NEW PATIENT INFORMATION PACKET

(Please read carefully and fill out all forms before arriving)

Enclosed in this packet are new patient forms that you will need to complete prior to your appointment. Please be sure to bring these forms with you. This packet contains the following:

1. Medication list (list all medications on this list)
2. Patient information form (complete blanks and make any necessary changes)
3. History and physical form (complete the front side of this form only)
4. Private consent form (complete blanks)
5. Patient consent form (complete blanks)
6. Notice of privacy practices form (please read and keep this for your records)

Please complete these forms but sign and date with the date that you will be coming in for your appointment. We ask that you complete the attached medication list, bring a picture id and insurance card. If your insurance requires co-pay, please be prepared to pay this at the time of your visit.

We look forward to having you as a patient. Please call us if you have any questions or concerns regarding your appointment.

Sincerely,

Receptionist

Renal Associates LLC
6228 Bradley Park Drive, Suite A
Columbus, Ga 31904
706-322-1486

RENAL ASSOCIATES, LLC

FERDINAND ALCAIDE,MD,FACP,FASN
RAJENDRAN ALAPPAN,MD,FACP,FCCP,FASN
RAJEEV CHAUHAN,MD
TAMORIE SMITH,MD
VINAYAK RAMANATH,MD

PATIENT INFORMATION

PATIENT'S NAME:_____ DATE OF BIRTH:_____
ADDRESS:_____ CITY:_____
STATE:_____ ZIP CODE:_____ EMAIL ADDRESS:_____
HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____
SOCIAL SECURITY:_____-_____-_____ RACE :_____
MARITAL STATUS:_____SPOUSE'S NAME:_____
EMERGENCY CONTACT NOT LIVING WITH YOU:_____
ADDRESS:_____
PHONE NUMBER:_____ RELATIONSHIP:_____

PRIMARY INSURANCE

INSURANCE COMPANY NAME:_____ ID#:_____
INSURED'S NAME:_____ INSURED'S DOB:_____
RELATIONSHIP TO PATIENT:_____ EMPLOYER:_____

SECONDARY INSURANCE

INSURANCE COMPANY NAME:_____ ID#:_____
INSURED'S NAME:_____ INSURED'S DOB:_____
RELATIONSHIP TO PATIENT:_____ EMPLOYER:_____

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and IS NOT substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay and DEDUCTIBLES, CONINSURANCE OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE.

In order to control costs of billings, we request that our charges for OFFICE VISITS be paid at the time of each visit. If this account is assigned to an attorney for collection and /or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

I request that PAYMENT of authorized insurance benefits, to include Medicare and any Medigap insurer benefits, be made either to me or on my behalf to Renal Associates, LLC, for any services rendered to me by the physician. I hereby agree and give consent for treatment by Renal Associates, LLC. I authorize any holder of medical information about me to release to insurance carrier, to include Health Care Financing Administration and any Medigap insurer and its agents, any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE:_____ DATE:_____

PATIENT RESPONSIBILITIES

Please be sure to bring all medications when coming to every appointment. It is very mportant that we keep a current list of your medications. Please inform the nurse of any medication changes or refills you need when you come in for your visit.

You are responsible for keeping up with your lab/test requests and ensuring that all labs and tests are completed 1 to 2 weeks prior to your appointment. Please take your renal associates, llc request form when going to have any test done for our doctors. If labs/test are not completed prior to your appointment please call the office to reschedule. We request that you have your labs done at a hospital or independent lab. If you have your labs done at another physicians office, you will be responsible for ensuring that we receive your labs 2 days prior to your office visit. Please do not add any other doctor's request to renal associates, llc request form. You can take a separate request form from other doctors when you go for your labs.

Please notify your pharmacy of any prescription refills before your medication runs out. They will send us a refill authorization which your doctor will approve and send back. Please note that your doctor here at renal associates can only authorize prescription refills for medications they prescribed for you. Allow the office at least 48 hours for medications to be authorized.

Please note that when you leave a message, your phone call will be returned within 24 to 48 hours. If you have an emergency, please go to the emergency room.

There will be a $5.00 charge for any form or letter that we complete for you. Please allow 5 to 10 business days unless otherwise stated.

Please arrive to scheduled appointments 15 minutes before your appointment time. Please notify the office when running late or unable to make your appointment. We do not take walk-ins. Please call to reschedule appointment if you are running more than 15 minutes late. If you arrive to your appointment early, please understand that you will be brought back by appointment time and not arrival time.

Thank You.

_____/_____

Renal Associates, LLC Patient's Signature Date

RENAL ASSOCIATES, LLC

PRIVATE CONSENT FORM
For Use and Disclosure of Protected Health Information

Renal Associates, LLC's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. As provided in the Notice, the terms of our Notice may change. If Renal Associates, LLC changes its Notice, you may obtain a revised copy by requesting a copy in writing from:

Renal Associates, LLC
6228 Bradley Park Drive
Suite A
Columbus, GA 31904
Telephone: (706)322-1486
Contact: Office Manager

or by coming to our facility and requesting a revised Notice in person. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment or health care operations. We are not required to agree to such a restriction, but if we do agree, we are bound by the agreement.

By signing this form, you consent to Renal Associates, LLC's use and disclosure of protected health information about you for treatment, payment and health care operations. You do not have to sign this consent and if you sign this consent, you have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By signing this form, you also represent that you have received a copy of our Notice of Privacy Practices on the date indicated below.

Patient Name: _____ _____
(Please Print) Signature of Patient

Legal Rep: _____ _____
(Please Print) Signature of Legal Rep

Patient DOB: _____

Date: _____

----------OFFICE USE ONLY----------

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

_____

Date Initials Reason

_____