Patient's Name:_____ Date: ___/___/___

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PATIENT INFORMATION SHEET

Name: _____DOB: _____ / _____ / _____

Sex: ☐ M ☐ F Race: ☐ African American ☐ Caucasian ☐ Hispanic Other_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Language: ☐ English ☐ Other_____

Address:_____

City: _____ State_____ Zip Code _____ SS # _____ - _____ - _____

Telephone No. (h) _____ (w) _____ (c) _____Marital Status: ☐ M ☐ S ☐ D ☐ W

Alternate/Emerg. Contact: _____ Relation: _____ Telephone No: _____

Patient's Employer: _____ Telephone No. _____

Spouse's Name: _____ Primary Physician: _____ Referring Physician: _____

Your email address _____ Preferred method of notification: ☐ Mail ☐ Phone

Do you have access to the internet? ☐ Yes ☐ No If Yes, have you visited our website at www.delawarekidney.com?

Primary Insurance Company:	
ID#	Group #
Subscriber's Name:	Relationship to Patient
Subscriber's Employer:	Subscriber's DOB:
Subscriber's SS #	
Secondary Insurance Company:	
ID#	Group #
Subscriber:	Relationship to Patient
Subscriber's Employer:	Subscriber's DOB:
Subscriber's SS #:	
Person Responsible For Payment, If Other Than Patient:	
Name:	Telephone #
Address:	Relationship to Patient:
Social Security #:	Employer:

Patient's Name:_____ Date: ___/___/___

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Patient Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. The following is a statement of our payment policy. This payment policy applies to all services provided by Nephrology Associates, regardless of the location.

Insurance Coverage - We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility, and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Referrals - If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician. A referral should be requested from your primary care physician's office at least 48-72 hours prior to your appointment.

Copays - We have a contractual obligation (with your insurance company) to collect your copay. We will collect it at the time of service. Our office does not bill copays. Copays are the patient's responsibility and are due at the time of service. We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service.
We cannot waive copays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

For our patients with no Medical Insurance Benefits

If you do not have group or individual medical insurance, payment for all services is expected at the time of your visit. If you pay the charges in full on the day of service, we will offer a 5% prompt pay discount. Partial payments or payments made after the date of service are not subject to the prompt pay discount. Please let us know if you are having difficulty paying your account. Nephrology Associates may be able to help by setting up a payment plan based on your financial needs. Our billing office is available Monday – Friday from 8:00 a.m. to 4:30 p.m. to assist you in satisfying your financial obligation. Please contact our billing department directly at **(302) 225-0462** to discuss payment plans, patient financial evaluations and discounts available.

Accepted Forms of Payment - We accept payment by cash, check, Visa and Mastercard.

Unpaid Accounts - In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

Other Possible Fees -

Missed Appointment Fee - A missed appointment is a scheduled appointment that you miss without notifying us in advance. A $20 fee will be billed for patients who do not show for a scheduled appointment. Our practice requests that you provide us with at least a 24-hour notice to cancel your appointment to avoid this charge. Insurance companies do not cover this charge. **Disclaimer:** The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

Returned Check Fee - It is the policy of Nephrology Associates to charge $20.00 to patients whose checks are returned by our bank for non-sufficient funds.

I have read and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

_____ _____
Signature of Patient or Responsible Party if a Minor Date

_____
Please Print the Name of the Patient

MEDICARE EXTENDED AUTHORIZATION – "SIGNATURE ON FILE": I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to Nephrology Associates, P.A. for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for related services.

Signed _____ Date _____

COMMERCIAL INSURANCE ASSIGNMENT OF BENEFITS: I request that payment of authorized Commercial Insurance benefits, both primary and secondary, be made on my behalf to Nephrology Associates, P.A., for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the above-mentioned insurance carrier, any information needed to determine these benefits payable or benefits payable for related services.

