

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have reviewed Naples Nephrology's Privacy Practices Notice.

Further by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purpose of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Signature (Patient or Personal Representative)

Date

If personal representative's signature appears above, please print name below and describe relationship to the patient:

Name

Relationship

NEW PATIENT INFORMATION FORM

NAME _____

ADDRESS (LOCAL) _____

APT/UNIT # _____ CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ CELL: _____ WORK: _____

ALTERNATE ADDRESS _____

APT/UNIT # _____ CITY _____ STATE _____ ZIP _____

ALTERNATE ADDRESS PHONE _____

DATE OF BIRTH _____ SEX (CIRCLE) MALE FEMALE

SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

EMPLOYMENT STATUS (CIRCLE) FULL-TIME PART-TIME RETIRED UNEMPLOYED

EMERGENCY CONTACT (LOCAL)

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

NEXT OF KIN CONTACT (IF DIFFERENT THAN ABOVE)

NAME _____

RELATIONSHIP _____ PHONE _____

PRIMARY INSURANCE PROVIDER: _____

CLAIMS ADDRESS _____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO INSURED _____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE PROVIDER: _____

CLAIMS ADDRESS _____

NAME OF POLICY HOLDER _____ RELATIONSHIP TO INSURED _____

POLICY NUMBER _____ GROUP NUMBER _____

PRIMARY PHYSICIAN _____ REFERRING PHYSICIAN _____

WHY ARE YOU HERE TODAY? _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM.

PATIENT SIGNATURE DATE

INITIAL ENCOUNTER QUESTIONNAIRE

Place a check mark by all that apply to the patient. If checked, explain in the space provided.

Do you have or have you had:

HEAD		NECK		BLOOD	
HEADACHES		SWOLLEN GLANDS		ANEMIA	
TRAMA		TRAMA		LEUKEMIA	
SURGERY		SURGERY		LOW PLATELETS	
EXPLAIN:		EXPLAIN:		DISEASES	
				EXPLAIN:	
EARS		PULMONARY		UINARY	
DIFFICULTY HEARING		SHORT OF BREATH		STONES	
DEAFNESS		COUGH		NIGHTTIME URINATING	
INJURY		ASTHMA		HESITANCY	
HEARING AIDES		SMOKING		FREQUENCY	
EXPLAIN:		TUBERCULOSIS		BLOODY URINE	
		TRAMA		FOAMY URINE	
		SURGERY		TRAMA	
		EXPLAIN:		SURGERY	
				EXPLAIN:	
MOUTH		CARDIAC/HEART		MUSCULOSKELETAL	
DIFFICULTY CHEWING		CHEST PAIN		WEAKNESS	
DIFFICULTY SWALLOWING		PALPITATIONS		LETHARGY	
DENTURES		ANGINA		BONE SURGERY	
MOUTH ULCERS		HEART ATTACK		JOINT SURGERY	
SORE THROAT		CATHETERIZATION		BACK SURGERY	
TRAMA		PACEMAKER		JOINT INJECTIONS	
SURGERY		TRAUMA		AMPUTATIONS	
EXPLAIN:		SURGERY		TRAMA	
		EXPLAIN:		SURGERY	
				EXPLAIN:	
EYES		GASTROINTESTINAL		OTHER	
TROUBLE SEEING		ULCER		PERSISTENT FEVERS	
BLINDNESS		NAUSEA/VOMITING		DIABETES	
RETINOPATHY		DIARRHEA		NIGHT SWEATS	
WEAR GLASSES		CONSTIPATION		THYROID DISEASE	
INJURY		BLODDY STOOLS		WEIGHT LOSS	
CATARACTS		DARK STOOLS		WEIGHT GAIN	
EYE SURGERY		APPENDICITIS		USE OF NSAID'S	
EXPLAIN:		GALLSTONES		e.g. ibuprofen, celebrex, vioxx, aleve, motrin, naproxen, etc.	
		HEMORRHOIDS		NON-PRESCRIPTION DRUGS	
		TRAMA		EXPLAIN:	
		SURGERY			
EXPLAIN:		EXPLAIN:			

The above represents a complete disclosure of all medical problems I have had. I will also provide Naples Nephrology with a list of all medications I am taking, including any known allergies.

SIGNATURE: _____ DATE: _____

FAMILY HISTORY (CIRCLE ALL THAT APPLY)

MOTHER ALIVE DECEASED

CURRENT AGE IF STILL LIVING _____

AGE AT TIME OF DEATH _____

CAUSE OF DEATH _____

ILLNESSES _____

FATHER ALIVE DECEASED

CURRENT AGE IF STILL LIVING _____

AGE AT TIME OF DEATH _____

CAUSE OF DEATH _____

ILLNESSES _____

SMOKING HISTORY (CIRCLE ALL THAT APPLY)

HAVE YOU EVER SMOKED ON A REGULAR BASIS

YES NO

(IF NO SKIP TO THE DRINKING HISTORY)

ARE YOU STILL USING TOBACCO?

