ Fever
- ❑ Night sweats
- ❑ Poor appetite
- ❑ Weight loss
- ❑ Weight gain
- ❑ Loss of energy

Eyes
- ❑ Sudden vision changes
- ❑ Double vision

Ears
- ❑ Sudden loss of hearing
- ❑ Ringing in the ears
- ❑ Frequent ear infections

Nose
- ❑ Nasal congestion
- ❑ Frequent sinus infection
- ❑ Frequent nose bleeds

Mouth/Throat
- ❑ Frequent throat infections
- ❑ Change in voice

Lungs
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ Shortness of breath with activity

Heart
- ❑ Chest pain or pressure
- ❑ Heart palpitations
- ❑ Irregular heartbeat
- ❑ Waking up short of breath
- ❑ Use many pillows to sleep

Swelling
- ❑ Legs/ankles/ feet
- ❑ Calf pain when walking

Stomach/Intestine
- ❑ Difficult swallowing
- ❑ Heartburn/ indigestion
- ❑ Stomach pain/ discomfort
- ❑ Nausea or vomiting
- ❑ Vomiting blood
- ❑ Blood in stools
- ❑ Constipation
- ❑ Chronic diarrhea
- ❑ Do you use laxatives?
- ❑ Black, tarry stools
- ❑ History of jaundice

Endocrine
- ❑ Excessive thirst
- ❑ Cold/heat intolerance
- ❑ Hot flashes

Genitourinary
- ❑ Prostate problems
- ❑ Weak/slow urine stream
- ❑ Kidney stones
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Burning with urination
- ❑ Wake at night to urinate

Nervous System
- ❑ Severe headache
- ❑ Dizziness/light headedness
- ❑ Loss of balance
- ❑ Numbness or tingling

Bones/Muscles/ Joints
- ❑ Painful joints
- ❑ Swelling of joints

Skin
- ❑ Skin rash
- ❑ Easy bruising

Blood
- ❑ Anemia
- ❑ Blood loss
- ❑ Blood transfusion

Psychiatric
- ❑ Mood swings
- ❑ Depression
- ❑ Anxiety
- ❑ Sleep problems

Other issues (please list below)

Comments/Notes:

____

____

____

How did you hear about us?

- ❏ My doctor referred me

  Please List: ____________________

- ❏ Personal recommendation

  Please List: ____________________

- ❏ Dr. Garcia Sanchez is my MD at another facility

  Please List: ____________________

- ❏ ZocDoc
- ❏ Online search for Internist
- ❏ Online search for Nephrologist
- ❏ Other

  Please List: ____________________

Patient Signature: ____________________

Representative Signature: ____________________

MEDICATIONS LIST

Please list below all medications currently being taken. Please include all prescription and over-the-counter medications as well as any vitamins and/or herbals.

PATIENT DOB: ___________________________ NAME: ____

MEDICATION NAME	**DOSE** (20 mg,mcg,ml,etc.)	**FREQUENCY** (daily,twice daily, etc.)

ALLERGIES: Please list below all medication allergies

____

____

____

Patient Portal

Kareo Patient Portal allows for transparency with all your medical records. It is the easiest way to manage your healthcare.

With Kareo Patient Portal you can:

- View easy-to-read patient statements
- Make fast, secure online payments
- Review your health information

If you would like to receive an email to sign up for Kareo Patient Portal please fill out the information below.

Email: ____

Patient Name: ____

Patient Signature: ____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB: ___________________________
Address: ____

City:______________________________ State:___________________________ Zip: __________________

Phone number: ____

Person(s) authorized to speak on my behalf: ____

Phone Number: ____

I authorize representatives from **NEPHROLOGY OF GEORGIA** to disclose the following protected health information to the following person/persons.

(If applicable)

Please send my health information to:

Name: ____

Address: ____

City: _______________________________ State: _________________________ Zip: __________________
Phone Number: ____

Fax Number: ____

Description of Health Information to be Disclosed:

Complete Medical Record (specify dates): ____

Partial Medical Record (specify records below):

Information to be released Dates or History/Physical: ____

Office notes/Progress notes: ____

Consultations: ____

Discharge Summary: ____

Lab Results: ____

View medication history retrieved from Surescripts for the patient

X Rays/CT/MRI/Ultrasound: ____

Operative Note: ____

Pathology Reports: ____

Right and Responsibilities:

1. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization it must be done in writing and presented to Nephrology Of Georgia LLC. I understand that the revocation will not apply to any health information that has already been released.

2. I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

3. I understand that the health information disclosed may include psychological information, chemical dependence, alcohol abuse, HIV status, and/or Hepatitis.

4. I understand that I am waiving any privilege concerning such information for the purpose of releasing it to the party authorized above. I release Nephrology Of Georgia LLC and its employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me.

