SOUTHERN CRESCENT NEPHROLOGY, P.C.

CONFIDENTIAL PATIENT INFORMATION SHEET
(Please Print)

TODAY'S DATE: **NAME OF PCP:** **Referring Physician:**

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: _____ Policy ID#:_____ Group#: _____

Insured's Name: _____ Insured's D.O.B: _____ Relation to Patient: _____

_____ Date: _____ Patient Information Updated on:_____
Signature of Patient

Medical History

Please Check Any of the Following Conditions that you are currently being treated for or have had within the past 10 years and the year you were first diagnosed/treated.

Condition(s)	Year Diagnosed	Condition(s)	Year Diagnosed
High Blood Pressure		Diabetes	
Congestive Heart Failure		Pacemaker	
Eye Problem from Diabetes		Stroke	
Heart Attack		Emphysema	
Stents in Heart		Arthritis	
High Cholesterol		Gout	
Heartburn (Acid Reflux)		Seizures	
Chronic Bronchitis		Cancer **	
Bleeding from Digestive Tract		Hepatitis B or C	
Liver Disease		Blood Clots	
Enlarged Prostate		Thyroid Disease	
Migraine Headaches		** List Below	

List Cancer Types and any other Medical Conditions you may have had in the past:

_____

_____

List Any Surgeries you have had and the year it was performed:

_____

_____

Family History

Check All That Apply

Medical Condition	Father	Mother	Brother	Sister	None
Kidney Disease					
Polycystic Kidney Disease					
High Blood Pressure					
Heart Disease					
Cancer					
Stroke					
Gout					
Diabetes					
Dementia					

Immunization History

Have you had these Vaccinations?

☐ **Flu Vaccine** ***Within the Past Year*** ☐ **Pneumonia Vaccine** ***Within the Past 5 Years***

Are you currently or have you ever taken any of the following Medications on a Daily/Weekly Basis?

Please Check All that Apply:

____ Advil / Ibuprofen	**____ Celebrex**	**____ Motrin**
____ Aleve	**____ Diclofenac**	**____ Naproxen**
____ BC Tablets/Powder	**____ Goody's Powder**	**____ Vioxx**
____ Bextra	**____ Mobic**	**____ Voltaren**

Review of Symptoms Related to your Kidneys

Check any of these Kidney Related Symptoms that you are currently experiencing:

____ Swelling in Hands / Legs / Feet	**____ Difficulty Starting Urine Stream**	**____ Shortness of Breath**
____ Frequent Urination	**____ Incomplete Bladder Emptying**	**____ Cough / Wheezing**
____ Painful Urination	**____ Nose Bleeds**	**____ Headache/Dizziness**

Personal History

Check all that Apply to You:

Tobacco Use	**____ Former**	**____ Current**	**____ Never**
Please Circle all that apply Cigarettes/Pipes/Cigars/Vape Snuff/Chew	When did you Quit? _____ How many years? _____ Packs per day? _____	How often? _____ Packs per day? _____	
Alcohol Use	**____ Former**	**____ Currently**	**____ Never**
	When did you Quit? _____	Rarely / 1-2 Drinks per Day / 3 or more Drinks per Day	
Recreational Drug Use	**____ Former**	**____ Current**	**____ Never**

Allergies

Please List any Allergies to Medications that you have and what Symptoms you had.

Medication	Symptoms

Current Medication List

Prescriptions and over the counter vitamins & supplements

	Medication Name	Dosage – mg, mcg, ml	Instructions
Ex:	Aspirin	81 mg	Once a day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Southern Crescent Nephrology, P.C.

Physician Office Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent continues in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

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, Sreyoshi Alam, MD, and staff to treat me.

I hereby acknowledge, by my signature, that I am ultimately responsible for payment in full for all services rendered in the event that my insurance carrier and/or managed care plan denies payment, in whole or in part, for any services rendered. This includes, but is not limited to, all co-payments, deductibles, and non-covered services, supplies, or other charges incurred during the course of my care.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Representative	**Date:**
Printed Name of Patient or Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Southern Crescent Nephrology, P.C.

Authorization to Release Protected Health Information

☐ I, _____, (DOB: _____) give authorization to share my Protected Health Information (PHI) with my Primary Care Provider, Referring Provider, and Insurance Company to carry out treatment, payment, and healthcare operations. (Please refer to Southern Crescent Nephrology, P.C.'s Notice of Privacy Practices for a complete description of such uses and disclosures). This authorization is valid until written notification terminates authorization.

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

Southern Crescent Nephrology, P.C.

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

We understand that your health information is important, and we are committed to protecting your privacy. This Notice of Privacy Practices ("notice") describes the ways we may use and disclose your information. It also describes your rights and our obligations regarding the use and disclosure of your information.

