



**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**



**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.



**New Patient Information**

**PERSONAL INFORMATION**

Name	Last:	First:	Middle: (Initial)
Address			
City	State	Zip	
Home Phone	( )	Cell Phone	( )
Date of Birth	/ /	SSN	____ - ____ - ____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Email Address			
Race	Ethnicity		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race: _____	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino  Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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		



**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



**Medical History - Continued**

HOSPITALIZATION	
Date (MM/YYYY)	Reason

FAMILY INFORMATION		
Relation	Status	List of Medical Problems
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown	

SOCIAL INFORMATION	
Do you use any <b>tobacco</b> ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If <b>YES</b> , how many packs per day? _____ packs /day. For how long? _____.	
Do you use any <b>drugs</b> ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If <b>YES</b> , which drug do you use? _____. For how long? _____.	
Do you smoke <b>marijuana</b> ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If <b>YES</b> , how often do you smoke? _____. For how long? _____.	
Do you drink <b>alcohol</b> ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If <b>YES</b> , how many drinks per day? _____ /day. For how long? _____.	



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



**Medical History – Continued**

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