Southern Crescent Nephrology, P.C.

TO OUR PATIENTS:

1. Do we have permission to leave a message on the telephone number(s) you have provided to us?

YES ______ NO ______

2. May we discuss your Medical Information with family members and friends?

YES ______ NO ______

➢ Please list the names of people we can discuss your medical care with:

- Name: ______________________ Phone #: ______________

  Relationship to you: ______________________

- Name: ______________________ Phone #: ______________

  Relationship to you: ______________________

- Name: ______________________ Phone #: ______________

  Relationship to you: ______________________

3. If someone calls for you or asks for you while you are in our office, do we have permission to tell them you are here?

YES ☐ NO ☐

______________________ ______________
Patient Signature Today's Date

______________________ ______________
Patient Printed Name Expiration Date

Southern Crescent Nephrology, P.C.

PATIENT ACKNOWLEDGEMENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge Southern Crescent Nephrology, PC, to use and disclose protected health (PHI) about me to carry out treatment, payment, and healthcare operations. (Southern Crescent Nephrology, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices; Southern Crescent reserves the right to revise its Notice at anytime. A revised Notice may be obtained by forwarding a written request to Southern Crescent Nephrology Privacy Office at 250 Village Center Parkway, Suite 100, Stockbridge, Georgia 30281.

Southern Crescent Nephrology may call my home or other alternative location and leave a message or voicemail or in person in reference to any items that assist the practice in carrying out our treatment, payment and healthcare operation (TPO) such as appointment reminders, insurances items, and any calls pertaining to my clinical care, including laboratory results among others. Southern Crescent Nephrology may mail to my home any items that assist in carrying out TPO, such as appointment reminder cards, patient statements, or lab request forms, as long as they are marked Personal and Confidential.

I acknowledge that I have the right to request that Southern Crescent Nephrology, PC restrict how it uses or discloses my PHI to carry TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I acknowledge Southern Crescent Nephrology, PC's use and disclosure of my PHI to carry out my TPO.

By signing this form, I also acknowledge receipt of a copy of Southern Crescent Nephrology Policy Notice of 01/20/2010.

____
(Printed Name of Patient or Patient's Guardian)

__________________________________ ____________________
(Signature of Patient or Patient's Guardian) (Date)

Southern Crescent Nephrology, P.C.

☐ I, ______________________________, (DOB: __________________) give authorization to share my PHI with any other Healthcare Organization. This authorization is valid until written notification to terminate authorization.

☐ I, ______________________________, (DOB: __________________) DO NOT give authorization to share my PHI with any other Healthcare Organization. This authorization is valid until I provide written notification to share my PHI with these Healthcare Organizations.

Signature: ___________________________________ Date: ____________________

Southern Crescent Nephrology, P.C.

NOTICE:

The following Policies are in effect for SOUTHERN CRESCENT NEPHROLOGY as of January 20, 2010:

- Co-pay and/or co-insurance payment is required at time of each office visit. If you cannot pay your co-pay/ co-insurance, it will be necessary to reschedule your appointment.
- Patients are required to present their insurance card(s) at each office visit.
- Patients are responsible for obtaining a referral from their Primary Care Physician, if referral is required by your insurance.
- Patients who are more than sixty (60) minutes late for an appointment will be asked to reschedule their appointment.
- Patients must inform our office if you cannot keep your scheduled appointment at least 24 hours in advance. If no notification is received from the patient, a $25.00 “No Show” fee will be added to your account. The “No Show” fee is due from the patient, and is not billable to your insurance company.
- Southern Crescent Nephrology orders labs from Labcorp, Quest, or a Hospital. If you have your labs done by your Primary Care Physician, you must bring a copy of the labs to your appointment or ensure that your Primary Care Physician will mail or fax a copy to our office.
- Policy for completion of patient paperwork is as follows:

    1. FMLA (Family Medical Leave) paperwork is to be dropped off at our office, will be completed by the physician within seven (7) business days, and may be picked up by the patient upon completion. There is a $25.00 charge for completion of the FMLA paperwork, and the fee is to be paid when the paperwork is dropped off. **Please note that a face-to-face visit may be required before the completion of your FMLA paperwork**.
    2. Disability paperwork will be completed during an office visit, and there is a $25.00 charge for completion of disability paperwork, and the $25.00 fee is due at the time of the paperwork visit. If the patient is also seen for a regular medical office visit at this time, the $25.00 charge is in addition to the patient’s co-pay/ co-insurance or cash payment due. **Please note that a face-to-face visit may be required before the completion of your Disability paperwork.**

