Florida Kidney
PHYSICIANS

Dear patient,

Hello and Welcome to Florida Kidney Physicians, LLC

You have been scheduled for an appointment on_____.
Please arrive at the office 30 minutes prior to your visit to ensure all the appropriate information is updated in our state of the art Electronic Health Records.

For your convenience, we have enclosed an informational packet. We request that you complete all enclosed forms and bring with you to your upcoming appointment, along with your insurance card(s) and a form of picture identification.

On your behalf, we will request your medical information from the referring physician with your permission. Please follow up with your physician to have it released.

Our policy is to collect co-payments and co-insurance at the time of service. If you are unable to make payment at the time of service, please call our office prior to your appointment to make financial arrangements. For your convenience, we accept cash, check, Visa, Mastercard, and American Express.

To summarize the information above:

- Complete the enclosed forms (double-side)
- Arrive 30 minutes before your scheduled appointment;
- Bring all completed forms along with insurance cards and a form of photo identification;
- Bring a medication list and/or all your medications;
- Be prepared to make any necessary co-payments and/or co-insurance at the time of your visit.

We would like to thank you for this opportunity to provide very good service and look forward to meeting you soon. If you have any questions on our directions to our office, please contact us directly.

Sincerely,

Florida Kidney Physicians, LLC

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Name: _____

Email Address: _____

□ I do not have an email account

Please mark if you are currently experiencing any of the following symptoms

□ Fever □ Fatigue **Wt gain(_____) Wt loss(_____)**

□ Dry Eyes □ vision changes

□ Frequent Nose Bleeds
□ Sore throat □ Snoring □ Dry Mouth

□ Chest pain on exertion □ Shortness of Breath when walking □ known heart murmur □ light headed on standing □Palpations □ Swelling in Legs

□ Cough □ Wheezing □ Shortness of Breath □ coughing up blood □ sleep apnea

□ Abdominal pain □ Vomiting □ Change in Appetite □ frequent diarrhea □ Nausea

□ Urinary loss of control □ Difficulty urinating □ Increased urination □ Blood in Urine

□ Muscle aches □ Joint Pain □ Back Pain

□ Jaundice □ Itching □ Rash

□ Depression □ Restless Sleep

□ Increased thirst □ Heat intolerance □ Cold Intolerance

□ Swollen Glands □ Easy bruising □ excessive bleeding

□ Runny Nose □ Itching □ Hives

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PLEASE HAND THIS FORM TO YOUR MEDICAL ASSISTANT WHEN CALLED

Patient Registration Form

Please print, complete in full, and make any necessary corrections

Use BLACK or BLUE INK

Patient Information

Date: _____

Last Name: _____ First Name: _____

Social Security Number: _____. Date of Birth: _____

Mailing Address: _____

City: _____. State: _____ Zip: _____

Home Phone: _____. Work Phone: _____

Mobile/Pager: _____

Email Address: _____

Sex: (Circle) Female Male

Marital Status (Circle) Married Widowed Divorced Separated Single

Race (Circle) African American Caucasian Hispanic Asian Native American

Driver's License #: _____. Exp. Date: _____

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Patient Employer Information

Status (Circle) Employed Retired Disabled Student Other

Employer's Name _____

Employer's Phone _____

Occupation _____

Emergency Contacts

Name	Relationship	Phone

Responsible Party Other than Patient

Responsible Party Information _____

Name _____

Address _____

City and State _____

Employer _____

Home Phone _____

Social Security # _____

Primary Care Physician and Referring Physician

Primary Care physician _____

Phone _____

Referring Physician (if different from PCP) _____

Phone _____

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Insurance information

Responsible Party Information _____

Name _____

Primary Insurance Name _____

ID# _____Group#_____

Subscriber's Name_____

Subscriber's Phone _____Relationship to Patient_____

Subscriber's Employer _____

Subscriber's Date of Birth_____Subscriber's SS # _____

Pharmacy information

Pharmacy Name:

_____

Pharmacy Address:

_____

Pharmacy Phone:

_____

Pharmacy Fax:

_____

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Patient Name and Last Name:

Patient Date of Birth:

Medication List

Have you ever taken any anti-inflammatory such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.

