David L. Tharpe, M.D.
Thomas W. Ozbirn, Jr., D.O.
Roman R. Brantley, Jr., M.D.
James L. Lewis, M.D.
John R. Brouillette, M.D.
Jeffrey H. Glaze, M.D.
Harold E. Giles, M.D.
Agata M. Przekwas, M.D.
Thomas H. Watson, M.D.
William D. Lyndon, M.D.
Michael B. Hovater, M.D.
Benjamin R. Broome, M.D.
Phillip N. Madonia, M.D.
Timothy A. Williams, M.D.
Theodore S. Feely, M.D.
James C. Harms, M.D.

Phone: (205)226-5900
Fax: (205)226-5937

Alabaster
644 2nd Street N.E., Suite 201
Alabaster, Alabama 35007

Anniston
1430 Christine Ave
Anniston, Alabama 36207

Bessemer
995 9th Avenue S.W., Suite 407
Bessemer, Alabama 35022

Birmingham
817 Princeton Avenue S.W., Suite 206
Birmingham, Alabama 35211

Centreville
405 Belcher Street
Centreville, Alabama 35042

Clanton
2030 Lay Dam Road
Clanton, Alabama 35045

Gadsden
405 South 2nd Street
Gadsden, AL 35901

Gardendale
1603 Decatur Highway, Suite 150
Gardendale, Alabama 35071

Greystone/ St. Vincent's 119
7191 Cahaba Valley Road
Hoover, Alabama 35242

Homewood
2700 Rogers Drive, Suite 102
Homewood, Alabama 35209

Jasper
3400 Highway 78 East, Suite 401
Jasper, Alabama 35504

Oneonta
101 Lemley Drive, Suite A
Oneonta, Alabama, 35121

Pell City
7063 Veterans Parkway, Suite 130
Pell City, Alabama 35125

Trussville
7201 Happy Hollow Road
Trussville, Alabama 35173

Toll Free 1-800-489-9031
email: mail@nephrologypc.com

NAP C NEPHROLOGY ASSOCIATES, P.C.

Dear _____,

Welcome to **Nephrology Associates, P.C.** We are honored you have chosen to partner with us in your care.

Your appointment is scheduled with:

Dr. _____

at our _____ office

on _____.

Please complete the forms in this packet and bring them with you on your appointment day. Have your **list of medications filled out completely**, including the strength and how often you take the medicine. If for any reason you are unable to complete the items listed above, please call our office so that we may assist you.

If you are covered by an insurance carrier that requires a referral, please contact your primary care physician prior to your visit. You cannot see the physician without a referral from your primary care physician.

After your initial new patient visit, your physician may occasionally request that you see our Certified Registered Nurse Practitioners. Please notify our staff if your insurance does not cover physician extenders.

IF YOU DO NOT HAVE INSURANCE, OR HAVE A COPAY, payment is due at time of your visit. For your convenience we accept cash, check, American Express, Visa, Discover, or MasterCard.

THERE IS ONE PHONE NUMBER FOR ALL LOCATIONS AND PHYSICIANS, 205-226-5900 OR TOLL FREE 1-800-489-9031.

Nephrology Associates, P.C. complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Again, thank you for choosing Nephrology Associates, P.C. We look forward to seeing you soon.

Terry Black
Practice Administrator

Date: ____/____/____

Age: ____

PATIENT INFORMATION

Patient Name: Last ____ First ____ Middle ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____ Cell Phone: ____

Sex: ____ Race: ____ Ethnicity: ____ Preferred Language: ____ Birth Date: ____

Retired: ____ Employed: ____ Full time student: ____ Part time student: ____ Marital Status: ____

Employer: ____ Phone: ____

Social Security: ____ Drivers License: ____

Person responsible for account: ____ Relationship: ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Employer: ____ Phone: ____

Social Security: ____ Drivers License: ____

Spouse's Name: ____ Employer: ____ Phone: ____

Person to notify in case of emergency: ____ Phone: ____
(Outside Your Home) (Other Than Your Number)

IF YOU ARE INSURED BY MEDICARE PLEASE SIGN THE FOLLOWING: EXTENDED PATIENT SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Nephrology Associates, P.C. for any services or items furnished me by that physician. I authorize any holder of medical information about me to release any information needed to determine their benefits payable for related services.

