Atlanta Kidney Specialists

Policy/Statement of Patient Financial Responsibilities

Patient Name: _____ **Date of Birth**: _____

Atlanta Kidney Specialists appreciates the confidence you have shown us in choosing us to provide for your kidney healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. If you are unable to pay at the time of service, we will be glad to reschedule your appointment.

Many insurance companies have additional stipulations that may affect your coverage. We ask that you make sure you are familiar with your healthcare coverage and its limits as you are responsible for any amounts not covered by your insurer.

We provide a variety of payment options by accepting American Express, VISA, MasterCard, Discover, Cash or personal checks.

Please note that should it ever become necessary to use the services of an outside collection agency to collect your account balance, you will be responsible for any cost incurred for that purpose.

By signing below you are authorizing your insurance benefits to be paid directly to Atlanta Kidney Specialists and allowing us to release medical information to your insurance company when requested to facilitate payment of a claim.

Lastly, we understand there may be times when you miss an appointment due to emergencies or obligations to work or family. Please be aware that should you “no show” for two consecutive appointments or cancel for a total of four appointments, you may be discharged from our practice. Should this occur, you will be notified in writing.

You have read, understand, and agree to the above Financial Policy.

_____	_____	_____
Patient/Guarantor Signature	**Printed Name**	**Date**

Atlanta Kidney Specialists

Authorization for Disclosure/Release of Health Information
(Insurance Companies and Referring Physicians)

I, _____, Date of Birth _____ authorize Atlanta Kidney Specialists to release my Protected Health Information to insurance companies and referring physicians.

I request that the information to be released to consist of the following information.

_X_ - Complete Medical Record

It is my understanding that the information to be released will be used for the following purposes:

- At the request of the individual
- Legal investigation or action
- Insurance eligibility and benefits
- Additional medical care

I understand that if the authorized recipient is not a provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed by the recipient without obtaining any further authorization.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon, and this authorization will otherwise remain in effect.

_____	_____	_____
Patient/Guarantor Signature	**Printed Name**	**Date**

Atlanta Kidney Specialists

Notice of Privacy Practices

Dear Patient,

Physicians have always protected the confidentiality of health information by locking medical records away in filing cabinets and refusing to reveal your health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers, and health plans. Effective April 14, 2003, your physician has to comply with the privacy rule standards for protecting the confidentiality of your health information.

The new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital, and the health plan will need to consider the privacy rule. All health information including paper records, oral communication, and electronic formats (such as email) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. In addition we will be taking even more precautions in our office to safeguard your health information such as training our employees and employing computer security measures.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Practices Administrator at 470-419-4000.

Privacy Practices Acknowledgment

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

My signature below indicates that I agree to allow Atlanta Kidney Specialists to use and disclose personal health information to carry out treatment and health care options.

Name _____ **Date of Birth** _____

Signature _____ **Date** _____

Your signature is **required** by HIPAA (Health Insurance Portability and Accountability Act) in order to release information to your insurance company and referring physicians.

Atlanta Kidney Specialists

New Patient Information

PERSONAL INFORMATION						
Name	Last:		First:		Middle: (Initial)	
Address						
City		State		Zip		
Home Phone	( )		Cell Phone	( )		
Date of Birth	/ /	SSN	_____ - _____ - _____	Sex	□ M □ F	
Email Address						

Race	Ethnicity
□ American Indian or Alaska Native □ Asian □ Native Hawaiian or Other Pacific Islander □ African American □ Caucasian □ Hispanic □ Other Race: _____	□ Hispanic or Latino □ Not Hispanic or Latino **Primary Language** □ English □ Spanish □ Other:_____

EMERGENCY CONTACT			
Name		Relation to Patient	
Phone	( )		

PHARMACY INFORMATION			
Pharmacy Name		Pharmacy Phone	( )
Pharmacy Address			

MEDICAL INFORMATION			
Primary Care Physician		Office Phone	( )
Office Address			

Atlanta Kidney Specialists

Medical History

CURRENT MEDICATIONS Please list all prescriptions, over-the-counter, herbs, etc.		
Name of Medicine	Dosage	Frequency

MEDICAL CONDITION INFORMATION Please list all past medical conditions.	ALLERGIES Are you allergic to any medications, x-ray dyes, or other substances? Please list them all.
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

PAST SURGICAL / PROCEDURE	
Date (MM/YYYY)	Name of Surgery / Procedure

Atlanta Kidney Specialists

Medical History - Continued

HOSPITALIZATION	
Date (MM/YYYY)	Reason

FAMILY INFORMATION		
Relation	Status	List of Medical Problems
Mother	□ Alive □ Deceased □ Unknown	
Father	□ Alive □ Deceased □ Unknown	
□ Brother □ Sister	□ Alive □ Deceased □ Unknown	
□ Brother □ Sister	□ Alive □ Deceased □ Unknown	
□ Brother □ Sister	□ Alive □ Deceased □ Unknown	
□ Brother □ Sister	□ Alive □ Deceased □ Unknown	