For purposes of this Notice, Southern Crescent Nephrology, PC "SCN" and the pronouns "we," "us,

" and "our" refer to all the physicians and physician practice locations operated or managed by Southern Crescent Nephrology. These entities have been designated as a single affiliated covered entity for HIPAA Privacy Rule compliance purposes.

SCN uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive, and for other purposes permitted by HIPAA. SCN is required by law to maintain the privacy of your health information and provide you with notice of our legal duties and privacy practices with respect to that information and to provide you with a notice of a breach of your unsecured protected health information (PHI).

This Notice of Privacy Practices applies to all records involving your care that are created, and/or maintained by SCN. Your health information is contained in a medical record that is the physical property of SCN. SCN is required to abide by the terms in this Notice.

SCN reserves the right to change its privacy practices, as reflected in this Notice, to revise this Notice, and to make the new provisions effective for all PHI it maintains. Revised Notices will be available in the clinic, or upon request.

If you are a patient insured by the United States Department of Veterans Affairs, you may be entitled to rights, and we may be subject to restrictions regarding the use and disclosure of your health information other than as set forth in this Notice. At all times, we will comply with the applicable requirements of the Department of Veterans Affairs regarding the use and disclosure of your health information.

1. Who **Will Follow This Notice**

The privacy practices in this notice are followed by:

- Health care professionals who enter or access information in your medical record.
- Employees, contractors, physicians, and other health care professionals on our medical staff when they provide services in our facilities with access to your medical or billing records or health information about you; and
- Residents and students who may be in our facilities.

2. Our Privacy Obligations

Medical information that identifies you is known as protected health information (PHI). PHI includes demographic, clinical, and financial information that relates to treatment or payment for treatment.

We are required by law to:

- Make sure that your PHI is kept private.
- Give you this notice of our legal duties and privacy practices.
- Follow the terms of the notice that is currently in effect; and
- Notify you if there is a breach of your unsecured PHI.

3. How we may use and disclose PHI without your written authorization

This section describes how we may use your PHI for treatment, payment and health care operations purposes WITHOUT your written authorization.

Treatment
We use and disclose your PHI to provide treatment and other services to you. For example, we may consult with your physician about your care. We may also recommend alternative treatments, therapies, health care providers, or settings of care, or describe a health-related product or service. We may also contact you as a reminder that you have an appointment. In addition, we may share your PHI with other health care providers involved in your treatment.

Payment
We may use or disclose your PHI to obtain payment for our services. For example, we may disclose your PHI to Medicare, Medicaid, your health insurer, HMO, or other company or program that arranges or pays the cost of your health care. We may also share PHI with your other health care providers if they need this information to receive payment for the services they provide to you.

Health Care Operations
We may use or disclose your PHI for our health care operations, which include internal administration and planning and activities that improve the quality and cost effectiveness of care. For example, we may use your PHI to evaluate the quality and competence of our staff and other health care professionals.

Disclosure to Relatives, Close Friends and Other Caregivers
We may use or disclose your PHI to a family member, another relative, close friend or other person identified by you if: 1) we obtain your agreement, 2) provide you with the opportunity to object and you do not object; or 3) we reasonably infer that you do not object to the disclosure.

If you are not present or are unable to agree (for example, if we receive a telephone call from a family member or other caregiver), we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information under these circumstances, we disclose only information that is directly relevant to the person's involvement with your care.

Health Information Exchanges
A health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers and patients to access and share medical information electronically to improve the speed, quality, safety and cost of patient care. We may participate in a health information exchange through which we may disclose your health information, as permitted by law, to other health care providers or external entities for treatment, payment, or health care operations purposes.

Research
As part of our efforts to improve treatments, we may conduct and participate in clinical trials and research activities. We may use and disclose your PHI for research purposes without your authorization if an institutional review board (IRB) or privacy board has waived the authorization requirement. Under certain circumstances, your PHI may also be disclosed without your authorization to researchers preparing to conduct a research project, for research on decedents, or as part of a data set that omits your name and other information that can directly identify you

As Required by Law
We will disclose your PHI if we are required to do so by federal, state, or local law.

Public Health Activities
We may disclose your PHI to public health authorities to prevent or control disease, injury or disability. We may also alert a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

We may also disclose your PHI to government agencies to report child abuse and neglect, or if we reasonably believe that you are a victim of abuse, neglect or domestic violence.

In addition, we may report information about medical devices and medications to the manufacturer and the U.S. Food and Drug Administration.

Threat to Health and Safety
We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. For example, we may give your PHI to an entity assisting in a disaster relief effort.

Health Oversight Activities
We may disclose your PHI to an agency that oversees the health care system and is responsible for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Workers' Compensation
We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

Lawsuits, Disputes, and Administrative Proceedings
We may disclose your PHI in response to a court or administrative order, subpoena, warrant, discovery request or other lawful due process.

