Athens Limestone Nephrology Associates

1005 W Market St * Suite 16 * Athens, AL 35611
Phone (256) 232-0801 Fax (256) 262-5717

Kunal Bhuta, MD

Thank you for choosing Athens Limestone Nephrology Associates for your medical needs. Please complete the enclosed paperwork and return it to our office as soon as possible to be reviewed and approved by the physician. We will request your medical records from your previous physician (if needed). The office will contact you regarding your request for an appointment.

Please arrive 10 - 15 minutes before your scheduled appointment time and bring your driver's license and all insurance cards. Please bring any medications that you are currently taking (prescription or over the counter), always bring the actual bottles with you.

We look forward to seeing you!
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WELCOME TO OUR PRACTICE!

We are so very pleased that you have selected our clinic as your health care provider. Please complete the enclosed forms with your signature where indicated and return them before your appointment day.

APPOINTMENTS: First time patients are asked to arrive at least 10 minutes early to allow adequate time for completing the initial registration. For purposes of maintaining continuity of care, we ask that you request that your latest, relevant records with the most recent test results and current medication list be faxed to us prior to your visit. Alternatively, you may bring those records with you to your first appointment. Your initial visit in establishing care with the doctor will consist of routine checking of vital signs and complete discussion of your medical history, medications you are currently taking, and health issues you may currently be experiencing. Once you are an established patient, we ask that you **have labs done 2-3 days before your appointment** so the doctor can go over the results with you in person.

WEB PORTAL: Most communications from the clinic will be sent through a secure online portal; so all patients are expected to register for the free service prior to their first appointment. You may submit refill requests, message clinic staff on non-urgent matters, and review your medical history including lab results through the portal. Registrations instructions are included with this packet.

INSURANCE: Our office participates in most insurance plans. If you are unsure about your insurance coverage, please call your insurance provider for clarification. Remember that your health coverage is a contract between you and your insurance company. We will assist you in getting full benefits from your insurance carrier. **Your co-payment must be collected at the time of your visit.** If you accrue an unpaid balance with no effort to pay, you will be denied medical treatment from our office. We accept cash, checks (payable to Athens Limestone Nephrology Associates), Master Card, Visa, American Express, Discover and Debit Cards.

BILLING: Payment is expected at the time of service. If you do not have insurance coverage, please discuss financial options with the office staff prior to your visit. As a courtesy, if we accept your insurance, a statement will not be issued until after your insurance carrier has paid your allotted benefits. If your insurance carrier reimbursement is delinquent for 90 days, you may be asked to contact your insurance carrier. Please remember that any balance not covered by your insurance company is your responsibility to pay.

MEDICATIONS: We utilize electronic prescription writing for most medications and routine medication refills will be handled during scheduled appointments. Generally, when a routine prescription has no more refills remaining, this indicates that it is time for an appointment to review that particular condition for which the medication was prescribed. If a refill is necessary, please notify the clinic **at least 3 days prior to the need for refill** to allow time for the doctor to confirm the prescription details, review records and fill the medication appropriately and in a timely manner. Medication refills should preferentially be requested using the secure online portal (not calling the office). No antibiotics or narcotics will be prescribed without an examination; this is not considered good medical practice. Please bring ALL medications that you are taking with you to each appointment. This includes prescription as well as over-the-counter medications such as vitamins and aspirin. An up-to-date list of all medications is sufficient if all necessary information is on the list, such as medications strength, and quantity.

Hours: Our normal business hours are Monday-Thursday 8:00AM-4:30PM, excluding lunch from 12:00PM-1:00PM and Friday 8:00AM-12:00PM

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PATIENT INFORMATION:

Last Name_____ First Name_____ Middle_____

Male/Female_____ SS#_____ Marital Status_____

Date of Birth_____ Race_____ Ethnic Group_____

Primary Language Spoken _____

Street Address_____ City/State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Preferred Reminder Method_____

Employer_____ Retired___ Homemaker___ Disabled ___Unemployed___

Preferred Pharmacy_____

INSURANCE: _____ Contract # _____ Group # _____

Secondary Insurance _____ Contract # _____ Group # _____

EMERGENCY CONTACT:

Name_____ Phone_____ Relationship_____

RESPONSIBLE PARTY INFORMATION (If Not Self)

Full Name_____

Street Address_____ City/State_____ Zip_____

Home Phone _____Cell Phone_____ Work Phone _____

Date of Birth _____ Marital Status _____

SS# _____ Relationship _____

***How did you hear about us?**

___Source Magazine ___Facebook ___Friend/Family ___Billboard ___ Internet search
___Hospital Inpatient ___Other, Please specify_____

I hereby authorize and direct payment to Athens Limestone Nephrology Associates for medical benefits, if any, otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for the charges not covered by this authorization. I understand that checks returned for non-payment will incur a $30.00 fee. I hereby authorize Athens Limestone Nephrology Associates to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing claims for medical services. I understand that regardless of my insurance status, I am solely responsible for payment of any services rendered to me, or on my behalf, whether or not paid by my insurance company.

