SOUTHERN KIDNEY CARE

Dear _____

Welcome to our practice!

We are both privileged and honored to be partnering with you for your kidney care. At Southern Kidney Care, our mission is to improve the health and well-being of our patients by providing high-quality, individualized, and patient-centered service. We look forward to working closely with you and your primary care provider to offer state-of-the-art kidney care.

Your appointment is scheduled with Dr. _____ on _____ at _____. If you are unable to keep this appointment, please contact our office 24 hours prior to your scheduled appointment at 205.354.2100.

In the enclosed information, you will find a practice overview, a medical history questionnaire, and practice policies that you may find helpful.

We look forward to serving your medical needs. In the interim, please do not hesitate to call the office with any questions that may arise.

Sincerely,

_____

SOUTHERN KIDNEY CARE

Practice Overview

Important Reminders

Please bring to every appointment:

Your photo ID and current insurance card(s).

A complete list of your current medications (or medication bottles) including dose, route and frequency information and, pharmacy name and phone number

Primary Care and other physician names and addresses

Co-pays and balance payments (cash, check, Visa, MasterCard, and Discover accepted)

Office Hours

Southern Kidney Care is open Monday – Thursday 8am – 5pm and Friday 8am – 12pm.

Our physicians and staff make every effort to return non-urgent calls within 24 hours, Monday – Friday. Urgent calls or requests will be returned within 24 business hours. If it is an emergency, we request that you go to the nearest Urgent Care Facility or hospital Emergency Room.

Laboratory Orders & Policy

If your physician orders lab work, you will receive an order at your appointment. The order will list any lab studies that need to be done before your appointment. Please take the order to a lab/clinic of your choice 1-2 weeks before your appointment to ensure the results have been faxed to us. Your physician will review the results with you at your appointment. Should an appointment not be required, the physician or staff will call you. If orders are lost or misplaced, will will be happy to send you a duplicate or fax them directly to the lab. Please note we are unable to create, fax, or send any orders outside of normal business hours.

Cancel/ No Show Policy

We have a strict **NO-SHOW** policy that includes a $25 fee for missed appointments without a call **24 HOURS** prior to the appointment. Patients who no-show two or more times in a 12-month period, may be dismissed from the practice at the discretion of the provider.

Medication Refill Policy

We ask our patients to monitor their prescription medication closely, and to assess supplies before each office visit. We request that patients get their medications refilled at the time of their appointments or call their pharmacy several days in advance or running out of medication. We will review and respond to all medication refill requests within 2 business days. However, certain classes of medications, such as pain medicines (narcotics), may require a visit to the office. Our on call providers will not refill any narcotic prescription written/ordered by another provider.

Reminder calls and mailings

As a courtesy to all of our patients, we provide automated reminder calls to all of our patients starting 2 days prior to the scheduled appointment. Please notify one of the office staff members at check-in if you would like to opt out of our automated reminder call system.

We encourage our patients to visit our website, https://www.southernkidneycare.com 24 hours a day 7 days a week for patient educational materials, physician bios, pay your bill, and much more.

SOUTHERN KIDNEY CARE

PATIENT INFORMATION

Last Name _____ **First Name** _____ **MI** _____ **Date of Birth** _____

Address _____ **City** _____ **State**_____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Email Address _____**Gender** Male / Female **SSN #** _____
Preferred Language _____

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
( ) Married	( ) Home Phone	( ) Hispanic/Latino	( ) American Indian
( ) Single	( ) Cell Phone	( ) Non-Hispanic	( ) Asian
( ) Divorced	( ) Opt out of Reminders	( ) Filipino	( ) Black or African American
( ) Separated		( ) Other	( ) White
( ) Widowed		( ) Decline	( ) Other
			( ) Decline

Primary Care Provider **Referring Provider**

_____ _____

Primary Insurance Information

Insurance Company _____ ID# _____ Group# _____

Policy Holder Information

Insured Full Name _____ Date of Birth _____ Subscriber's SSN
_____ Effective Date _____

Secondary Insurance Information

Insurance Company _____ Date of Birth _____ Subscriber's SSN
_____ Effective Date _____

Emergency Contact

First Name _____ Last Name _____

Phone # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

I also authorize Southern Kidney Care or insurance company to release any information required to process my claims.

