NEPHROLOGY HYPERTENSION ASSOCIATES OF CNY, PC

Last Name First M Sex Date of Birth Marital Status

Street Address City State Zip County

Home Phone Work Phone

Race Ethnicity Language(s) spoken

Emergency Contact Phone Number Relationship

Primary Care Physician Referring Physician

Primary Insurance Insured's Name Policy No. Effective Date

Secondary Insurance Insured's Name Policy No. Effective Date

Tertiary Insurance Insured's Name Policy No. Effective Date

If you are covered under your spouse for any of the above insurances:

Spouse's Name Date of Birth

If you are a minor and/or covered under your parents health insurance:

Mothers Name Address Phone Number

Fathers Name Address Phone Number

I hereby authorize Nephrology Hypertension Associates of CNY to release any medical information pertaining to my treatment to insurance, medical providers, pharmacies, state and federal agencies as needed to secure reimbursement. I hereby authrosie my health insurance carrier(s) to make payment of benefits directly to Nephrology Hypertension Associates of CNY for services rendered.

Patients Signature Date

Nephrology Hypertension Associates of CNY
Office Policies

Welcome to our practice. We are committed to providing you with the best possible care. In order to achieve these goals; we need your assistance and your understanding of our office policies. If you have any questions regarding the following information or any uncertainty, please do not hesitate to ask.

By initialing each of the following policies, this will state that you understand and agree to the following terms.

_____**Prescriptions:** We require a three (3) day notice for all prescriptions, including refills. Please keep this in mind and monitor your prescription needs. We will no longer be mailing routine prescriptions to patients' homes.

_____**Labs and Other Test Results:** If lab or other test results are requested, please give us five (5) days for the results to be available. We do not routinely call with these results as they will be discussed at your next scheduled appointment.

_____**Completion of Forms:** We are happy to complete your needed forms, but should you need a form completed, there will be a charge of $5.00 per form that must be paid at the time the form is submitted. This cost is solely patient responsibility, and we will not be billing your insurance company. We will require five (5) business days to complete forms, such as insurance and disability.

_____**Payment Policy:** If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. We will bill insurance companies direct for most services, providing we have the correct billing information, which is your responsibility to provide. We do participate with a number of insurance companies, and are aware of many of their requirements. However, all policies are different, and it is impossible for our staff to know about your individual coverage. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

_____**Co-payments and Unpaid Balances:** Are due at the time services are rendered unless payment arrangements have been made in advance by our staff. If you have a balance of $10.00 or less we will not bill you, the payment will be expected at your next scheduled appointment.

Scheduled Appointments: If you are unable to keep your scheduled appointment our office does require you to give a 24 hour notice. If you need to cancel your appointment and it's within the 24 hours of your scheduled appointment time there will be a **$15.00 cancellation fee**. Also if you no-show your appointment you will be charged a **no-show fee of $25.00**. This cost is solely the patient's responsibility, and will need to be paid in full at your next scheduled appointment. All appointments that are scheduled are important and should be kept in order to provide you with the best care possible.

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered. I have read and completed all information on this sheet.

_____ _____

Signature of Patient Date

_____

Print Name

Nephrology Hypertension Associates of CNY

Salil Gupta, M.D., FACP
Pawan K. Rao, M.D., FASN
Anita Gofran, M.D.
Board Certified in Nephrology
Diplomates American Board Internal Medicine

Spirithoula D. Vasilopoulos, M.D.
Ma. Clarissa Hernandez Del Rosario, M.D.
Andrea J. Noffey, RPA-C

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Nephrology Hypertension Associates of CNY, PC** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of you protected health information.

Nephrology Hypertension Associates of CNY, PC may or may not agree to restrict the use or disclosure of your protected health information.

If Nephrology Hypertension Associates of CNY, PC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Nephrology Hypertension Associates of CNY, PC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to **Nephrology Hypertension Associates of CNY, PC** to use and disclose my health information in accordance with it.

_____

Name of Patient (print or type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

NEPHROLOGY HYPERTENSION ASSOCIATES
Medical History Questionnaire

Name: _____ Age: _____ Height:
Sex: M F Weight:
Date of birth: _____
Do you know why you were referred for this visit? _____

Kidney history:

1) Do you have:
1) High Blood pressure? Y or N For how long? _____
Home blood pressure readings _____
2) Diabetes Type I or II? Y or N For how long? _____
Blood sugar readings _____ Hemoglobin A1C _____
Do you have eye problems from diabetes? Y or N
Who is your eye doctor? _____
Do you have nerve problems from diabetes? Y or N
3) Have you ever been told you have:
Kidney stones: Y or N
Blood in your urine: Y or N
Protein in your urine: Y or N

2) Have you ever seen a kidney doctor before? Y or N
If yes then who? _____
3) Do you take medication for pain (including over the counter medication)? Y or N
If yes what do you use and how often? _____
4) Have you been on any medications that have been stopped recently? _____
5) Have you recently had any X ray/Radiology studies with dye injected? Y or N
6) Any history of exposure to toxic materials? Y or N
If yes then what? _____
7) Do you have a pacemaker or metal parts in your body? _____

Past Medical History:

Do you have, or have you ever had, any of the following: (Please Circle)

Stroke	Anemia or blood disorder	Thyroid problems
Seizures	High Cholesterol	Hepatitis (Type) _____
Coronary Artery Disease	Chronic Bronchitis	Peptic ulcers
Irregular Heartbeat	Emphysema	GERD/Acid Reflux
Heart Attack	Asthma	Stroke
Congestive Heart Failure	Cancer	Blood clots in legs or lungs
Arthritis	Osteoporosis	Diverticulosis/bowel problem

List any other medical problems that do not appear above: _____
_____
List any medication allergies (with reaction if know): _____
_____
List any hospitalizations and/or surgeries (with dates and complications): _____
_____
_____

List current medications (with dose and frequency): _____

Social History: Marital status: _____ Children? _____
Occupation and employer (if retired past work): _____
Do you: 1) Smoke: Y or N For how long? _____ How much? _____
Approximate year you quit? _____
2) Drink alcohol? _____ How much? _____
3) Take any illegal drugs? _____
4) Engage in risky sexual behavior? _____

Family History: (If deceased please provide age and cause if known)
Mother: _____ Father: _____
Siblings: _____
Is there any family history of kidney problems? Y or N
If yes what problems: _____
Is there any history of: (Please circle)
High blood pressure Diabetes Heart problems
High cholesterol Cancer Types _____

Review of Systems: (Please circle symptoms and describe and/or add others below)

Constitutional: Fever, weight gain/loss, loss of appetite, weakness

Eyes: Double vision, difficulty seeing, blurring

ENT: Sinus problem, deafness, hoarseness

Heart: Chest pain, palpitations Fast or irregular heartbeat

Lungs: Shortness of breath, cough, coughing up blood

Skin: Rashes, ulcers, lesions that don't heal

Digestive: Abdominal pain, Nausea, vomiting, diarrhea, Constipation, blood in stool

Urologic: Pain when urinating, bleeding, foaming, increased frequency, incontinence, decreased force, incomplete emptying, swelling in feet/ankles

Neurologic: loss of balance, tremor, Numbness, tingling, memory loss

Psychiatric: Depression, anxiety, sleep problems

Musculoskeletal: joint pain, stiffness

Endocrine: heat/cold intolerance, Increased thirst or urination,

Gynecologic (women): Breast masses, pain, discharge, Last gynecologic visit: _____
Last mammogram: _____, Last PAP: _____

Other symptoms not listed above: _____
Patient signature: _____ Date: _____
Physician signature: _____ Date: _____