Name of Medication	Strength	Directions (i.e. 1 per day, 2 every 6 hours)

If yes, please list medications:

_____

_____

_____

_____

Medication allergies:

_____

_____

_____

_____

_____

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Patient Name and Last Name:

Patient Date of Birth:

General Info/Vaccines

When was Your Last:

Mammogram _____

Pap Smear _____

Colonoscopy _____

Prostate Exam _____

Pneumonia Vaccine _____

Influenza Vaccine _____

Hepatitis B Vaccine _____

PSA _____

Health History

Have you ever had the following? Please circle all that apply

	NO	YES		NO	YES
Anemia			Hyperlipidemia		
Arthritis			Hyperparathyroidism		
Asthma/COPD			Hypertension		
Atrial Fibrillation (AFIB)			Kidney Cist		
Congestive Heart Failure (CHF)			Kidney Failure		
Cancer			Kidney Stones		
Cancer within Last 5 Years			Lupus		
Coronary Artery Disease			Polycystic Kidney Disease		
Diabetes Type 2			Protein in Urine - Proteinuria		
Diabetes Type			Recurrent Urinary Tract infections		
Blood in Urine-Hematuria			Stroke		
Hepatitis A			Thyroid Disorder		
Hepatitis B			Transplant		
Hepatitis C			Vitamin D Deficiency		

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Other _____
Previous Hospitalizations and Surgeries (Please Include dates)

_____

_____

_____

_____

Family Medical History

Has anyone in your family had any of the following:

Kidney Disease:	Yes__	No__	If yes, list family member(s)_____
SLE:	Yes__	No__	If yes, list family member(s)_____
Kidney Stones:	Yes__	No__	If yes, list family member(s)_____
Polycystic Kidney Disease:	Yes__	No__	If yes, list family member(s)_____
Cancer:	Yes__	No__	If yes, list family member(s)_____
Deafness	Yes__	No__	If yes, list family member(s)_____

Current Social History (Circle)

Advance Directive: Yes No.

Alcohol Intake: Occasionally Moderate Heavy_____

Chewing Tobacco: None 1 per day 2-4 per day 5+per day _____

Tobacco- years of use: _____

Smoking Status: Never Smoker Former Smoke Current every day smoker

Smoker-current status unknown Unknown if ever smoke

Smoking- How much?: None 1 PPW 2 PPW 1/4 PPD 1/2 PPD 1 PPD 1 1/2 PPD 2 PPD 3+ PPD

Has smoked since age: _____

Illicit Drugs: _____

Marital Status: Married Widowed Divorced Separated Single Unknown

Occupation: _____

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Patient Name and Last Name:

Patient Date of Birth:

PAYMENTS OF BENEFITS

I authorize payment of benefits, as determined by the company, directly yo Florida kidney Physicians, LLC

YES_____. NO _____

I understand that unless I have checked “yes” above, benefit payment will be paid by to me. I also understand that even if I have checked “yes”above, I may still be responsible for any amounts not paid by my insurance company in the event that the charges made are not reasonable and customary.

MEDICAL RELEASE AUTHORIZATION

I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claims. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

RESPONSIBLE PARTY INFORMATION

As a responsible party, I agree that all shares that are not directly paid by my insurance company will me my responsibility.

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Patient Name and Last Name:

Patient Date of Birth:

Acknowledgment of Receipt of
Notice of Privacy Practices

You may Refuse to Sign this Acknowledgement

I acknowledge that I have received a copy of this office's Notice of privacy Practices that outlines how the confidential information will be used, disclosed and protected.

Patient Name and Last Name:

_____
Name/Relationship if signed by individual other than patient

_____
Patient Signature

_____
Witness

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For office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice but, acknowledgement could not be obtained because:

____Individual Refused to sign
____Communication barriers prohibited obtaining the acknowledgment
____An emergency situation prevented us from obtaining acknowledgment
____Other _____

HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your medical condition and your Diagnosis (including treatment, payment and health care operations):

Name:_____Phone number:_____

Name:_____Phone number:_____

Name:_____Phone number:_____

Name:_____Phone number:_____

2. Please list family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name:_____Phone number:_____

Name:_____Phone number:_____

Name:_____Phone number:_____

Name:_____Phone number:_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home*** **(Confidential Communications)**

_____

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked as **"CONFIDENTIAL":** Yes:_____ ☐

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5. Please print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information ***if other than your home phone number:*** **(_____)_____Email Address:_____@_____**

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? Yes:_____☐ No: _____☐

7. **I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.**

PATIENT NAME _____(guardian if under 18 years)

_____

PATIENT/GUARDIAN SIGNATURE DATE

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for providers to send electronically, an accurate, error fee, and understandable prescription from the provider to the pharmacy. This program also includes:

- Medication History Transactions: Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug- allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Florida Kidney Physicians LLC as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information

Consent

By signing this consent form you are agreeing that your provider at Florida Kidney Physicians LLC may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.
You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. You also have a right to receive a copy of this form after you have signed it.
This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.
Understanding all of the above, I hereby provide informed consent to Florida Kidney Physicians LLC to enroll me in this ePrescribe Program.
I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____
Signature of individual (or Legal Representative)

_____
Individual's Name (Print)

_____
Relationship

_____
Date