____ ____/____/____
Signature of beneficiary or person signing for beneficiary Date signed

IF YOU ARE INSURED BY AN INSURANCE COMPANY REQUIRING A REFERRAL - YOU MUST CONTACT YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT.

INSURANCE POLICY INFORMATION

Insurance Company (Primary): ____

Policy holder's name: ____ Birthdate: ____/____/____

Employer: ____

Contract or group: ____

Relationship of patient to policy holder: ____

Insurance Company (Secondary): ____

Policy holder's name: ____ Birthdate: ____/____/____

Employer: ____

Contract or group: ____

Relationship of patient to policy holder:

Referred by: ____

CONSENT FOR TREATMENT: - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize Nephrology Associates, P.C. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Nephrology Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Nephrology Associates, P.C. charges for these services. I understand that I am financially responsible to Nephrology Associates, P.C. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Nephrology Associates, P.C. I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE: ____ DATE: ____

CONTINUED ON REVERSE SIDE

TO BE COMPLETED BY BENEFICIARY OR AGENT - Directions For Payment of Benefits And Release of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to

Dr. _____ or to _____ (the Supplier) for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to

_____ for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP insurer)

_____ for any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary or person signing for Beneficiary ***Date Signed***

Address of Person Signing for Beneficiary *(Street, City, State, Zip Code)*	Relationship of Agent to Beneficiary

Reason Beneficiary is Unable to Sign

PERSONAL AND MEDICAL HISTORY

NAME: _____ DATE: _____

AGE: _____ PHONE #'S- HOME: _____ CELL: _____ WORK: _____

DATE OF BIRTH: _____ REFERRING PHYSICIAN: _____

REASON REFERRED TO KIDNEY DOCTOR: _____

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY

MEDICATION ALLERGIES: _____

DO YOU TAKE OVER THE COUNTER MEDICATIONS? _____

HAVE YOU EVER BEEN ON DIALYSIS? _____

HAVE YOU EVER HAD A KIDNEY BIOPSY? _____

HAVE YOU EVER BEEN HOSPITALIZED FOR OTHER THAN SURGERIES? _____

_____

PFSH/ROS DATA WIZARD FORM

Name: *(Last, First, M.I.)*	☐ M ☐ F	**DOB:**

PAST MEDICAL HISTORY – COMMON DISEASES

Do you have a personal history of any of the following?

Kidney Disease	☐ CKD Stage: 1 2 3 4 5 ☐ Transplant ☐ Cadaveric ☐ Living - Related ☐ Living - Unrelated	☐ Dialysis ☐ HD ☐ PD ☐ Polycystic Kidney Disease ☐ Acute Kidney Injury ☐ Glomerulonephritis
Diabetes	☐ Type 1 ☐ Type 2	☐ Type Unknown
High Blood Pressure	☐ Essential ☐ Renovascular	☐ White Coat Hypertension ☐ Conn's Syndrome
Ischemic Heart Disease	☐ Heart attack ☐ Angina ☐ Angioplasty	☐ Coronary Stent ☐ CABG (Coronary Artery Bypass Graft)
Cancer	☐ Lung ☐ Breast ☐ Prostate (male) ☐ Colon ☐ Melanoma ☐ Bladder	☐ Lymphoma ☐ Kidney ☐ Thyroid ☐ Leukemia ☐ Endometrial (female) ☐ Pancreatic
Stroke	☐ Stroke	
Gout	☐ Gout	

PAST MEDICAL HISTORY – ADDITIONAL CONDITIONS

Do you have a personal history of any of the following?