Patient Signature _____ Date _____

PHARMACY INFORMATION

Preferred Pharmacy

Name _____

Address _____

Phone _____

Fax _____

Secondary Pharmacy

Name _____

Address _____

Phone _____

Fax _____

MEDICATIONS- *List all medications you take, prescriptions and non-prescription, and the dosage*

Medication Name	Dosage	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES- List all allergies

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY- Check ( ) if you have ever experienced the following conditions

( ) None
( ) Anemia
( ) Asthma
( ) Bleeding Problems
( ) Broken Bones
( ) Coronary Artery Disease
( ) Cancer – Type _____
( ) Congestive Heart Failure
( ) Depression
( ) Diabetes
( ) Deep Vein Thrombosis
( ) Eye Disease
( ) GI Disorders
( ) Gout
( ) Hearing Problems
( ) Heart Disease
( ) Hepatitis – Type _____
( ) High Blood Pressure
( ) Hyperlipidemia
( ) Kidney Disease
( ) Kidney Stones
( ) Neuromuscular Disease
( ) Neuropathy
( ) Peripheral Vascular Disease
( ) Retinopathy
( ) Sleep Apnea
( ) Stroke
( ) Thyroid
( ) UTI's
( ) Other _____

Patient Name_____

Surgical History – *Check ( ) if you have received the following procedures, and year performed*

Surgical Procedure	Year	Surgical Procedure	Year
( ) None		( ) Hernia Repair	_____
( ) Angioplasty	_____	( ) Hip Replacement	_____
( ) Angioplasty w/Stent	_____	( ) Knee Replacement	_____
( ) Appendectomy	_____	( ) LASIK	_____
( ) Arthroscopy Knee	_____	( ) Liver Biopsy	_____
( ) Back Surgery	_____	( ) Kidney Biopsy	_____
( ) CABG (Heart Bypass)	_____	( ) Pacemaker	_____
( ) Carpal Tunnel Release	_____	( ) Small Bowel Resection	_____
( ) Cataract Extraction	_____	( ) Thyroidectomy	_____
( ) Cholecystectomy	_____	( ) Tonsillectomy	_____
( ) Colostomy	_____	( ) Other	_____
( ) Gastric Bypass	_____	( ) Other	_____

HOSPITALIZATIONS

Type of hospitalization reason	Hospital	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IMMUNIZATION HISTORY- *check ( ) if you have received the following*

Immunization	Date/Year
( ) Influenza	_____
( ) Pneumonia	_____
( ) Hepatitis	_____
( ) Tetanus	_____
( ) Chickenpox	_____
( ) MMR (Measles, Mumps, Rubella)	_____

PERSONAL AND SOCIAL HISTORY

Occupation _____

Who do you live with _____

Do you have children _____

Patient Name_____

Do you drink alcohol? ☐Yes ☐No **If yes, How often?** _____

Recreational or street drug use? ☐Yes ☐No

Analgesic/Painkiller drug abuse? ☐Yes ☐No

Have you ever had a blood transfusion? ☐Yes ☐No

Current Smoking Status ☐Current Every Day Smoker ☐Current Some Day Smoker ☐Heavy Smoker (11 or more cigarettes/day)

☐Light Smoker (less than 11 cigarettes/day) ☐Former Smoker ☐Never Smoker

☐Smoking Status Unknown

Quantity _____/per _____

Start date _____Quit date _____

Do you have a **Surrogate Decision Maker**? ☐Yes ☐No If yes, Who _____

Do you have a **Documented Advanced Care Plan**? ☐Yes ☐No If yes, please provide a copy to the office

Do you have a **DNR or Living Will**? ☐Yes ☐No If yes, please provide a copy to the office

Do you have a **Durable Power of Attorney or health care proxy**? ☐Yes ☐No If yes, please provide a copy to the office

***Surrogate Decision Maker: A surrogate decision maker, also known as a healthcare proxy or an agent, is an advocate for your healthcare if you become incapacitated.**

If you are unable to make decisions or decide on your health care, someone else must provide direction in decision-making, as the surrogate decision maker.

FAMILY HEALTH HISTORY- check ( ) if any family member(s) has had any of the following conditions

	No History	Father	Mother	Brother	Sister	Son	Daughter	Other
Anemia	( )	( )	( )	( )	( )	( )	( )	( )
CAD	( )	( )	( )	( )	( )	( )	( )	( )
Cancer- Type _____	( )	( )	( )	( )	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )	( )	( )	( )	( )
Heart Disease	( )	( )	( )	( )	( )	( )	( )	( )
Hyperlipidemia	( )	( )	( )	( )	( )	( )	( )	( )
Hypertension	( )	( )	( )	( )	( )	( )	( )	( )
Kidney Disease	( )	( )	( )	( )	( )	( )	( )	( )
Kidney Stones	( )	( )	( )	( )	( )	( )	( )	( )
Stroke	( )	( )	( )	( )	( )	( )	( )	( )

NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document a patient's acknowledgement of receipt of our Privacy Practices, or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

PATIENT NAME: _____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

☐ I acknowledge that I received the Privacy Practices Notice of this health care provider.

