Kidney Associates Inc
Registration Form

(Please Print)

Today Date:		Primary Care Provider:			
Patient Information					
Patient last name: First: Middle:		☐ Mr. ☐ Mrs.	☐ Miss. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Wid	
Is this your legal name? ☐ yes ☐ no	If not, what is your legal name?	Former name:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street Address:		Social Security no:		Phone Number:	
P.O. Box no:	City:	State:		Zip Code:	
Occupation:	Employer:	Employer Phone no:			
Chose Clinic because/Referred to clinic by(please check one box):	☐ Dr.	☐ Insurance plane	☐ Hospital		
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other	
Other family member seen here:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist)					
Person responsible for bill:	Birth date: / /	Address (if different):	Home Phone no:		
Is this person a patient here? ☐ Yes ☐ No					
Occupation:	Employer:	Employer Address:	Employer Phone no:		
Is this person a patient covered by insurance ? ☐ Yes ☐ No					
Please indicate primary insurance:	☐ Medicare	☐ Medicaid	☐ Aetna	☐ Blue Cross	☐ Cigna
☐ UHC:	☐ Care Improvement:	☐	☐	☐ Other	
Subscriber's name:	Subscriber's S.S.no.:	Birth date: / /	Group no:	Policy no:	Co-payment:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ child	☐ Other	
Name of secondary Insurance(If applicable):	Subscriber's name:	Group no:	Policy no:		
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ child	☐ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative(not living at same address):	Relationship to patient:	Home phone no:	Work phone no:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Kidney Associates Inc. I understand that i am financially responsible for any balance. I also authorize Kidney Associates and Insurance company to release any information required to process my claims.

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Patient/Guardian signature **Date:**

Kidney Associates Medical History Form
Please complete entirely and bring to appointment

Name: _____ Date of Birth: _____
Address: _____Social Security #_____
Phone #_____Cell phone # _____
Emergency Contact Name: _____Phone #_____
Referring Physician: _____ Primary Care Physician: _____
Other Specialty Physicians: _____

Past Medical History:

Medical Conditions	Yes	No	Onset	Physician treating Condition
Anemia (low blood count)				
Diabetes (sugar)				
Diabetes affecting nerves				
Diabetes affecting eyes				
Diabetes affecting organs				
High Blood Pressure				
Heart Attack				
Irregular Heart Rhythm				
Congestive Heart Failure				
High Cholesterol				
Stroke				
Peripheral Vascular Disease				
Kidney Disease				
Kidney Failure				
Kidney Stones				
Kidney Infections				
Bladder Infections				
Lung Disease				
Liver Disease				
Emphysema/COPD/Sleep Apnea				
Arthritis				
Cancer				
If yes which type of Cancer?				
Did you receive radiation or chemo?				

Please list any medical conditions not listed above: _____
_____
Do you use any nonsteroidal medications such as Celebrex, Mobic, Indocin, Aleve, Motrin, or ibuprofen?
If yes, please list medication and how often it is taken _____
When was the last time the medication was taken? _____

Surgical History:
Please list all surgeries: _____
_____
_____
_____

Please list any hospitalizations, ultrasounds or CT scans that have occurred within the past year, please include the location._____
_____
_____
_____

Social History:
Marital Status: _____ Occupation: _____

Do you currently or have previously used tobacco products? Yes or No
Which type of tobacco products do you use and how often do you use them?
_____
How many years have you used tobacco products? _____
If you are a former tobacco product user, when did you quit? _____
Do you use alcohol? Yes or No
How much alcohol do you consume and how often? _____
Do you consume caffeine? Yes or No
How much caffeine do you consume on a daily basis? _____

Family History:

Family Member	Age	Living	Deceased	Medical History
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Do you have any family members with kidney disease or on dialysis? Yes or No

Please list all prescribed medications, over-the-counter medications and supplements

Medication	Dose	How many times a day	Prescribing Doctor

Please list all medication allergies and the type of reaction: _____
_____
_____

Pharmacies:
Local pharmacy: _____
Mail order pharmacy: _____

Please remember to bring your insurance cards along to your appointment.

Kidney Associates Inc

661 South Trimble Road, Mansfield, Ohio 44906

Mohan R. Kamadana, MD
Suresh Vadada, M.D
Swapna Kamadana, M.D.

Ravindra Pawar, M.D.
Jackson Liu, M.D.

Thank you for choosing us as your healthcare provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

PLEASE UNDERSTAND THAT PAYMENT IS DUE AT THE TIME.OF SERVICE.