Thank you,
SOUTHERN CRESCENT NEPHROLOGY

DIRECTIONS-STOCKBRIDGE:

From Clayton County, take I-75 south to exit #224 (Eagles Landing Parkway/Hudson Bridge Road exit), turn left (crossing back over I-75). After you cross the bridge, go to the fourth (4th) red light (the red lights are only one block or so apart), turn right on to Village Center Parkway (beside the Truist Bank). Our office is 250 Village Center Parkway, last building on the right before you get to the STOP sign at Country Club Drive, and our offices are on the first floor which is the second (2nd) driveway entrance. (There is a big "250" on the front of the building, which is red brick with tall white columns).

From McDonough, take I-75 North to exit #224 (Eagles Landing Parkway/Hudson Bridge Road exit), turn right at the top of the exit ramp, go to the third (3rd) red light, which is Village Center Parkway (follow the underlined directions above).

From Highway 42, turn onto Eagles Landing Parkway, go two (2) miles to the second (2nd) red light, which is Village Center Parkway. Turn left beside Kentucky Fried Chicken. Building address is 250 Village Center Parkway, last building on the right before you come to the STOP sign at Country Club Drive. (There is a big "250" on the front of the building). We are on the first floor which is the second (2nd) driveway entrance.

DIRECTIONS-RIVERDALE:

Going North on I-75, Take exit 235 (Old Dixie Highway/Highway 19/41). Turn left at the top of the ramp (cross over I-75) to the first (1st) red light. Turn right onto Upper Riverdale Road. Go approximately one mile to 34 Upper Riverdale Road. "Urgent Care" building on the left, directly across the street from Southern Regional Medical Center, Suite 202 (second floor).

Going South on I-75, take exit 235 (Highway 19/41). Turn right at first red light which is Upper Riverdale Road. (follow underlined directions above).

DIRECTIONS-LOCUST GROVE:

From McDonough, I-75 South to Tanger Mall exit (Bill Gardner Parkway), turn left cross under expressway, proceed to Stanley K. Tanger Boulevard, turn right, go approximately one-quarter mile to 531 Stanley K. Tanger Boulevard (building on left, back to Tanger Outlet Mall).

From Jackson, take I-75 North to Tanger Mall Exit (Bill Gardner Parkway), turn right, follow underlined directions above.

DIRECTIONS-GRIFFIN:

From Jackson, take Highway 16 into Griffin. Turn left on 8th Street (Spalding Hospital's street) Go 0.39 miles and 415 will be on the right.

From Jonesboro, take Highway 19/41 south to Highway 16/ Downtown Griffin exit, to 8th Street (same street as Spalding Regional Hospital.) Turn right onto 8th Street, go 0.39 miles and 415 will be on your right.

DIRECTIONS-FAYETTEVILLE

From GA-54 East**-** Head northeast on GA-54 N toward Old Hwy 54. **Turn right to stay on GA-54, continue straight, and pass Chick-fil-A (on the left in 1.8 mi). Turn left onto Ginger Cake Rd, right onto Brandywine Blvd (approximately 0.4 mi), turn right and destination will be on the left.**

From GA-54 West- (Soccer Complex) Take GA-54 West approximately 1.0 miles and then turn back (make a U-turn) onto GA-54 East. **Follow underlined directions above**.

From GA-85 S- Head north on GA-74 N/GA-85 N toward Greenville Flat Shoals Rd. Continue to follow GA-85 N, pass by Starbucks (on the right in 25 mi). Turn left onto Grady Ave (Grady Ave turn slightly right and becomes Grady Ave). Turn left onto Floy Farr Pkwy/W Lanier Ave. Turn right onto Brandywine Blvd approximately 0.4 miles and then turn left) destination will be on the left.

From GA-85N GA 92- Take GA-85N into Fayetteville, head northeast on Glynn St N, take a slight left toward GA-85 S/Glynn St N. Sharp left ontoGA-85 S/Glynn St N (pass by Taco Bell – on the right in 0.5 mi). Turn right onto Floy Farr Pkwy/W Lanier Ave. approximately 1.1 miles and then turn right onto Brandywine Blvd (0.4 mi). Turn left and destination will be on the left in 1.0 mi.