Signed _____ Date _____

Patient's Name:_____ Date: ___/___/___

NEPHROLOGY ASSOCIATES

Providers

Feroz Abubacker, M.D
Piyaporn Apivatanagul, M.D.
Manmeet Brar, M.D.
Peter Burke, D.O.
Helen Chang-DeGuzman, M.D.
Farhana Chowdhury, M.D.
Jeffrey S. Cicone, M.D.
Daniel N. Coar, M.D.
William J. Dahms, Jr. D.O.
Nealanjon Das, D.O.
Svastijaya Daviratanasilpa, M.D.
Manthodi K. Faisal, M.D.
Gertrude Findley-Christian, M.D.
Martin F. Gavin, D.O.
Stephanie Gilibert, M.D.
Sumanth R. Kacharam, M.D.
Carlos A. Machado, M.D.
Arun Malhotra, M.D.
Collette J. Mehring, D.O.
G. Jeffrey Milan, M.D.
Wilson Nino, M.D.
Rabail Qureshi, M.D.
Theodore F. Saad, M.D.
Sangeetha Satyan, M.D.
Shalini Sehgal, M.D.
Lindsey M. Slater, M.D.
Prayus T. Tailor, M.D.
Miroslaw P. Zdunek, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____TODAY'S DATE: _____

Address:

_____

City:_____State:_____Zip:_____

Birth Date: _____/_____/_____ SS # _____-_____-_____ Phone # _____

I hereby authorize Nephrology Associates, PA to RELEASE / OBTAIN medical records TO / FROM:

Name of Physician, Hospital, Relative:

_____

Address: _____

Phone # _____Fax: _____

INFORMATION TO BE RELEASED:

❒ All Medical Records

❒ Other (Please specify) _____

PURPOSE:

❒ Medical Care ❒ Insurance ❒ Other _____

I specifically authorize the release of information relating to:

❒ Substance abuse (including alcohol/drug abuse)
❒ Mental health (including psychotherapy notes)
❒ HIV related information (including AIDS related testing)

X_____

SIGNATURE OF PATIENT OF LEGAL GUARDIAN / DATE

I understand that my medical records may not be disclosed without my written permission; that this authorization will automatically expire one year (1 year) from the date signed; that I may revoke this consent at any time by notifying Nephrology Associates, PA.; that my private health insurance, once disclosed to others, may be disclosed to individuals or organizations not subject to HIPAA; that I may see and copy the information described on this form. I understand that, except in certain limited circumstances, NAPA may not condition my treatment on whether I sign an authorization form.

X _____ **OR** _____

SIGNATURE OF PATIENT **DATE** **LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

PLEASE SEND / FAX RECORDS TO THE FOLLOWING OFFICE LOCATION:

❒ 4923 Ogletown-Stanton Rd., Suite 200, Newark DE 19713 · (302)225-0451 · Fax (302) 225-0472
❒ St. Francis MSB, 701 N. Clayton St., Suite 401, Wilmington, DE 19805 · (302) 421-9411 · Fax (302) 421-9460
❒ 1198 Governor's Avenue, Building B, Suite 100, Dover, DE 19904 · (302) 734-3227 · Fax (302) 734-0391
❒ 201 West Liberty Way, Independence Commons, Milford, DE 19963 · (302) 424-3694 · Fax (302) 424-3697
❒ 34434 King Street Row, Suite 4, Lewes, DE 19958 · (302) 360-0142 · Fax (302) 360-0145
❒137 W. High Street, Suite 1A, Elkton, MD 21921 · (410) 620-9200 · Fax (410) 620-9207

Patient's Name:_____ Date: ___/___/___

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MEDICAL HISTORY FORM

NAME: _____**Date of Birth:** _____

Family Doctor: _____ Other Specialists: _____

CURRENT KIDNEY PROBLEM			
Why are you being referred? _____			
How long have you had this condition? _____			
Is there a family history of this condition? _____			
CURRENT KIDNEY PROBLEM			
OTHER MEDICAL PROBLEMS: Have you ever been treated for the following problems?			
YES	NO		Year Diagnosed
		Anemia	
		Asthma / COPD / Emphysema	
		Diabetes	
		Gout	
		Heart Disease – Congestive Heart Failure	
		Heart Disease – Heart Attack	
		High Cholesterol	
		High Blood Pressure	
		Arthritis – Rheumatoid / Osteoarthritis	
		Lupus	
		Peripheral Vascular Disease	
		Renal Failure (Acute / Chronic)	
		Polycystic Kidney Disease (PKD)	
		Kidney Stones	
		Thyroid Disease	
		Seizure Disorder	
		Stroke (TIA)	
		Prostate Disease	
		Hepatitis	
		HIV	
		Cancer	
		Other (Hospitalizations / Injuries)	

Patient's Name:_____ Date: ___/___/___

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Have you ever taken (circle): Lithium Fleets Phosphosoda Gentamycin Tobramycin Cisplatinum

Have you had previous exposure to ***gadolinium*** (a contrast agent) during an MRI? Yes___ No___

Allergies: Do you have any allergies to medications? Yes _____ No _____ *(if yes, please list below)*

If yes	Name of Drug	Type of Reaction

Do you have any other allergies?