Patient Signature (or Patient's Representative): ____

Printed Name: ____

Date: ____

HIPAA Authorization Form

1. I hereby authorize the use or disclosure of my protected health information as described below

Patient's Name: ____

Persons or organizations providing information:

____
____
____

Persons or organizations receiving information:

____
____
____

Description of information to be disclosed (including dates of service):

____
____
____

****(Note: "At the request of the individual" is adequate if the individual initiated authorization without a stated purpose).**

2. Complete this section if healthcare provider requested authorization.

Healthcare provider: Will the healthcare provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____ No__X__

Individual: I understand that I may request a copy of this form after I sign it. **Initials**:_________

3. You may disclose information about alcohol/substance abuse, HIV/aids, or mental health:
YES. Initial: __________ NO, DO NOT. Initial: __________

4. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. **Initial: __________**

5. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. **Initial: __________**

Patient Signature (or Representative): ____

Representative Name (Print): ____

Relationship to Patient: ____

Date: ____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **You may request a copy to read at your convenience**

This Notice explains the ways in which we may use and disclose medical information about you. It describes your rights and certain obligations we have regarding the use and disclosure of your medical information. The law requires us to (1) Ensure your medical information is protected; (2) Provide you with this Notice describing our legal duties and privacy practices with respect to medical information about you; (3) Follow the current terms of the Notice in effect.

WAYS WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories.

Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Our office shall abide by all applicable state and federal laws related to the protection of this information.

1. **Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in your care. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may also share medical information about you with our office personnel or other providers, agencies or facilities in order to provide or coordinate such things as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside our office who may be involved in your continuing medical care after you leave our office such as other health care providers, transport companies, community agencies and family members.
2. **Payment**. We may use and disclose medical information about the treatment and services you receive at our office so that payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about treatment you received at our office so your health plan will pay us or reimburse you. We may also tell your health plan about a proposed treatment in order to obtain prior approval or to determine whether your plan will cover the treatment.
3. **Health Care Operations**. We may use and disclose medical information about you to support our office operations. These uses and disclosures are made to improve our quality of care. Your medical information may also be used or disclosed to comply with laws and regulations, for contractual obligations, patients. claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of our office to another entity, underwriting and other insurance activities. For example, we may review medical information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians, and other personnel for performance improvement and educational purposes.
4. **Appointment Reminders**. We may contact you to remind you that you have an appointment at our office.

5. **Treatment Alternatives**. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. **Health-Related Benefits and Services**. We may contact you to tell you about benefits or services that we provide.

7. **Others Involved in Your Care.** We may release medical information to anyone involved in your medical care, For example, a friend, family member, personal representative, or an individual you identify. We may give information to someone who helps pay for your care or we may tell your family or friends about your general condition.

8. **Research**. Your medical information may be important to further research efforts. We may use and disclose your medical information for research purposes, subject to the confidentiality provisions of state and federal law.

9. **As Required By Law**. We will disclose medical information about you when required to do so by federal or state law; If asked to do so by law enforcement in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process; or for intelligence, counterintelligence, and other national security activities authorized or required by law.

10. **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you for public health purposes or when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat

11. **Workers' Compensation**. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

12. **Inmates**.If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Although the medical information we obtain about you is the property of our office, you do have the following rights:

I. **Inspect and Copy**. With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing information. To inspect and/or to receive a copy of your information, you must submit your request in writing to our Office Manager 3790 Holcomb Bridge Road Suite 204 Peachtree Corners GA 30092. If you request a copy of the information, we may charge a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by the Our office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

II. **Request an Amendment or Addendum**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or our office. To request an amendment, your request must be made in writing and submitted to our Office Manager. In addition, you must provide a reason that supports your request. We may deny your request for an amendment 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: Was not created by our office; Is not part of the medical information kept by or for Our

office; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete in the record. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

III. **Accounting of Disclosures**. You have the right to receive a list of the disclosures we have made of medical information about you that were for purposes other than treatment, payment, health care operations and certain other purposes. To request this accounting of disclosures, you must submit your request in writing to our Office Manager. Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, we may charge you for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

IV. **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. ***We are not required to agree to your request.*** If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our Office Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

V. **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Office Manager. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

VI. **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO OUR PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our office's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our office. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our our Privacy Office or with the Secretary of the Department of Health and Human Services. To file a complaint please contact our Privacy Officer by mail at Office for Civil Rights Department of Health & Human Services 61 Forsyth Street, SW. - Suite 3B70 Atlanta, GA 30323 (404) 562-7886; (404) 331-2867 (TDD) (404)

562-7881 FAX. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Patient Signature: ____

Representative Signature): ____