Patient/Responsible Party Signature_____

Date_____

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Patient Health Assessment

Name _____ Date of Birth _____

Please use ink pen and fill in all applicable areas. If you have any questions, please discuss with doctor or nurse at your initial visit.

Indicate special communication needs of which we should be aware

□ Vision □ Speech □ Learning Disability □ Hearing □ Language

Recent Immunizations

Indicate whether or not you have received the following immunizations. If yes, indicate approximate year received.

Yes	No		Yes	No	
□	□	Flu _____			
□	□	Hepatitis B _____	□	□	Chicken Pox _____
□	□	Pneumovax 23 _____	□	□	TB Skin Testing_____
□	□	Prevnar 13_____	□	□	T DAP_____
□	□	Tetanus (TD) _____	□	□	Meningitis_____

Nutrition

Yes No

□ □ Do you follow any special diet (diabetic, low protein, low sodium, low fat)? If yes, specify:

_____

□ □ Do you have any other nutrition needs (food preferences, food intolerance, texture modification)? If yes, explain:

_____

Life Habits

Yes No

□ □ Do you live alone? If no, with whom do you live? _____

□ □ Have you ever used nicotine? (Circle: Cigarettes, pipe, cigar) How much per day? _____ How many years? _____

□ □ Do you currently use nicotine? If yes, what do you use? (Circle: Cigarettes, pipe, cigar, smokeless tobacco, nicotine gum/patch?) How much per day? _____ For how many years? _____

□ □ Are you regularly exposed to secondhand smoke?

□ □ Do you currently use alcohol? If yes, how much per day? _____ How often? _____
Past use?_____

□ □ Do you currently use any illicit drugs? If yes, what? _____ How often?_____
Past use?_____

□ □ Are you currently exposed to occupational hazards?
If yes, what kind?_____

□ □ Do you have problems sleeping?
If yes, explain_____

□ □ Will you need help in planning for your care?_____

□ □ Do you walk independently? If not, explain_____

Do you need help with: Feeding □ Dressing □ Bathing □ Toileting □ If yes, explain _____

Domestic Violence

Yes No

□ □ Are you being abused, injured or frightened by anyone at home or in another area of your life?

Beliefs, Rights, and Values

Yes No

□ □ Do you have ethnic, religious, spiritual or cultural practices that need to be part of your care?

_____

□ □ Do you have financial concerns related to your medical care? Circle those that apply: job insurance other

□ □ Do you have children? How many? Adult_____ Minor_____

□ □ Do you have a guardian? If yes, whom?_____

□ □ Do you have an Advance Directive (e.g. living will or durable medical power of attorney)? If yes, please bring a copy with you to the office. If not, information is available upon request.

□ □ Are you an organ/tissue donor?

Athens Limestone Nephrology Associates – PAST MEDICAL HISTORY

Check the box if the condition pertains to you and write comments if necessary.

Cardiovascular

□ Arrhythmia _____
□ Angina _____
□ Atrial Fibrillation _____
□ CHF _____
□ Heart Disease _____
□ Heart Attack _____
□ High Blood Pressure _____
□ High Cholesterol _____
□ Pacemaker/Defibulator _____
□ Vascular Disease _____
□ Other _____

Respiratory

□ Asthma _____
□ COPD _____
□ Emphysema _____
□ Sleep Apnea _____
□ TB _____
□ Other _____

Gastrointestinal

□ Celiac Disease _____
□ Constipation _____
□ Diarrhea _____
□ Diverticulitis _____
□ Diverticulosis _____
□ GERD _____
□ Heartburn _____
□ Hepatitis _____
□ Hiatal Hernia _____
□ IBS _____
□ Other _____

Renal/Genitourinary

□ BPH _____
□ Endometriosis _____
□ Erectile Dysfunction _____
□ Kidney Stones _____
□ Polycystic Kidney Disease _____
□ Renal Failure _____
□ Urinary Incontinence _____
□ UTI, Recurrent _____
□ Other _____

Musculoskeletal

□ Arthritis _____
□ Chronic Pain _____
□ Fibromyalgia _____
□ Gout _____
□ Numbness/Weakness _____
□ Osteoarthritis _____
□ Osteoporosis _____
□ RA _____
□ Other _____

Endocrine

□ Addison Disease _____
□ Cushing Disease _____
□ Type I Diabetes _____
□ Type II Diabetes _____
□ Hyperthyroidism _____
□ Hypothyroidism _____
□ Other _____