FAMILY HISTORY: (Example – diabetes, hypertension, heart disease, kidney disease, etc.)

	Alive (Y –or- N)	Age –or- Age at Death	Medical Problem
Mother			
Father			
Siblings			
Children			

SOCIAL HISTORY:

Occupation:

Marital Status: Married _____ Single _____ Divorced _____ Widow _____

Industrial Exposures (i.e. dust, fumes, solvents, chemicals, etc):

Cigarettes:

Do you smoke cigarettes, cigars or a pipe? Yes _____ / No_____

How many did you or do you smoke per day (packs)? _____

For how many years? _____ When did you quit? _____

Alcohol:

Do you drink alcohol? Yes _____ No _____ # of drinks per day? _____ **For how many years?** _____

Drugs:

Do you use illegal / street drugs? Yes _____ No _____ What?_____**For how many years?** _____

Patient's Name:_____ Date: ___/___/___

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SURGICAL HISTORY					
	Year	Surgeon		Year	Surgeon
Hysterectomy/Ovary Removal			Cancer Surgery		
Hernia Repair			Joint Surgery		
Tonsillectomy			Back Surgery		
Appendectomy			Gall Bladder		
Heart – Coronary Bypass			Kidney		
Heart / Valve			Bladder		
Heart - AICD / Pacemaker			Transplant		
Heart – Angioplasty or Stent			Vascular		
OTHER Surgery:					

Other Medical History (including Immunizations)					
	Date	Provider		Date	Provider
Colonoscopy			Pneumonia Vaccine		
Flu Vaccine			Hepatitis Vaccine		

Patient's Name:_____ NEPHROLOGY ASSOCIATES delawarekidney.com Date: ___/___/___

MEDICATION LIST - Include all medications including inhalers used for respiratory problems

Name and Address of Local Pharmacy_____

Name of Mail Order Pharmacy _____

Name of Medication	Dose (mgs.)	How many times per day

Do you take any Over-The-Counter medications for pain or other problems?

Advil, Tylenol, Motrin, Prilosec, Prevacid, Zyrtec, Allegra, Claritin, etc.)

Do you take any herbal supplements or vitamins? (Please List)

Do you have any other medical history you feel would be helpful in your care?

Patient's Name:_____ Date: ___/___/___

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GENERAL MEDICAL HISTORY REVIEW

Do you have chronic difficulty with:

		Y	N			Y	N			Y	N
GENERAL	Appetite loss			CARDIOVASCULAR	Chest pain				Painful urination		
	Chills				Leg pain/swelling				Urinating at night		
	Fatigue				Palpitations			MUSCULO-SKELETAL	Joint pain		
	Fever				Shortness of breath				Muscle aches		
	Weight gain			GASTROINTESTINAL	Constipation			NEUROLOGICAL	Loss of consciousness		
	Weight loss				Diarrhea				Numbness		
SKIN	Itchy skin				Heartburn				Seizures		
	Skin rash				Jaundice				Weakness in extremities		
HEENT	Blurred vision				Liver disease			PSYCHIATRIC	Anxiety		
	Dental/Mouth problems				Nausea				Confusion		
	Double vision				Painful swallowing				Depression		
	Headache				Rectal bleeding				Mood changes		
	Hearing loss				Vomiting			ENDOCRINE	Cold flashes		
	Nose Bleeds/Sinusitis				Vomiting blood				Excessive sweating		
	Ringing in the ears			GENITOURINARY	Blood in urine				Hot flashes		
RESPIRATORY	Chronic cough				Cloudy urine			HEMATOLOGY	Easy bruising		
	Coughing up blood				Excessively foamy urine				Excessive bleeding		
	Difficulty breathing				Foul smelling urine						
	Wheezing				Frequent urination						

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____