Sierra Nevada NEPHROLOGY

Medical History

Patient Name:_____ DOB: _____

Primary Care Doctor: _____ Referring Doctor: _____

*If more room needed continue on back or attach list.

Prescriptions	Dosage	Times per day

Drug Allergies	Yes	No	Name:

Over the counter meds	Dosage	Times per day

Patient medical history	Yes	No	How long		Yes	No	How long
Kidney disease				Cancer			
High blood pressure				Seizures			
Diabetes				Stroke			
Heart attack				Lung Problems			
Heart disease/failure				Bladder/Prostate problems			
Kidney stones				Gallstones			
Stomach/bowel problems				Arthritis/Back problems			

Previous surgeries	Hospitalizations (last 3yrs)

Family medical history	Yes	No	Family Member		Yes	No	Family Member
Kidney disease				Cancer			
High blood pressure				Seizures			
Diabetes				Stroke			
Heart attack				Lung problems			
Heart disease/failure				Bladder/prostate problems			
Kidney stones				Gallstones			
Stomach/bowel problems				Arthritis/back problems			

Other information	Yes	No	How often	Yrs.		Yes	No
Do you smoke?					Former smoker?		
Do you use Alcohol?					Do you have any special diet?		

Have you had any of the following during the last six (6) months?					
GENERAL HEALTH	Yes	No	MUSCULOSKELETAL	Yes	No
Good general health			Joint pain or stiffness		
Weight gain			Joint swelling		
Weight loss			Muscle weakness		
Fever or chills			Muscle pain or cramps		
Fatigue			Back pain		
EYES	Yes	No	SKIN	Yes	No
Blurry vision			Rash		
Eye irritation			Itching		
Eye discharge			Un-healing wounds		
Vision loss			Changes to skin color		
Eye pain			Skin dryness		
EARS,NOSE,THROAT	Yes	No	NEUROLOGICAL	Yes	No
Earache or drainage			Headaches		
Ringing in the ears			Light headed or dizzy		
Decreased hearing			Paralysis		
Nasal/sinus congestion			Convulsions or seizures		
Sore throat			Sensation changes		
CARDIOVASCULAR	Yes	No	PSYCHIATRIC	Yes	No
Chest pains			Memory loss		
Palpitations			Anxiety		
Difficult breathing			Depression		
Fainting			Suicidal ideations		
Swelling of feet			Hallucinations		
RESPIRATORY	Yes	No	ENDOCRINE	Yes	No
Frequent coughing			Cold intolerance		
Spitting up blood			Heat intolerance		
Shortness of breath			Excessive thirst		
Asthma or wheezing			Excessive hunger		
Pain with breathing			Excessive urination		
GASTROINTESTINAL	Yes	No	HEMATOLOGICAL/LYMPHATIC	Yes	No
Nausea			Slow to heal after cuts		
Vomiting			Enlarged glands		
Frequent diarrhea			Easily to bruise or bleed		
Constipation			Anemia		
Abdominal pain			Blood transfusions		
GENITOURINARY	Yes	No	ALLERGIC/IMMUNOLOGIC	Yes	No
Frequent urination			Skin itching		
Burning or painful urination			Skin rashes		
Blood in urine			Hay fever symptoms		
Getting up @ night to urinate			Chronic infections		
Incontinence or dribbling			Reactions to medications		
			KNOWN FOOD ALLERGIES?	Yes	No
List foods:					

Patient signature:_____

Patient Information

Last Name: _____ First Name: _____ Initial: _____

Previous Name:_____ Preferred First name:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph:( ) _____ Cell Ph:( )_____ Work Ph:( )_____

Email: _____ Marital Status: □ single □ married □ widowed □ divorced □ legally separated

Ethnicity: ☐ African American ☐ American Indian ☐ Hispanic/Latino ☐ White ☐ Other

Date of Birth: _____ Sex: □ F □ M Social Security #: _____-_____-_____

Emergency Contact: _____ Relationship: _____ Ph:( )_____

Insurance Information

Primary Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____SS#: _____

Employer Name: _____ Employer Phone: (_____) _____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____SS#: _____

Employer Name: _____ Employer Phone: (_____) _____

Referring Doctor: _____
Primary Care Doctor: _____
Pharmacy: _____

I hereby authorize the release of any medical information necessary to process my claim, and authorize payment of medical benefits to the undersigned physician or supplier for the services rendered.

Date: _____ Signature of Patient/Guardian:_____

Sierra Nevada
NEPHROLOGY

Patient Responsibilities

We at Sierra Nevada Nephrology Consultants would like to thank you for the opportunity to provide care to you and your family. At SNNC we view healthcare as a collaborative approach between you the patient and our healthcare providers. Please initial each of the following to indicate you have read and fully understand the following responsibilities:

_____ After your first few appointments with a physician and once your treatment plan has been established, you may be scheduled with one of our nurse practitioners in order to provide you with high-quality care, personalized health counseling, education and accessibility. This physician/nurse practitioner collaboration will continue for as long as you are an SNNC patient.