(Please sign in the space indicated below)

TO THE TEAMMATE: Please complete the following if the patient is unable to sign/refuses to sign.

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

☐ The individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

Please provide an explanation of the patient's refusal and inability to sign: _____

_____

☐ Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are therefore not required to obtain an acknowledgement.

THIS FORM HAS BEEN SIGNED BY: (please check one)

☐ PATIENT

☐ PATIENT'S REPRESENTATIVE

☐ TEAMMATE

I attest that the above information is correct.

_____ _____

Signature Date

_____

Printed name

_____

Witness signature

SOUTHERN KIDNEY CARE

PERMISSION TO DISCUSS HEALTH INFORMATION WITH OTHER INDIVIDUALS

Purpose: The purpose of this document is to provide permission for Southern Kidney Care to discuss your healthcare with the other people listed on the form as it relates to their involvement in your care. You must provide the names, relationships and numbers of those individuals you wish to be on the form, and you can update or revoke it at any time. If you wish for us not to speak with any individuals, please do not complete the form.

Instructions:

1. Write the name of the family members or other individuals who are involved in the patient's health care, and have the patient or the patient's Representative sign and date the form.
2. If the patient's Representative is signing the form on behalf of the patient, the Representative must also sign and date the acknowledgement that he or she has the legal authority to do so.

INDIVIDUALS TO WHOM SOUTHERN KIDNEY CARE MAY DISCLOSE MY PHI FOR COORDINATION OF CARE PURPOSES.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

NAME **RELATIONSHIP** **PHONE NUMBER**

_____

_____

_____

1. I understand that if I do not list anyone and I am not present or am incapacitated, Southern Kidney Care may share my information with family, friends, or others that Southern Kidney Care has determined, based on professional judgment, is in my best interest and necessary for coordination of care and/or payment for health care services I have received from Southern Kidney Care.
2. I understand that I may revoke or change the list of people with whom my provider may share my information by notifying the facility in writing.
3. I understand that a revocation is not effective to the extent that any person or entity has acted in reliance on my authorization.
4. I understand that information used or disclosed under this authorization may no longer be protected by federal or state law.
5. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on signing this authorization.

Signature of Patient or Legal Representative. Date of Signature

_____

If the patient is a minor. Signature of Legal Guardian/Representative Date of Signature

_____

FINANCIAL POLICY
(PRIVATE INSURANCE AND SELF-PAY PATIENTS)

PATIENT NAME: _____DOB:_____
Please Print

Any healthcare insurance policy that you may have is a contract between you and your insurance company and/or employer. Southern Kidney Care will assist you in obtaining payment from any healthcare insurance policy for medical services and goods that you receive at our practice; however, you remain primarily responsible to pay for medical services and goods rendered from Southern Kidney Care.

OUR FINANCIAL POLICY
(please initial each box)

_____ **You are responsible for any and all applicable co-payments, coinsurance, and unmet deductibles.** It is the patient's responsibility to provide us with current insurance information at each visit. According to your insurance, payment is expected at the time of your visit.

_____ **Payment is due when services are provided.** Southern Kidney Care requires that all applicable co-payments, coinsurance, deductibles, and any past-due amounts on the account be paid on the date of the visit. If you are not covered by a healthcare plan, full payment is required on the date of the visit.

_____ **Assignment of Benefits.** I hereby assign Southern Kidney Care any insurance or other third-party benefits available for healthcare services provided to me. I understand that Southern Kidney Care has the right to refuse or accept the assignment of such benefits.

_____ **Payment Methods and Returned Check Fee.** Southern Kidney Care accepts MasterCard/Visa, personal checks, and cash. If the bank returns your check due to non-sufficient funds you will be charged a $25.00 service charge which will be due, along with the amount of the returned check, within 3 business days.

_____ **Prompt Payment of Mailed Invoices.** In the event that you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 14 days.

_____ **Non-covered Services.** While the filing of insurance claims is a courtesy that we extend to our patients, not all services provided by Southern Kidney Care may be covered by every healthcare plan. Any service determined not to be covered by your plan will be your responsibility.

ACKNOWLEDGEMENT

I HAVE READ AND UNDERSTAND the Financial Policy of Southern Kidney Care and agree to be bound by it. I understand that healthcare insurance does not cover all medical goods and services and my responsibilities with respect to healthcare insurance as explained above. I understand that I am ultimately responsible for payment for medical goods and services provided to me by Southern Kidney Care. I hereby grant Southern Kidney Care the right to bill and collect from my healthcare insurance plan for medical goods and services provided to me. ***If the patient is a minor (younger than 18 years old), the parent or guardian must sign below.***

X_____ _____
Responsible party/Guarantor Printed Name — Relationship

X_____ _____
Responsible party/Guarantor Signature — Date