EENT	☐ Blindness ☐ Cataracts	☐ Hearing Problems ☐ Glaucoma
Cardiovascular	☐ Atrial Fibrillation ☐ Pacemaker ☐ High Cholesterol	☐ AICD (Cardiac Defibrillator) ☐ Valvular Heart Disease ☐ Congestive Heart Failure ☐ Mitral Valve Prolapse
Respiratory	☐ COPD ☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema	☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea

Gastrointestinal	☐ GERD (Gastric Reflux) ☐ Stomach/Bowel Ulcers ☐ Gall Bladder Disease ☐ Hepatitis	☐ Inflammatory Bowel Disease ☐ Irritable Bowel Syndrome ☐ Gluten Intolerance ☐ Lactose Intolerance
Genitourinary	☐ Enlarged Prostate(male) ☐ Kidney Stones	☐ Frequent UTIs (Urinary Tract Infections)
OB History	☐ Preeclampsia (female) ☐ Pregnancy Induced Hypertension (female)	☐ Gestational Diabetes (female) ☐ History of Complicated Pregnancy (female)
Musculoskeletal	☐ Osteoarthritis	☐ Osteoporosis
Neurological	☐ Multiple Sclerosis ☐ Seizures	☐ Parkinson's ☐ Dementia
Psychiatric	☐ Depression	☐ Anxiety Disorder
Endocrine	☐ Hypothyroidism ☐ Hyperparathyroidism	☐ Hyperthyroidism ☐ Adrenal Insufficiency
Hematology	☐ Anemia ☐ Sickle Cell Disease	☐ Sickle Cell Trait ☐ Blood Transfusion ☐ Thalassemia
Immuno/Allergy	☐ HIV ☐ AIDS	☐ Rheumatoid Arthritis ☐ Lupus

PAST MEDICAL HISTORY – SURGERY HISTORY

Have any of the following surgeries been performed on you?

☐ Appendectomy	☐ Hip Replacement	☐ Renal Transplant
☐ CABG	☐ Left ☐ Bilateral	☐ Thyroidectomy
☐ Carotid Endarterectomy	☐ Right	☐ Tonsillectomy
☐ Cataract Surgery	☐ Knee Replacement	☐ Valve Replacement
☐ D & C (female)	☐ Left ☐ Bilateral	☐ AV Fistula
☐ Gall Bladder Removal	☐ Right	☐ AV Graft
☐ Gastric Bypass	☐ Hysterectomy (female)	☐ PD Catheter
☐ Hemorrhoidectomy	☐ Prostatectomy (male)	☐ Other_____
☐ Hernia Repair	☐ Nephrectomy	

Other Health Problems Not Listed Above:

FAMILY HISTORY – ILLNESSES

Do the following family members have any of the following medical conditions?

Kidney Disease	☐ Father ☐ Mother	☐ Sibling ☐ Child
Diabetes	☐ Father ☐ Mother	☐ Sibling ☐ Child
High Blood Pressure	☐ Father ☐ Mother	☐ Sibling ☐ Child
Ischemic Heart Disease	☐ Father ☐ Mother	☐ Sibling ☐ Child
Cancer	☐ Father ☐ Mother	☐ Sibling ☐ Child
Stroke	☐ Father ☐ Mother	☐ Sibling ☐ Child
Gout	☐ Father ☐ Mother	☐ Sibling ☐ Child
ADPKD	☐ Father ☐ Mother	☐ Sibling ☐ Child
Dementia	☐ Father ☐ Mother	☐ Sibling ☐ Child

FAMILY HISTORY – STATUS

Father	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:_____ ☐ Cause of Death:_____
Mother	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:_____ ☐ Cause of Death:_____

Other Family History Not Listed Above:

SOCIAL HISTORY – GENERAL

Current Marital Status	☐ Married ☐ Separated ☐ Single	☐ Widowed ☐ Divorced
Living Arrangement	☐ Alone ☐ Family Member ☐ Spouse	☐ In Home Caregiver ☐ Significant Other ☐ Assisted Living Facility
Occupation	☐ Retired ☐ Unemployed ☐ Employed ☐ Full - time ☐ Part - time ☐ Student List your Current or Former Occupation:_____	
Functional/ Cognitive	☐ No Impairment ☐ Hearing Loss ☐ Limited Mobility	☐ Memory Deficit ☐ Poor Vision or Blindness ☐ Transportation Challenges
Advanced Care Planning	☐ Yes I have a Living Will	☐ No I do not have a Living Will