_____ For all appointments, please bring a current insurance card, a photo ID and all current medications.

_____ For prescriptions refills, please call your pharmacy. They will contact us via fax or by phone with the necessary information. Please allow 24-48 hours for all refills. Refills will not be called in after normal operating hours or on weekends. You will need to allow longer if a prescription requires a prior authorization.

_____ If you should need to cancel your appointment, please provide our office with at least a 24 hour notice. Multiple no-shows can lead to dismissal from this practice.

_____ All co-pays, deductibles, and payments for non-covered services are due at check-in. If the co-payment cannot be paid, the office has the right to reschedule your appointment. We accept cash, check, and credit cards. We do not accept debit cards.

_____ If you would like to have your labs reviewed you will need to call and make an appointment with a nurse practitioner or wait until your next scheduled appointment. Routine labs will not be reviewed over the phone.

_____ If you require a surgical clearance letter, please allow at least 72 hours from request to pick-up. Depending on the date of your last appointment and lab work, and the nature of the surgery, we might require that you be seen in our office to evaluate your surgical risk.

Sierra Nevada
NEPHROLOGY

Financial Policy

- We are providers for many local and national health plans. We will work with your insurance carrier to file and collect payment for claims; however, you are responsible for all co-payments and deductibles. These are due at the time services are provided. You need to keep the billing department updated with all your current insurance information.

- Managed health care plans require pre-authorization for many procedures and treatments. We will contact your primary care physician and insurance carrier to obtain authorizations. Ultimately, it is the responsibility of the patient to insure all authorizations are in place before the service is provided.

- Uninsured patients are required to pay at the time services are provided. There are several payment options available. Please contact our billing department to discuss your account.

- If we do not receive payment from you or your insurance carrier within 30 to 90 days, your account will be considered delinquent. No patient may carry a balance over 90 days without payment arrangements with the billing department.

- We understand that each patient has unique circumstances that can affect their ability to pay. Each account will be considered individually, and we may request poof of income before your account is given financial hardship status.

- Accounts are turned over to our collection agency only as a matter of last resort. In our experience these accounts are the result of patients not communicating with the billing department. We are willing to assist you to ensure your account remains in good standing.

- Any patient whose account has been turned over to collections will received 30 days emergency care only and must transfer their care to another Nephrologist not associated with our group.

I have read and understand the above policy.

_____ _____

Signature Date

Sierra Nevada
NEPHROLOGY

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act) of 1966 law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

This information may be released to: I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

☐ Spouse name_____

☐ Child(ren) name_____

☐ Other/name_____

☐ Information is NOT TO BE RELEASED TO ANYONE.

May we phone, email, or send a text message to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

This consent was signed by: _____
(PRINT NAME PLEASE)

SIGNATURE:_____ Date: _____

WITNESS:_____ Date: _____

Sierra Nevada
NEPHROLOGY

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. ***Please review carefully:***

Sierra Nevada Nephrology Consultants (SNNC) is required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This is to inform you of the uses and disclosures of confidential information that may be made by SNNC, and of your individual rights and SNNC legal duties with respect to confidential information.

Ways in which SNNC may use and disclose your protected Health information:

SNNC may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing medical health care and related services.
- **Payment** means activities such as obtaining payment for the medical health care services we provided to you from your insurance or another third party payer.
- **Health care operations** includes the business aspects of running a practice.

SNNC may contact you to provide appointment reminders or other services that may be of interest to you. SNNC will disclose your protected health information to any person you identify that is involved in payment for your care.

SNNC will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which a Medical professional is required by ethical standards to reveal information obtained during care to persons or agencies, even if you do not give permission. These situations are as follows; (a) If you threaten grave bodily harm or death to yourself or another person, SNNC is required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to SNNC our knowledge of physical or sexual abuse of a minor child and of an elder (over 65) or any sexual conduct/contact with a minor, SNNC is required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) SNNC is required by a court of law (court order) to turn over records to the court or if SNNC is ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. **A separate form will be needed for each request for release of information.** The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing and SNNC is required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Consent to Access Medical Records for Clinical Research Screening

Sierra Nevada Nephrology Consultants participates in clinical research trials. As part of this effort, we screen patient records to identify if they are eligible for participation.

I understand that by checking the "YES" box, I am giving my permission for SNNC to access my medical records for the purpose of identifying whether or not I am eligible to participate in a clinical trial. By checking the "NO" box, I am stating that I am not willing to participate in clinical research and do not want my information to be used for identifying whether or not I am eligible to participate in a clinical trial.

☐ **YES -** I do give my permission to SNNC to screen my medical records for the purpose of identifying if I am eligible for participation in clinical research.

☐ **NO -** I do not give my permission to SNNC to screen my medical records for the purpose of identifying if I am eligible for participation in clinical research.

_____ _____

Printed name Signature

_____ _____

Date Signature of parent/guardian

**We reserve the right to make changes to this notice at any time. In the event that there is a material change to this notice, the revised notice will be posted.

**If you have any complaints concerning our privacy practices you may contact our Privacy Officer, by mail at the above address or phone.