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Kidney Disease & Hypertension Centers, P.A.
Nephrology

Tracy B. Pittman, MD
Hristo S. Shivarov, MD
12 Marks Road • Ocean Springs, MS 39564
Phone (228) 872-6329 • Fax (228) 872-2909

Date: _____

Name: _____ Birthdate: _____
Last First Middle Initial (Jr. Sr. II)

Address: _____City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Email Address: _____ Social Security #: _____

Ethnicity: Caucasian Black Asian Hispanic Native American Other: _____

Gender: Male Female Marital Status: S M D W Preferred Language: English Spanish Other: _____

Check One: ____ Employed ____ Retired ____ Full Time Student ____ Disabled ____ Other

Employer Name: _____ Employer Phone Number: _____

Spouse/Partner: _____ Phone # _____

Pharmacy Name: _____Phone # _____

Primary Care Physician: _____ Phone #_____

In case of emergency, please notify (must have another phone number different from you):

Name: _____Phone _____Relation: _____

Name: _____Phone _____Relation: _____

Name:_____Phone: _____ Relation: _____

Insurance Information (PLEASE PROVIDE INSURANCE CARDS AND PHOTO ID AT CHECK-IN)

Primary Ins. _____ Policy Holder _____

If policy holder is not the patient – Policy Holder's Date of birth _____ Relationship _____

Secondary Ins. _____ Policy Holder _____

If policy holder is not the patient – Policy Holder's Date of birth _____ Relationship _____

_____(**Patient initials**) Assignment of Insurance Benefits: I do hereby authorize payment of all insurance benefits, basic and major medical, to be made directly to Kidney Disease & Hypertension Centers, PA. for any services or items furnished to me. I authorize payment of Medicare benefits to be made on my behalf to the providers of Kidney Disease & Hypertension Centers, PA, for any services or items furnished to me. I authorize the release of my medical or other information about me to my insurance carrier or its agents or the Centers for Medicare and Medicaid Services and its agents to determine these benefits or the benefits payable for related services or items. I also agree to pay for services I receive that are not covered by my medical insurance as well as for any deductible or co-payment due at the time of service.

_____(**Patient initials**) I authorize that payment of Medigap benefits is made on my behalf to Kidney Disease & Hypertension Centers, PA, for any services furnished to me by the providers/physicians. I authorize any holder of medical information about me to be released to my insurer any necessary information to determine these or the benefits payable.

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Consent/Authorizations

_____ (Patient initials) I have received a brochure of the practice's Notice of Privacy Practice before signing this consent. KDHC reserves the right to revise its Notice of Privacy Practices at any time. Revised NPP brochure copies are available at both locations in the lobbies and are free to the public and are also on our website https://kidneydiseasems.com/**. A revised NPP may also be obtained by forwarding a written request to KDHC, Privacy Officer at 2712 Criswell Ave. Pascagoula, MS 39567**

With my consent, Kidney Disease & Hypertension Centers, PA, may share my protected health information (PHI) with the following individuals:

Name:_____Phone: _____ Relation: _____

Name:_____Phone: _____ Relation: _____

Name:_____Phone: _____ Relation: _____

Consent to Text Messaging and/or Email for Appointment Reminders and Other Healthcare Communications:

We now have the ability to email and/or text you regarding various functionalities of our healthcare record system. If you would like to receive this such notifications, please read the consent below and sign.

Patients in our practice may be contacted via text messaging and/or email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information

I consent to receive appointment reminders and other healthcare communications/information from KDHC. I understand that this consent includes an authorization for the communication of Protected Health Information via text message and/or email.

_____ (***Patient initials***) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number.

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is

(_____) _____ - _____ Carrier: _____

_____ (**Patient initials**) I consent to receive e-mails from the practice at my e-mail address.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

-I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Please sign below. Your signature is your acknowledgment/agreement to all the above items under the section: Consent/Authorizations

Patient's Signature: _____Date:_____

Witness: _____ Date: _____

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Patient Financial Policy

As your health care provider, we are committed to giving you the best possible medical care. Your clear understanding of our Patient Financial Policy is essential to our professional relationship. We must work together for you to receive your full benefits and for us to be paid fairly for our services. Please look over the information and return this form with your signature and today's date. Please feel free to ask any questions about our fees, policies, or your responsibilities.

Please understand that your insurance information will need to be verified with the receptionist at every visit.

Please be sure to let us know of any patient information changes (i.e., address, name, insurance, contacts & phone number #).

Referrals: If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician. A referral should be requested from your primary care physician's office before your appointment. If you are a Veteran and intend on using your VA benefit to pay for services at KDHC, it is your responsibility to notify our office of this when your appointment is made. If not and a referral has not been obtained, you will be responsible for the bill.

Insurance: We participate in most insurance plans, including Medicare & Medicaid. If you are not insured by a plan we accept, arrangements **must** be made before your appointment (see uninsured/self-pay below). If you cannot provide proof of insurance, you will be expected to pay $100.00 for your first visit at the time of service, $50.00 for each visit after that. **Knowing your insurance plan is your responsibility.**

Copays/Coinsurance: Copays/Co-ins are generated from hospital admissions, treatment @ DaVita Dialysis Centers, and office visits at KDHC clinic facilities. The copay/co-ins are a legally binding contract that you, as well as Kidney Disease & Hypertension Centers, PA, have with your healthcare insurance provider. Your copay/co-ins must be paid before you see your provider on the day services are rendered. If you have a balance from a hospital admission or DaVita facility treatment, you can call before your appointment to make arrangements for theses balances.

Payments: We accept payments by cash, check, VISA, MasterCard, and some local community financial assistance voucher programs. We also accept payments on our website https://kidneydiseasems.com.