Law Enforcement Officials
We may disclose your PHI to the police or other law enforcement officials as required by law or to comply with a court order.

Military Officials
If you are a retired or active member of the United States or foreign armed forces, we may disclose your PHI as required by law.

Correctional Institution
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the institution or officials as permitted by law so that the institution may provide you with health care, protect your health and safety, and protect the health and safety of others.

Organ and Tissue Donation
We may disclose your PHI to organizations that facilitate organ transplantation.

Coroners, Medical Examiners and Funeral Directors
We may release PHI to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

4. Use and Disclosures of your PHI that require your written authorization
We must obtain your written authorization before we can use your PHI for marketing, as that term is defined by HIPAA. Similarly, we may not sell your PHI without your permission.

For example, we will not accept any payments from other organizations or individuals in exchange for communicating with you about treatments, therapies, health care providers, settings of care, case management, care coordination, products or services unless you have given us your written authorization to do so or the communication is permitted by law.

However, we may provide refill reminders or inform you about a medicine that is currently prescribed to you under certain circumstances. We may also market to you when we see you in person.

Psychotherapy Notes
Except in limited circumstances, we will not use or disclose any psychotherapy notes about you without your written authorization.

Highly Confidential Information
Federal and applicable state law may require special privacy protections for certain health information about you, for example, information relating to HIV testing, mental/behavioral health, and genetic information. If required by law, we will obtain your authorization before disclosing this information.

5. Your Individual Rights
How to Exercise Your Rights
You may exercise your rights by making a request in writing to the location where you receive treatment or to the Practice Administrator at the address found at the end of this notice. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights. We will make sure that the person has this authority before we take any action.

Right to Request Restrictions
You may ask us not to use or disclose certain PH for treatment, payment and health care operations. You may also ask us not to share information with individuals who are involved in your care or payment for care, for example, a family member or friend.

We are not required to agree to your requests, and we may say "no" if it would affect your care or if we are legally required to share the information. However, we will agree to a request to restrict disclosure to a health plan for an item or service for which you (or someone on your behalf other than the health plan) have paid out-of-pocket in full and the disclosure is not required by law.

Right to Request Confidential Communications
You have the right to ask us to communicate with you about your PHI in a certain way or at a certain location. For example, you may ask us to contact you at home or office phone number, or to send mail to a different address. We will say "yes" to all reasonable requests.

Right to Inspect and Copy
You may ask to see or get a copy of your medical record and certain other information we have about you. If you request copies, we will provide them at no charge. We will inform you if we cannot fulfill your request, and you may ask us to reconsider by contacting the Practice Administrator at the address below.

Right to Amend
If you think that information in your medical or billing records is incorrect or incomplete, you may ask us to amend that information. We are not required to agree to your request, and we may say "no" if the information is accurate and complete. We may also say "no" if we do not maintain the information or in certain other circumstances.

Right to an Accounting of Disclosures
You may ask us for a list (accounting) of disclosures of your PHI during the past six years. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as those you asked us to make). We will provide one account a year for free, but will charge a reasonable, cost-based fee for additional requests you make within 12 months.

Right to a Paper Copy of This Notice
You may ask for a paper copy of this notice at any time.

6. Changes to this Notice
We may change the terms of this notice at any time, and the changes will apply to all PHI we have for you. The new notice, identifying the effective date, will be available on request, in our office, and on our website.

7. For more Information or to file a Complaint
If you want further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Practice Administrator at:

Southern Crescent Nephrology
250 Village Center Pkwy
Suite 100
Stockbridge, GA 30281
678-289-0508

You may also file a written complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services at:

200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775
www.hhsgov/ocr/privacy/hipaa/complaints

SCN will not retaliate against you for filing a complaint or grievances. SCN will not retaliate against you for requesting access to your medical records, Notice of Privacy Practices or any other HIPPA-related documents.

I acknowledge Southern Crescent Nephrology, PC, to use and disclose protected health information (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 any time. 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 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 restricts 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 P.C. HIPPA Privacy 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.

Office Financial Policy

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 the time of each office visit. If you cannot pay your co-pay/ co-insurance, it will be necessary to reschedule your appointment.
- Please note that if your account remains past-due, it may be sent to a collection agency. Feel free to contact us regarding past-due bills so we can work together to get a payment plan in place as needed.
- 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.
- Patients who are more than **fifteen (15) 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.
- Due to difficulty obtaining lab results from PCP offices, **all labs must be completed at Quest Diagnostics, LabCorp, or a Local hospital.**
- The 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.**
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 currently, the $25.00 charge is in addition to the patient's co-pay/ co-insurance or cash payment due.

Thank you,

SOUTHERN CRESCENT NEPHROLOGY