SOUTHERN CRESCENT NEPHROLOGY, P.C.

CONFIDENTIAL PATIENT INFORMATION SHEET
(Please Print)

TODAY'S DATE: **NAME OF PCP:** **Referring Physician:**
Reason for Referral:

Patient Name:________________________________ Age: ______ D.O.B:________ Sex: ____
(Last) (First) (MI)
Street Address: ________________________________ Apt: ________ SS#: ______________

City:______________ State:___ Zip:_______ Marital Status: ☐ Single ☐ Div. ☐ Sep. ☐ Wid. ☐ Married

Home Phone: ________________ Cell#: ________________ Work Phone: ________________

Email: ______________________________ ☐ I do not have email. ☐ I do not want to share my email.

Pharmacy: ____________________ City: ______________ Phone#: __________________

Race: (Required By Medicare)
☐ American Indian/ Alaska Native ☐ Native Hawaiian ☐ White
☐ Asian ☐ Other Pacific Islander
☐ Black/ African American ☐ Undefined
☐ More than 1 race ☐ Refused to Report

Ethnicity: ☐ Hispanic/ Latino ☐ Other:

Primary Language Spoken: ____________

Emergency Contact: (not living with patient): ______________________ Relationship: ______________

Home Phone: ________________ Cell#: ________________ Work Phone: ________________

Insurance Information

(Please present Insurance & ID cards to front desk for photocopying)

Are you covered by Insurance? ☐ YES ☐ NO ☐ SELFPAY

Name of Primary Insurance: ____________________ Policy/ID #: __________ Group#: __________

Insured's Name:__________________ Insured's D.O.B:__________ Relation to Patient: ____________

Secondary Insurance: ________________ PolicyID#:____________ Group#: ______________

Insured's Name: __________________ Insured's D.O.B: __________ Relation to Patient: ____________

Other physicians you would like us to know about or send letters to?
Name:__________________ Phone: ________________ Type of Physician:______________
Address:____
Name:__________________ Phone: ________________ Type of Physician:______________
Address:____

Allergies (Please list reaction)

Penicillin _______________ Sulfa _____________ Iodine/Contrast ____________ Latex __________
Other ____

Family History

Mother: Alive:____ Deceased: ___
Medical Problems: ____
Father: Alive: ____ Deceased: ___
Medical Problems:____
Other family history (*Please indicate relationship to you and age at which occurred*):
Kidney Disease ___________________________ Diabetes______________________________
Kidney Stones ____________________________ Stoke _______________________________
Heart Disease ____________________________ Cancer ______________________________
High Blood Pressure _______________________ Other_______________________________

Employment

Employed: ____//Occupation: _____________________________ Unemployed: ____
Retired: ____ On Disability: ____
Student: ____

Tobacco:

Never Smoked: ____
Former Smoker: ____
-Quit: When: ______ //How long were you smoking ____years // How many cigarettes/day _____
Still Smoking: ____
-How long have you been smoking ____ years
-How many cigarettes/day _____

Alcohol:

Never: ____ Rare: ____ Social/Occasional: ____ Frequent: _____drinks/week

Illicit Drugs:

Never: ____ Previously Used: Drug(s)____
Quit: ____//When: ________________________
Currently using: Drug(s) ____
Previously Used: Drug(s)____

Medications (please include vitamins, supplements, herbals, and over the counters):

Name	Dose	Frequency	Name	Dose	Frequency

Past Medical History

Cardiovascular

High blood pressure: ___
Heart disease: ___
Prior angiogram (cardiac cath): ____
Angioplasty (balloon) or stents placed: ____
Open heart surgery: ____
Heart attack: ____
Congestive heart failure (CHF): ____

Arrhythmia (irregular heart rhythm): ____
Pacemaker placement: ____
Defibrillator (AICD) placement: ____
High cholesterol: ____
Heart valve problems or replacements: ____
Rheumatic heart disease: ____
Other heart problems:________________

Pulmonary

COPD (emphysema or chronic bronchitis): ____
Use oxygen at home: ____
Sleep apnea: ____
Use BiPap, CPAP or oxygen at night: ____

Asthma: ____
Pneumonia: ____
Other lung disease: __________________

***Endocrine*:**

Diabetes: ____
- -On insulin: ____
- -Diabetic retinopathy (diabetic eye disease): ____
- -Diabetic neuropathy (numbness, burning or poor sensation in feet): ____