YES NO

WHAT AGE DID YOU START SMOKING? _____

WHAT AGE DID YOU QUIT SMOKING? _____

IN TOTAL, I SMOKED _____ PACKS OF CIGARETTES PER DAY FOR _____ YEARS.

CURRENT MEDICATIONS

Include Supplements / over the counter medications
(Name, dosage, how often taken)

DRINKING HISTORY

HAVE YOU EVER USED ALCOHOL ON A REGULAR BASIS?

YES NO

ARE YOU STILL USING ALCOHOL?

YES NO

IN TOTAL, I CONSUMED _____ BEVERAGES PER DAY FOR _____ YEARS.

SOCIAL HISTORY

DESCRIBE YOUR LIVING ARRANGEMENT
(ALONE, WITH SPOUSE, NURSING HOME, ASSISTED LIVING, ETC)

SLEEPING HISTORY

DO YOU SNORE LOUDLY? YES NO

DO YOU FALL ASLEEP EASILY DURING DAYTIME HOURS? YES NO

OCCUPATION: _____ **RETIRED?** YES NO

ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS (LIST REACTION, IF KNOWN)

OTHER ALLERGIES: FOOD, ENVIRONMENTAL, etc

NAPLES NEPHROLOGY, PA
PATIENT NOTICE

- PAYMENT IS DUE AT TIME OF SERVICE – INCLUDING ALL CO-PAYMENTS AND DEDUCTIBLES.

- WE WILL TRY TO CONTACT YOUR INSURANCE COMPANY FOR YOU TO INQUIRE ABOUT YOUR DEDUCTIBLES. IF THE INFORMATION IS NOT AVAILABLE, YOU WILL BE ASKED TO MAKE THE PAYMENT.

- IF THE PATIENT’S ACCOUNT SHOULD BE HANDED OVER TO COLLECTION, THE PATIENT WILL BE RESPONSIBLE FOR ALL ATTORNEY AND COLLECTION FEES.

- PAST DUE BALANCES WILL HAVE A 2% LATE CHARGE ADDED TO THE ACCOUNT.

PRESCRIPTIONS: Refills can no longer be filled by phone or fax. Make sure to inform the Doctor or office staff if you need your prescription refilled at the time of your appointment.

Acknowledged and agreed:

Signature Date

Naples Nephrology, P.A.

Mark S Russo, MD, PhD

Vera M Stricevic, MD

Kidney Disease • Transplant Nephrology • Hypertension • Nephrolithiasis • Hemodialysis • Peritoneal Dialysis

1. Each person signing below, whether signing as parent or guarantor, or in any other legal capacity (the “undersigned”), agrees that in consideration of the services to be rendered to the patient, which consideration is acknowledged by each of the undersigned as adequate and sufficient, (s)he is hereby jointly and severally obligated to pay all charges arising from the services administered to the patient, as well as costs of collection including court costs and attorney fees. This obligation to pay all charges and costs of collection is unconditionally absolute.

If payment of services fees and charges is not received in full within 10 days after the service date, your account will become delinquent and a delinquency charge will be added to your account at the end of each 30 day period at the rate of 1.5% of the unpaid amount for as long as your account remains unpaid.

2. I hereby authorize my current insurance carrier to forward all medical payment(s) on my behalf to Naples Nephrology, PA for any services furnished me by physician(s) of this practice. I further authorize for any holder of medical information about me to release any information needed to determine these benefits payable to related services. This authorization will not be canceled until further notice, as this is a lifetime signature of Patient/Guardian. I understand that any amount not covered by my insurance company for ANY reason is my responsibility and I, being the patient/guarantor am solely responsible for payment of balance. I further understand that if my account should be turned over for legal collection, I agree to pay for all collection fees including postage, court costs and attorney fees.

3. I authorize Naples Nephrology, PA to submit insurance claims on my behalf. I am aware that this service is being provided as a courtesy. I understand that I will be financially responsible for all services not paid in full within 10 days of service regardless of any reason that may be given by the insurance company. If this account should become delinquent and past due after 60 days, I agree to pay all costs of collection including, but not limited to, court costs, sheriff fees and collection costs as may be necessary.

4. I hereby assign all medical/surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Naples Nephrology, PA. This order will remain in effect until revoked by me in writing. I understand that I am ultimately responsible for all charges, whether or not paid by said insurance. I also understand that, should I default on my account, all costs of attorney’s fees, interest and cost of collections would be my responsibility. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms on my behalf.

Acknowledged and Agreed

Date