Renal Associates, LLC

Ferdinand Alcaide, MD, FACP, FASN
Raj Alappan, MD, FACP, FCCP, FASN
Rajeev Chauhan, MD
Tamorie Smith, MD
Vinayak Ramanath, MD
Carrie Whitehead, FNP-C

6228 Bradley Park Dr., Suite A Columbus, GA 31904 (706) 322-1486	1216 Stark Ave. Columbus, GA 31906 (706) 320-0801	1300 LaFayette Pkwy, Bldg. D LaGrange, GA 30241 (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 ACCEPT CREDIT/DEBIT CARDS, CASH AND CHECKS.

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

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

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

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: _____

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Would you like to receive a text message to remind you of your appointment/balance?

If so, please complete form below.

Name: _____

DOB: _____

Cell Number: _____

Cell Phone Carrier: (circle one) Verizon TMobile AT&T Sprint Other: _____

Once you complete the form you will start receiving texts as appointment reminders 2 days prior to your appointment. You will also receive an email that you have a balance after your insurance pays. (More than likely your copay)

Thanks for signing up!

Sincerely,

Renal Associates, LLC

Initial Clinical History and Physical Form

Date: _____

Patient Information

Name: _____ Age: _____ Date of Birth: _____/_____/_____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Multi-Racial ☐ Other _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed # Children _____

Previous Family Physician: _____ Referring Physician: _____

Reason for Visit: _____

Past Medical History

(Please check all conditions that you have or have had.)

☐ None	☐ Anxiety	☐ High Cholesterol	☐ Allergy: Food
☐ Heart Disease	☐ Bleeding Difficulties	☐ Seizure	☐ Allergy: Seasonal
☐ High Blood Pressure	☐ Hepatitis A B or C	☐ Loss of Consciousness	☐ TB
☐ Stroke/TIA	☐ HIV	☐ Arthritis (Type) _____	☐ Hypothyroid
☐ Obstructive Sleep Apnea	☐ Diabetes-Diet Controlled	☐ Asthma	☐ Hyperthyroid
☐ Coronary Artery Disease	☐ Diabetes-Oral Meds	☐ Emphysema	
☐ Depression	☐ Diabetes-On Insulin	☐ Osteoporosis	

☐ Cancer: Type/Treatment: _____

☐ Other (Specify): _____

Past Surgical History

(Type of Surgery & Year)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

For Females:

Are you pregnant? ____ Are you breast feeding? ____ # of Pregnancies/Deliveries: ____ Type of Birth Control: _____

Date of first menstrual period: _____ Date of last menstrual period: _____

Last Mammogram: _____ Last Pap: _____ Last Bone Density Scan: _____

For Males:

Do you experience impotency? _____ Erectile Problems: _____

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Tetanus Date: _____

Other:

Screenings: _____ Colonoscopy Date: _____

Patient Name: _____

Drug Allergies /Type of Reaction

☐ No known drug allergies
☐ Latex
☐ Tape

1. _____
2. _____
3. _____
4. _____

Social History

(Please check the appropriate listings)

Tobacco Use
☐ Never
☐ Quit/When? _____
☐ Cigarettes/Pack per Day? ____
☐ Pipe
☐ Cigars
☐ Chewing Tobacco

How many years? _____

Alcohol Use
☐ None
☐ Socially
☐ Daily
☐ Heavy

Have you ever been treated for alcoholism?
☐ Yes ☐ No
If yes, when? _____

Drug Use
☐ None
☐ Marijuana
☐ Amphetamines
☐ Other _____

Have you ever been treated for drug use?
☐ Yes ☐ No
If yes, when? _____

Exercise
☐ None
☐ 1-2x/week
☐ 3-4x/week
☐ 5-7x/week

Type: _____
_____
_____

Caffeine Use
☐ None
☐ Occasional
☐ Daily

How much? _____
_____
_____

Any religious beliefs that would affect your medical care? _____

Education

(Please check highest level)

☐ **Grade School** ☐ **High School** ☐ **College** ☐ **Post Graduate**

Occupational History

Employer: _____ Job Title: _____

Have you altered your job as a result of the problem you brought here today? ☐ Yes ☐ No

If yes, please explain: _____

If you're currently off work as a result of the problem, how long have you been off? _____

Family History

Father	☐ Living ☐ Deceased	Age: _____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type _____ ☐ Other _____
Mother	☐ Living ☐ Deceased	Age: _____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type _____ ☐ Other _____
Brothers	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type _____ ☐ Other _____
Sisters	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type _____ ☐ Other _____

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**

Renal Associates, LLC
Financial Policy

We would like to thank you for choosing Renal Associates, LLC as your nephrologist. As one of our patients, we would like to keep you informed of our current office and financial policies. We require an initial and signature to document that you have read and understand these policies.

Payment
Payment is expected at the time of service. This is an insurance company rule. This includes co-payments or coinsurance for participating insurance companies. Renal Associates, LLC accepts cash, personal checks, Visa, MasterCard, American Express, and Discover. There is a service charge of $35.00 for returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or contractual agreement.
_____ Initials

Insurance
It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit.
_____Initials

Office Fees/Charges
Due to the increasing amount of requests for specific paperwork to be filled out, we charge a fee for all paperwork that has to be completed by our physicians and nurses. The fees will be as follows: Letters will be charged $10.00. FMLA paperwork will be charged $25.00. CD will be charged $5.00. If you want a copy, Medical Records are charged per page.
_____ Initials

Prescriptions/Paperwork
Please request prescription refills during office hours and allow 3 business days for your request to be filled. Leave your name, date of birth, and medication needing refilled in your message. Plan ahead to assure you have an adequate supply of medication. Please allow 7 business days to fill out any requested paperwork. Please note that these are business days and more days may be required if the physician is out of the office.
_____ Initials

More Information
Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call can prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.
_____ Initials

_____ _____
Print Name Signature

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

Patient Responsibilities

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

- You are responsible for making sure your labs are done 1-2 weeks before your appointment. If you do not complete your labs, your appointment will need to be rescheduled. If you request to have your lab work done anywhere other than *LabCorp* or *Quest* YOU will be responsible for bringing in the results to your appointment. We cannot guarantee that another office will fax them to us by the time you arrive.

- Please notify your pharmacy of any prescription refills before your medication runs out. The pharmacy can request a refill on your behalf through e-prescribe. Make sure that the medication you're requesting to be refilled was prescribed by us and not another doctor. We do require 24-48 hours for medication refills to be processed.

- Please note that when you call and leave a message for the office your phone call will be returned within 24-48 hours. Please do not call and leave multiple messages as it ties up the time it takes to check voicemails. If you have an emergency, please call 911 or go to the emergency room.

- Please arrive for your scheduled appointment on time. If you are running late, please notify the office. If you are running more than 15 minutes late your appointment most likely will need to be rescheduled. We do not accept walk-ins.

Thank you for your understanding.

Renal Associates, LLC

_____

Patient's Signature

_____

Date