Thyroid disease: ____
Other: __________________________________

***Gastrointestinal*:**

Peptic ulcer disease (stomach or intestinal ulcer): ___
Gastric bypass (weight loss surgery): ____
Gallstones or gallbladder disease: ____
Pancreatitis: ____
Hepatitis or any liver disease: ____
Bowel obstruction: ____

Crohn's disease: ____
Ulcerative colitis: ____
Irritable bowel syndrome: ____
Diverticulosis or diverticulitis: ____
Hemorrhoids: ____
Other: __________________________

***Genitourinary*:**

Kidney (renal) failure: ____
Required dialysis in past?: ____
Kidney stones: ____
Blood in urine: ____
Urinary tract infection: ____
Kidney infection: ____
Previous kidney transplant: ____

Enlarged prostate (BPH): ____
- -Prostate Surgery: ____

Erectile dysfunction (ED): ____
Fibroids: ____
- -Ovarian cysts: ____

Other:_____________________

***Vascular*:**

Aortic aneurysm: ____
Peripheral vascular disease (PAD, PVD, poor circulation in legs): ____
Other vascular disease: ______________________________

***Neurologic*:**

Seizure: ____
Loss of consciousness: ____

Stroke or warning stroke: ____
Other: _____________________________

***Psychiatric*:**

Depression: ____
Bipolar disorder: ____

Anxiety: ____
Other: _____________________________

***Hematology/Oncology*:**

Anemia: ____
Prior blood transfusion: ____
Blood clots (DVT or PE) in legs or lungs: ____
Cancer: ____//If so, what type: ________________________
Other: _________________________

***Rheumatology*:**

Lupus: ____
Sjogren's: ____
Scleroderma: ____
Mixed connective tissue disease: _____
Rheumatoid arthritis: _____
Arthritis (Osteoarthritis) Joint Pain: ____
Joint Replacement(s): ____
Gout: ____
Fibromyalgia: ____
Other: ______________________

Infectious Disease:

Tuberculosis: ____
Hepatitis B: ____
Hepatitis C: ____
HIV/AIDS: _____
Other: _________________________

Immunizations:

Hepatitis A: ____
Hepatitis B: ____
COVID Vaccines
Pfizer: ___ / Moderna: ___ /
Johnson & Johnson: ___
Booster(s): ☐ YES ☐ NO
Pneumovax: ____
Influenza (Flu Shot): ____
Other _________________________

Past Surgical History

Have any of the following surgeries been performed on you?

____Appendectomy	____ Hip Replacement ____ Left ____ Bilateral ____ Right	____ Renal Transplant
____CABG	____ Knee Replacement ____ Left ____ Bilateral ____ Right	____ Thyroidectomy
____Carotid Endarterectomy	____Hysterectomy	____ Tonsillectomy
____Cataract Surgery	____ Prostatectomy	____ Valve Replacement
____D & C	____ Nephrectomy	____ AV Fistula
____Gall Bladder Removal		____AV Graft
____Gastric Bypass		____PD Catheter
____Hemorrhoidectomy		____ Other ________________
____Hernia Repair		

Other Health Problems/Surgeries Not Listed Above:____
____

MEDICAL CONSENT- ASSIGNMENT OF BENEFITS- RELEASE OF INFORMATION

I hereby authorize the physicians and staff of Southern Crescent Nephrology, P.C., to provide medical care for the above named patient.
I hereby authorize Southern Crescent Nephrology, P.C., to release any information in my examination or treatment to any insurance, government agency providing benefits or other policies to process any claims on my behalf for payment.
I hereby with my signature assign and authorize my insurances carrier(s) to make payment directly to Southern Crescent Nephrology, P.C., for all services rendered. Thereby give my permission for M. Hafiz Rahman, MD, Sanjay Sharma, MD, Janice Weatherspoon, MD, Srikar Kumar, MD, Saba Khan, MD, and Latoya Williams, APRN BC and staff to treat me.
I hereby with my signature understand that I am ultimately responsible for payment in full of all services rendered in the event my insurances carrier and or managed care plan denies payment in full or part of any services rendered. Including but not limited to all co-payments and or deductibles, and no covered services and supplies obtained during the course of care.

X____ Date: ________________ Patient Information Updated on: ____________
Signature of Patient