SOCIAL INFORMATION	
Do you use any **tobacco**?	□ YES □ NO
If **YES**, how many packs per day? _____ packs /day. For how long? _____.	
Do you use any **drugs**?	□ YES □ NO
If **YES**, which drug do you use? _____. For how long? _____.	
Do you smoke **marijuana**?	□ YES □ NO
If **YES**, how often do you smoke? _____. For how long? _____.	
Do you drink **alcohol**?	□ YES □ NO
If **YES**, how many drinks per day? _____ /day. For how long? _____.	

Atlanta Kidney Specialists

Medical History – Review of Systems

IMMUNIZATION HISTORY			
Hepatitis B Vaccine	□ YES □ NO When? _____	Flu	□ YES □ NO When? _____
Pneumovax Immunization	□ YES □ NO When? _____	Mammogram	□ YES □ NO When? _____
Other			
GENERAL / CONSTITUTION			
Change in appetite	□ YES □ NO	Fever	□ YES □ NO
Fatigue	□ YES □ NO	Headache	□ YES □ NO
Weight gain	□ YES □ NO	If yes, how much?	Gained _____ lbs
Weight loss	□ YES □ NO	If yes, how much?	Lost _____ lbs
History of blood transfusion	□ YES □ NO	If yes, when?	_____
ALLERGY / IMMUNOLOGY			
Sinus Congestion	□ YES □ NO	Rash	□ YES □ NO
Hives	□ YES □ NO	Runny nose	□ YES □ NO
OPHTHALMOLOGIC			
Blurry vision	□ YES □ NO	Double vision	□ YES □ NO
Diminished visual acuity	□ YES □ NO	Itching and redness	□ YES □ NO
ENT			
Decreased hearing	□ YES □ NO	Ringing in the ears	□ YES □ NO
Decreased sense of smell	□ YES □ NO	Sinus pain	□ YES □ NO
Nose bleed	□ YES □ NO	Sore throat	□ YES □ NO
ENDOCRINE			
Cold intolerance	□ YES □ NO	Heat intolerance	□ YES □ NO
Diabetes	□ YES □ NO	Thyroid problem	□ YES □ NO
Difficulty sleeping	□ YES □ NO	----------	----------

Atlanta Kidney Specialists

Medical History – Continued

RESPIRATORY					
Cough	□ YES	□ NO	Sputum production	□ YES	□ NO
Coughing up blood	□ YES	□ NO	Wheezing	□ YES	□ NO
Shortness of breath	□ YES	□ NO	----------	----------	
CARDIOVASCULAR					
Chest pain	□ YES	□ NO	Swelling in hands/feet	□ YES	□ NO
Palpitation	□ YES	□ NO	Weakness	□ YES	□ NO
GASTROINTESTINAL					
Abdominal Pain	□ YES	□ NO	Heartburn	□ YES	□ NO
Blood in stool	□ YES	□ NO	Hepatitis	□ YES	□ NO
Liver disease	□ YES	□ NO	Nausea	□ YES	□ NO
Constipation	□ YES	□ NO	Black stool	□ YES	□ NO
Diarrhea	□ YES	□ NO	Vomiting	□ YES	□ NO
Difficulty swallowing	□ YES	□ NO	----------	----------	
HEMATOLOGY					
Anemia	□ YES	□ NO	Easy bruising	□ YES	□ NO
Bleeding problem	□ YES	□ NO	Swollen gland	□ YES	□ NO
GENITOURINARY					
Blood in urine	□ YES	□ NO	Painful urination	□ YES	□ NO
Difficulty urinating	□ YES	□ NO	Excessive urination at night	□ YES	□ NO
Frequent urination	□ YES	□ NO	Kidney stone	□ YES	□ NO
Recurrent UTI	□ YES	□ NO	Urinary incontinence	□ YES	□ NO
MUSCULOSKELETAL					
Arthritis	□ YES	□ NO	Joint stiffness	□ YES	□ NO
History of gout	□ YES	□ NO	Painful joints	□ YES	□ NO
DERMATOLOGY					
Dry skin	□ YES	□ NO	Itching	□ YES	□ NO
NEUROLOGIC					
Gait abnormality	□ YES	□ NO	Seizures	□ YES	□ NO
Headache	□ YES	□ NO	Tingling/Numbness	□ YES	□ NO
Memory loss	□ YES	□ NO	Dizziness	□ YES	□ NO