Neurological

□ Alzheimer's Disease _____
□ ADD/ADHD _____
□ Dementia _____
□ Faint/Dizziness _____
□ Headache-Migraine _____
□ Headache-Tension _____
□ MS _____
□ Neuropathy _____
□ Seizures _____
□ Stroke _____
□ Cognitive Impairment _____
□ Other _____

Hematologic

□ Anemia _____
□ Hepatitis B _____
□ Hepatitis C _____
□ Iron Deficiency _____
□ Other _____

Allergy/Immunology/Dermatology

□ Allergies _____
□ Chicken Pox _____
□ Eczema _____
□ Sinus, frequent _____
□ Other _____

Ears/Nose/Throat

□ Vertigo/Dizziness _____
□ Hearing Loss _____
□ Otitis _____
□ Tinnitus _____
□ Other _____

Psychiatric

□ Anxiety _____
□ Depression _____
□ Bipolar Disorder _____
□ Schizophrenia _____
□ Personality Disorder _____
□ Substance Abuse _____
□ Panic Attacks _____
□ PTSD _____
□ Eating Disorder_____

Other Conditions

□ Insomnia _____
□ AIDS/HIV _____
□ Cancer _____
□ Cataracts _____
□ Glaucoma _____
□ Other _____

ALLERGIES

Check Appropriate Allergy, Then Write Specific Allergy / Reaction

- ❑ **NO KNOWN DRUG ALLERGIES**
- ❑ **FOOD:** _____
- ❑ **MEDICATIONS:** _____
- ❑ **OTHER:** _____

Previous Surgeries

Date: _____ Surgery_____
Date: _____ Surgery_____
Date: _____ Surgery_____
Date: _____ Surgery_____
Date: _____ Surgery_____
Date: _____ Surgery_____

Last:

Colonoscopy: _____ Mammogram: _____ Bone Density: _____
Pap Smear: _____ Eye Exam: _____ Dental Exam: _____

Please list all other Healthcare Providers you see:

Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____
Doctor: _____ Specialty: _____

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Patient's Name: _____ **Date of Birth:** _____

Family History (Complete Health Information about your family)

Disease	Family Member (Circle one)				
Alzheimer's / Dementia	Father	Mother	Sibling	Grandparent	Other: _____
Asthma, Hay Fever	Father	Mother	Sibling	Grandparent	Other: _____
Cancer, Type: _____	Father	Mother	Sibling	Grandparent	Other: _____
Cataracts	Father	Mother	Sibling	Grandparent	Other: _____
CHF	Father	Mother	Sibling	Grandparent	Other: _____
CVA / Stroke	Father	Mother	Sibling	Grandparent	Other: _____
COPD	Father	Mother	Sibling	Grandparent	Other: _____
Diabetes	Father	Mother	Sibling	Grandparent	Other: _____
GI Problems	Father	Mother	Sibling	Grandparent	Other: _____
Glaucoma	Father	Mother	Sibling	Grandparent	Other: _____
Heart Attack	Father	Mother	Sibling	Grandparent	Other: _____
Heart Bypass	Father	Mother	Sibling	Grandparent	Other: _____
Heart Disease	Father	Mother	Sibling	Grandparent	Other: _____
Heart Stent	Father	Mother	Sibling	Grandparent	Other: _____
Hyperlipidemia	Father	Mother	Sibling	Grandparent	Other: _____
Hypertension	Father	Mother	Sibling	Grandparent	Other: _____
Kidney Problems	Father	Mother	Sibling	Grandparent	Other: _____
Seizures	Father	Mother	Sibling	Grandparent	Other: _____
Thyroid Disease	Father	Mother	Sibling	Grandparent	Other: _____
Other: _____	Father	Mother	Sibling	Grandparent	Other: _____
Other: _____	Father	Mother	Sibling	Grandparent	Other: _____

List any other family history on the back of this form.

MEDICATIONS CURRENTLY IN USE

Medication Name Check here if NO MEDS ____	Dose	Frequency

List any additional medications on the back of this form.

Athens Limestone Nephrology Associates

Authorization to Disclose and/or Obtain Protected Health Information

Patient Name _____ Date of Birth _____ SS #XXX-XX-_____
Phone _____ Address_____
Date(s) of Service _____

I hereby authorize Athens Limestone Nephrology Associates to use, disclose, and/or obtain my health information as follows: (please check all that apply)

Disclose health information to: Athens Limestone Nephrology Associates
1005 W Market St STE 16
Athens, AL 35611
Phone: 256-232-0801 Fax: 256-262-5717

_____Obtain health information from: _____
(Patients check) (Name of Physician or Facility)

_____
(City/State)

Request for Records: ___ Chart Notes (ALL) _____
___ Labs ___Radiology (Phone Number)

_____
(Fax Number)

. 1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. For the purpose of to Obtain or Disclose and treat the patient.

3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

4. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:
_____.