Understanding your bill

When you receive your bill, you will have the name of the physician whom treated you. Bills for physician services are separate from bills you will receive for any services performed outside our office.

Regarding Insurance

WE DO REQUIRE YOUR CO-PAYMENT, DEDUCTIBLES AND ANY CO-INSURANCES BE PAID AT THE TIME SERVICES ARE RENDERED. IF YOU ARE UNABLE TO PAY AT THE TIME SERVICES ARE RENDERED, YOU MAYBE REQUIRED TO RESCHEDULE YOUR APPOINTMENT IF OTHER ARRANGEMENTS HAVE NOT BEEN MADE WITH THE BILLING DEPARTMENT. It is your responsibility to provide us with complete and accurate insurance information. If you are a member of a managed healthcare system or an HMO (Health Maintenance Organization), such as Aetna, Blue Cross Blue Shield IMO or POS, Cigna, etc., a referral is required from your primary care physician before we can see you. **IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL FROM THE PHYSICIAN or PRACTICE LISTED ON YOUR INSURANCE CARD**.

Uninsured Patients

Full payment is due at the time services are rendered. We accept your personal check, VISA and Master Card. If you are unable to pay the full amount of your bill, please ask to speak to someone in our billing department in order to make payment arrangements.

Other Policies

For any checks returned unpaid, your account will be charged a 30.00 service fee. We do not balance bill for any co pays. Co pays are to paid at the time services are rendered.

Billing Inquiries

When you have a question regarding your bill, you may call 419.774.0478 and ask to speak with a representative in the billing department.

I have read and agree to this financial policy. I understand that failure to follow this policy may result in delay of medical services.

DATE

PATIENT SIGNATURE

KIDNEY ASSOCIATES INC.

Mohan R. Kamadana, M.D. Ravindra Pawar, M.D.
Suresh Vadada, M.D. Jackson Liu, M.D.
Swapna Kamadana, M.D.

HIPAA PATIENT ACKNOWLEDGEMENT

ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement, but, in refusing, we will not be allowed to process your insurance claims

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Kidney Associates Inc. A copy of this signed, dated acknowledgement shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

_____ _____

Please print your name Please sign your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR

HEALTHCARE INFORMATION.

(This includes spouse, children, grandchildren, sister, brother, and any care takers who can have access to this your records)

Name\	Relationship
Name	Relationship
Name	Relationship

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- Cell phone Confirmation
- Home phone Confirmation
- Work phone Confirmation
- Email Confirmation
- U.S. Mail/Postcard

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Email message
- U.S. Mail/Postcard
- **Any of the above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS OR NEW HEALTHCARE INFO VIA:

- Phone Message
- Email
- U.S. Mail/Postcard
- **Any of the above**

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Formulary Benefits Data Consent

Formulary Benefits Data is maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

This consent will enable Kidney Associates Inc. and its clinical staff to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's plan allow electronic prescribing to Mail order pharmacies and if so, e-prescribe to these pharmacies.
- Download a historical list of all medications prescribed for a patient by any provider.

By signing below, I hereby give permission for the health care providers at Kidney Associates Inc. and its clinical staff to access my pharmacy benefits data, electronically, which includes information about other prescriptions prescribed by other providers using Pharmacy Benefits Mangers.

_____ _____

Patient Name (printed) Date of Birth

_____

Patient Signature

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Informed Consent to use Patient Portal

Kidney Associates Inc., is offering a secure, HIPAA compliant communication tool as a courtesy to our patients. It is an optional service, and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly a possible. This form is intended to inform you of the facts and risks surrounding the use of the patient portal. By signing below, you confirm that you have read, understand and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Kidney Associates Inc, or any of their staff liable for network infractions beyond their control.

Privacy and Security

The Patient Portal has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons form being able to access and read your health information or your communication to us. To help insure that the tunnel remains secure, we need to have your current email address and be informed if it ever changes. Keep your portal user ID and password secured so you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to the portal site and change it.

Your email address is confidential and protected information and with our best effort, we will protect this information as we do your medical and other personal information. We will never purposefully share this information with any third party. All access to our internal network and electronic medical records (EMR) is password protected. Our staff are instructed to log off their workstations when not physically present. Additionally, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity.

Similar to phone communications, messages may be read and addressed by different NNC staff. When your provider is ill or on vacation, your emails will be addressed by a covering physician.

Patient Name _____ Date of Birth _____

Patient Signature _____

Confidential email, please print clearly:

_____(your portal login will go to this email address)