NSF Fee: There will be a $35.00 charge for checks returned due to Non-Sufficient Funds. If you have extenuating circumstances, please call our Patient Account Specialist.

Uninsured/Self Pay: If you do not have insurance, you will be expected to pay $50.00 at the time of each visit. Our Patient Account Specialist will also meet with you or speak with you by phone to establish a payment plan for any remaining account balances.

Hardship Application: Kidney Disease & Hypertension Centers, PA, offers a Hardship Application for patients that meet federal poverty income requirements, which can provide patients with an opportunity for a sliding scale reduction or wholly written off based on income requirements. Please speak with our Patient Account Specialist for more information.

Nonpayment: As a courtesy, KDHC sends a monthly statement to our patients. After you have received three statements and one letter, your account will be 120 days past due. At 120 days, your account will be placed in collection status and reported to the credit bureau. Please, we encourage you to contact our Patient Account Specialist so that we can avoid any adverse action.

By signing below, I acknowledge that I understand and accept the above terms.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

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Patient Consent for Treatment

I acknowledge that I may be or have been diagnosed with a condition that requires medical treatment or further diagnostic evaluation. I do hereby voluntarily consent to the rendering of such medical treatment. Including, but not limited to diagnostic procedures, hospital care, examinations, and treatment as are necessary and appropriate in the judgment of the provider(s) in charge of my care.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me in the results of examination or treatment in the office or hospital/dialysis facility. I understand that my provider(s) will explain the most common risk of treatment and available alternatives, but that it is not possibile to list each and every possible risk or outcome of a particular treatment. If I have any questions or concerns regarging my condition or medical treatment after my providers(s) have explained my condition or medical treatment to me, I will ask my provider(s) for additional information.

I hereby authorize Kidney Disease & Hypertension Centers, PA, to retain or dispose of any specimens that may be taken during examination treatment.

Authorization to release medical information

I give permission to Kidney Disease & Hypertension Centers, PA, to submit full medical records, within discretion, to my Insurance companies if they so request and to other providers that I am consulting if they so request.

Signature_____ Date_____

Print_____ DOB_____

Wittness_____ Date_____

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Medical History Form

Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ Phone #: _____

Referring Physician: _____ Pharmacy: _____

Personal Medical History - (List your medical problems, past & present)

Examples – diabetes, hypertension, High Cholesterol, Heart Issues (CHF), Heart Attack, Stroke, Gout, Cancer, Swelling in feet & ankles

	CURRENT		CURRENT
1.	**yes no**	**7.**	**yes no**
2.	**yes no**	**8.**	**yes no**
3.	**yes no**	**9.**	**yes no**
4.	**yes no**	**10.**	**yes no**
5.	**yes no**	**11.**	**yes no**
6.	**yes no**	**12.**	**yes no**

Family Medical History

List family member with these conditions	Mother, Father, grandparent	Sister, brother, son, daughter
High Blood Pressure or Diabetes		
Need for kidney dialysis or kidney transplant		
Kidney Disease, Stones, protein in urine, other abnormal urine tests, or conditions.		
Brain aneurysm or brain hemorrhage		
Other:		

Allergies

Medication/Substance	Reaction

Current Medication – (**Include all over the counter medicines like Tylenol, Advil, Motrin, Aleve, vitamins, supplements, etc.)**

BRING ALL YOUR MEDICATIONS TO YOUR APPOINTMENT!

1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**
5.	**11.**
6.	**12.**

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Renal History

Have you ever had a kidney problem other than your current condition?	**Yes**	**No**
Have you ever been told that you have chronic kidney disease?	**Yes**	**No**
Blood or protein in the urine?	**Yes**	**No**
Passing stones or tissue in your urine?	**Yes**	**No**
Red, black, or Coca-Cola colored urine?	**Yes**	**No**
Frequent urinary tract infections?	**Yes**	**No**
Have you had unexplained any of the following? Circle the items that are YES **RASH ● JOINT SWELLING ● FEVER ● ABDOMINAL PAIN ● CHEST PAIN ● WEIGHT GAIN or LOSS**	**Yes**	**No**

Review of Systems – (Please mark Yes – Y, No – N if you have any of the following symptoms)

General, Mental Health	Y	N	Abdomen	Y	N	Heart	Y	N
Fever			Nausea			Chest Pain		
Sweats			Vomiting			Skipping heartbeats		
Tried or weak			Abdominal Pain			Shortness of breath		
Unexplained Weight gain or loss			Diarrhea			Leg swelling		
Loss of Appetite			Constipation			Swelling around the eyes		
Depression, feeling down			Bloody or Black Stool					
Anxiety								
Head, Neck, & Lungs			**Urinary**			**Skin, Joints, & Neurological**		
Sinus problems			Feeling of not emptying Bladder completely			Rash		
Bloody nose			Pain with urination			Hot, red, or swollen joints		
Cough			Blood in urine			Lightheadedness or dizziness		
Sputum production			Foamy urine			Numbness or tingling in feet		
			Smelly urine			Numbness or tingling in hands		
						Muscle twitching		
Other:								

Social History

Marital Status M W D S **Occupation** _____ **Employed** _____ **Retired** _____ Date

Non-smoker (never-smoked) _____ **Ex-smoker (yr. quit)** _____ **Current Smoker** _____ **cigarettes/day** ____

Drink alcohol? __ Daily __ Weekly ___ Occasionally ___ Never **Drug Use**? __ Daily __ Weekly __ Occasionally __ Never

Race _____ **Living Arrangement** (circle) – Spouse ● Alone ● Family Member ● Assisted Facility/Nursing

History of Present Illness – Please give a brief description of the history and reason you were referred to our nephrology practice.

_____

_____

_____

_____