5. I understand that once the information is obtained pursuant to this authorization, it may be disclosed by the recipient and the information may not be protected by federal privacy regulations.

6. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

7. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
   I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
   Treatment Enrollment in the health plan Eligibility for benefits

_____	_____	_____
SIGNATURE	DATE	TIME
_____	_____ _____	_____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS DATE	TIME

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature_____

Date_____

PATIENT RESPONSIBILITIES

As a patient of Athens Limestone Nephrology Associates, your responsibilities include:

- To provide, to the best of your knowledge, complete and accurate information about your present condition, past illnesses, hospitalizations, medications, and other matters relating to your health.
- To report unexpected changes in your condition.
- To follow instructions and adhere to your plan of care.
- To review all educational materials given to you.
- To report the presence of pain to your physicians and nurses.
- To ask appropriate questions when you don't understand.
- To cooperate with nurses, physicians, and others who participate in administering your care.
- To recognize that your own behavior and actions influence treatment outcomes.
- To recognize that other patients and clinic personnel also have rights.
- To act with consideration and respect toward other patients and clinic personnel.

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Inclement Weather Policy

In the event of inclement weather, please call our office to confirm if open or closed.

Appointment No-Show / Same Day Cancellation Policy

It is the policy of Athens Limestone Nephrology Associates to monitor and manage appointment no shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least twenty-four (24) hours prior to the scheduled time is considered a "no show." The first time a patient is a no show, the fee will be waived, however, the 2nd-4th occurrence will be charged a **$25.00** fee and a letter will be sent to the patient. Payment must be made before the next appointment can be scheduled. A patient who consistently fails to present themselves more than five (5) times will be dismissed from Athens Limestone Nephrology Associates.

It is the policy of Athens Limestone Nephrology Associates to monitor and manage appointments that are canceled the day of the appointment. If you receive 5 same day cancellations, you will be dismissed from Athens Limestone Nephrology Associates.

_____Please initial here

Medication Refill Policy

It is the responsibility of each patient to bring all of their medications, in the original bottles, to each visit. Lists of medicines are not acceptable due to possible error and lack of information. It is imperative to notify the nurse if there is a need for any refills **at the time of each visit**. Calling at a later time for refills may cause a delay in receiving your medications. Please allow at least **3 business days for medication refills that are requested by call in**.

_____Please initial here

Forms Requests There will be a $25 charge for certain forms that require the doctor to complete, such as FMLA and Short Term Disability. Please allow 5-7 business days to complete.

_____

Patient's Signature **Date**

Athens-Limestone Health Services

PATIENT RIGHTS

Welcome to Athens Limestone Nephrology Associates. We want to ensure that each patient at our clinic receives information regarding patient rights. We are committed to provide a standard of care that ensures our patients are safe from accidental injury. These rights are stated to publish our commitment that each patient will receive the best possible care that we can offer.

As a patient at Athens Limestone Nephrology Associates your rights include the following:

- The right of access to treatment regardless of race, age, creed, sex or national origin in a safe setting, free from abuse or harassment.
- The right to reasonable access to care and acceptance for treatment within the clinic's capacity or referral to another facility when medically appropriate.
- The right to care that is considerate and respectful of your personal values, culture and beliefs.
- The right to personal privacy and confidentiality of your personal health
- The right to appropriate assessment and management of pain.
- The right to access information contained in your clinical record within a reasonable time frame.
- The right to participate in decisions regarding your care, to be involved in planning your care and treatment, and to receive information necessary to give informed consent.
- The right to accept medical care and refuse medical treatment, as permitted by law, and to be informed of the medical consequences if refused.
- The right to formulate an Advance Directive, such as a Living Will. Information will be provided to you upon your request.
- The right to legally designate a representative decision maker in the event you are incapable of understanding a proposed treatment or procedure or are unable to communicate your wishes regarding your care and to have effective communication.
- The right to receive an itemized, detailed explanation of your bill for services and explanation of benefits paid by insurance.
- The right to voice complaints concerning the quality of care you receive without fear of reprisal, to have those complaints reviewed, according to our Patient Grievance Resolution Policy, and, when possible, resolved.

If you have a patient safety or quality care concern please contact one of the following:

1. **Joint Commission on Accreditation of Healthcare Organizations**
   Office of Quality Monitoring
   One Renaissance Boulevard
   Oakbrook Terrace, IL 60181
   (Fax) 630-792-5636
(Email) complaint@jcaho.org

2. **State of Alabama Dept of Public Health Hotline**
   1-800-356-9595 Monday-Friday 8 a.m. to 5 p.m.

3. **Athens Limestone Hospital Patient Safety Officer**
   Administration Telephone: 256-233-9119

4. **Centers for Medicare and Medicaid Services**
   7500 Security Blvd, Mail Stop S2-12-25
   Baltimore, MD 21244-1850