Renal Associates, LLC

Ferdinand Alcaide, MD, FACP, FASN
Raj Alappan, MD, FACP, FCCP, FASN
Rajeev Chauhan, MD

Tamorie Smith, MD
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6228 Bradley Park Dr., Suite A
Columbus, GA 31904
(706) 322-1486

1216 Stark Ave.
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1300 LaFayette Pkwy, Bldg. D
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(706) 882-2800

5995 Spring St.
Warm Springs, GA 31830
(706) 882-2800

102 East Burkhalter Ave., Suite A
Buena Vista, GA 31803
(706) 320-0801

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 DO NOT ACCEPT CREDIT/DEBIT CARDS, PAYMENTS MUST BE PAID BY CASH OR CHECK.

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
6228 BRADLEY PARK DR. SUITE A
COLUMBUS, GA. 31904
706-322-1486

RENAL ASSOCIATES, LLC
MEDICATION LIST

PATIENT NAME:______________________________ ***ALLERGIC TO*:**______________________

PATIENT DOB:______________________________ PHARMACY:______________________

PCP:______________________________

MEDICATION	STRENGTH	DOSAGE	PRESCRIBED BY (DR)	COMMENTS
Aspirin	200mg	1 daily	Alappan	**EXAMPLE**

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PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ EMAIL ADDRESS: _____

HOME PHONE: _____ CELL: _____ WORK: _____

SOCIAL SECURITY NUMBER: ____-____-____ RACE: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

EMERGENCY CONTACT **NOT** LIVING WITH YOU: _____

ADDRESS: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____ MEMBER ID: _____

INSURED'S NAME: _____ INSURED'S DOB: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____ MEMBER 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 a 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 DEDUCTIBLES, COPAYS AND COINSURANCES.

In order to control costs of billing, 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 costs of collection.

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 my insurance carrier, to include Health Care Financing Administration and any Medigap insurer and it's agents, any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE: _____

To be completed by patient

Triple i/CliniForms

INTERNAL MEDICINE HISTORY & PHYSICAL

NAME _____ SS# _____ DATE _____

ADDRESS _____ OCCUPATION _____

PHONE (HOME) _____ (WORK) _____ DATE OF BIRTH _____ AGE _____

CHIEF COMPLAINT _____

DRUG ALLERGIES

_____

_____

_____

_____

_____

[redacted]

_____

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy /Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: PREGNANT? ❑ YES ❑ NO PLANNING PREGNANCY? ❑ YES ❑ NO

MEDICAL HISTORY

❑ HEADACHE _____
❑ HYPERTENSION _____
❑ STROKE / TIAs _____
❑ EPILEPSY _____
❑ FATIGUE _____
❑ SHORTNESS OF BREATH _____
❑ HEART PALPITATIONS _____
❑ HEART MURMUR _____
❑ CHEST PAIN / ANGINA _____
❑ DIZZINESS / FAINTING _____
❑ PNEUMONIA _____
❑ CLAUDICATION _____
❑ MI _____

❑ CONGENITAL HEART DISEASE _____
❑ ORTHOPNEA _____
❑ HYPERLIPIDEMIA _____
❑ CONGESTIVE HEART FAILURE _____
❑ ARRHYTHMIA _____
❑ ALLERGIES / HAY FEVER _____
❑ ASTHMA _____
❑ COPD _____
❑ LIVER DISEASE _____
❑ ULCER _____
❑ GI DISORDER _____
❑ SEXUAL DYSFUNCTION _____
❑ MENSTRUAL DYSFUNCTION _____

❑ INCONTINENCE _____
❑ VENEREAL DISEASE _____
❑ ANEMIA _____
❑ GOUT _____
❑ SCARLET FEVER _____
❑ RHEUMATIC FEVER _____
❑ DIABETES _____
❑ ENDOCRINE DISEASE _____
❑ ARTHRITIS _____
❑ OSTEOPOROSIS _____
❑ ANXIETY _____
❑ OTHER _____
❑ OTHER _____

HABITS

❑ SMOKE: PACKS DAILY _____
HOW LONG _____
INTERESTED IN STOPPING? _____
❑ EXERCISE ROUTINE: _____
_____
❑ CONTACT WITH BLOOD/BODILY FLUID AT WORK: _
_____

❑ COFFEE: CUPS DAILY _____
OTHER CAFFEINE _____
❑ ALCOHOL: TYPE _____
AMOUNT _____
❑ DIET: SALT INTAKE _____
FAT INTAKE _____
OTHER _____

❑ SLEEP: DIFFICULTY FALLING ASLEEP _____
CONTINUITY DISTURBANCES _____
SNORING _____
EARLY MORNING AWAKENING _____
DAYTIME DROWSINESS _____
OTHER _____
_____

RENAL ASSOCIATES, LLC

PATIENT CONSENT
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

With my consent, Renal Associates, LLC may use and disclose protected health information (PHI) about me to carry out **treatment, payment and healthcare operations (TPO).** Please refer to Renal Associates, LLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Renal Associates, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Renal Associates, LLC's Privacy Officer at 6228 Bradley Park Drive, Suite A, Columbus, GA 31904.

With my consent, Renal Associates, LLC **may call my home** or other designated location and leave a message on a voice mail or in person on reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Renal Associates, LLC **may mail** to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Renal Associates, LLC **may e-mail** to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Renal Associates, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it is does, it is bound by this agreement.

With my consent, Renal Associates, LLC **may discuss** my PHI with:
_____(name)_____(relationship)
_____(name)_____(relationship)
_____(name)_____(relationship)

By signing this form , I am consenting to Renal Associates, LLC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Renal Associates, LLC can exercise the option to decline to provide medical services to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

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

_____

_____

_

PATIENT RESPONSIBILITIES

PLEASE BE SURE TO BRING ALL MEDICATIONS WHEN COMING TO EVERY APPOINTMENT. IT IS VERY IMPORTANT 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.

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**

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RENAL ASSOCIATES, LLC PARTICIPATES WITH THE MEDICAL STUDENT TEACHING PROGRAM AT MEDICAL COLLEGE OF GEORGIA, MERCER AND PCOM. THESE STUDENTS SEE THE PATIENTS ALONG WITH THE DOCTOR. IF YOU PREFER THAT THE MEDICAL STUDENT DOES NOT PARTICIPATE WITH THE DOCTOR IN YOUR CARE, PLEASE NOTIFY THE FRONT DESK UPON YOUR ARRIVAL.

THANK YOU FOR YOUR ATTENTION TO THIS MATTER.

RENAL ASSOCIATES, LLC