SOCIAL HISTORY – HABITS

Tobacco Use	☐ Current or Former User ☐ Cigarettes ☐ Chewing Tobacco ☐ Pipes ~~☐ Snuff~~ ☐ Cigars If a former user, what year did you quit?	☐ Never Used ☐ Unknown

	Complete the following section if you are a current or former cigarette user: How often do you currently smoke or how often did you smoke before you quit? ☐ Every Day ☐ Some Days ☐ Unknown How many packs per day do you currently smoke or how many packs per day did you smoke before you quit? _____ How many total years have you used cigarettes? _____	
Alcohol Use	☐ Current or Former User ☐ Never Used ☐ Occasional/Social ☐ 1-2 per Day ☐ 3 or more per Day If a former user, what year did you quit? _____	
Recreational Drug Use	☐ Current or Former User ☐ Marijuana ☐ Amphetamines ☐ LSD ☐ Heroin ☐ Ecstasy ☐ Never Used If a former user, what year did you quit? _____	☐ Opium ☐ Cocaine ☐ Barbiturates ☐ Other _____

Other Social History Not Listed Above:

REVIEW OF SYSTEMS

Constitutional	☐ Fever ☐ Weight Gain ☐ Weight Loss	☐ Fatigue ☐ Chills ☐ Weakness
HEENT	☐ Vision Impaired ☐ Eye Pain ☐ Redness ☐ Color Blindness ☐ Double Vision ☐ Hearing Loss ☐ Ear Pain	☐ Sinus Problems ☐ Sore Throat ☐ Nose Bleeds ☐ Headache ☐ Hoarseness ☐ Tinnitus ☐ Vertigo
Respiratory	☐ Shortness of Breath ☐ At Rest ☐ With Activity ☐ Pain with Breathing	☐ Cough ☐ Wheezing ☐ Blood in Sputum ☐ Night Sweats
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Claudication	☐ Orthopnea ☐ Edema ☐ PND (Paroxysmal Nocturnal Dyspnea)
Gastrointestinal	☐ Abdominal Pain ☐ Nausea ☐ Diarrhea ☐ Heartburn ☐ Vomiting	☐ Constipation ☐ Anorexia ☐ Trouble Swallowing ☐ Indigestion
Genitourinary	☐ Urinary Urgency ☐ Urinary Burning or Pain ☐ Blood in Urine ☐ Urinary Frequency	☐ Urinary Hesitancy ☐ Foamy Urine ☐ Incontinence ☐ Nocturia
Musculoskeletal	☐ Back Pain ☐ Neck Pain ☐ Joint Pain ☐ Muscle Pain ☐ Arm Weakness ☐ Left ☐ Right ☐ Both	☐ Leg Weakness ☐ Left ☐ Right ☐ Both
Skin	☐ Rash ☐ Itching ☐ Scaling	☐ Dryness ☐ Color Change

Neurological	☐ Numbness ☐ Tremors ☐ Seizures	☐ Tingling ☐ Fainting
Psychiatric	☐ Depression ☐ Insomnia	☐ Anxiety
Endocrine	☐ Heat Intolerance ☐ Cold Intolerance	☐ Excessive Thirst ☐ Excessive Urination
Hematology	☐ Bleeding Gums	☐ Easy Bruising
Immuno/Allergy	☐ Seasonal Allergies	☐ Hives

Other Review of Systems Not Listed Above:

NEPHROLOGY ASSOCIATES, P.C.

PATIENT CONTACT INFORMATION SHEET

PATIENT NAME: _____

PATIENT SOCIAL SECURITY NUMBER: _____

Any physician, staff, employee or representative of Nephrology Associates, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Nephrology Associates, P. C. or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

PATIENT SIGNATURE: _____ DATE: _____

_____ COPY OF PRIVACY PRACTICE GIVEN TO PATIENT

NEPHROLOGY ASSOCIATES, P.C.'S 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 IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny *your* request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice. Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Privacy Officer at (205)226-5925, 35 West Lakeshore Drive, Suite 200, Homewood, Al 35209.All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____

Patient or Patient's Personal Representative **Date**