Naples Nephrology, P.A.
KIDNEY DISEASE • TRANSPLANT NEPHROLOGY • HYPERTENSION • HEMODIALYSIS • PERITONEAL DIALYSIS

MARK S. RUSSO, M.D., Ph. D
VERA M. STRICEVIC, M.D.

Thank you for choosing
Naples Nephrology, P.A.

For your upcoming appointment, please bring the following with you:

1. Insurance Cards - Primary and Secondary (if applicable)
2. List of all medications.
3. New Patient Paper work that has been COMPLETED.
4. A list of Doctors you would like your Medical Records shared with. Please make sure that you have a phone and fax number for each Doctor.

IN THE EVENT YOU NEED TO CANCEL YOUR APPOINTMENT, PLEASE CALL AT LEAST 24 HOURS IN ADVANCE.

878 109TH AVENUE NORTH • NAPLES, FLORIDA 34108 • 239-513-1002 • FAX 239-513-1915
www.naplesnephrology.com

Naples Nephrology, P.A.

NEW PATIENT INFORMATION FORM

878 109th Avenue North Naples, Florida 34108 239-513-1002 fax 239-513-1915

www.naplesnephrology.com

NAME ____

ADDRESS: ____

EMAIL ADDRESS ____

APT/UNIT # __________ CITY ____________________ STATE _____ ZIP ______________

PHONE: HOME _______________ CELL: _____________ WORK: ____________

ALTERNATE ADDRESS ____

APT/UNIT # __________ CITY ____________________ STATE _____ ZIP ______________

DATE OF BIRTH ______________________ SEX (CIRCLE) MALE FEMALE

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

EMERGENCY CONTACT (LOCAL)

NAME ______________________________ RELATIONSHIP ______________

ADDRESS ______________________________ PHONE ______________

NEXT OF KIN CONTACT (IF DIFFERENT FROM ABOVE)

NAME ____

RELATIONSHIP ______________________________ PHONE ______________

PRIMARY INSURANCE PROVIDER: ______________________________

NAME OF POLICY HOLDER ____________________ RELATIONSHIP TO INSURED __________

POLICY NUMBER ____________________ GROUP NUMBER ____________________

SECONDARY INSURANCE PROVIDER: ______________________________

NAME OF POLICY HOLDER ____________________ RELATIONSHIP TO INSURED __________

POLICY NUMBER ____________________ GROUP NUMBER ____________________

FAMILY HISTORY

NAME: ____

MOTHER (CIRCLE) ALIVE DECEASED

CURRENT AGE (IF STILL LIVING) ________

AGE AT TIME OF DEATH ________

CAUSE OF DEATH ________________

ILLNESSES ________________

____

____

FATHER (CIRCLE) 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.

DRINKING HISTORY (CIRCLE ALL THAT APPLY)

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.)

____

CURRENT MEDICATIONS

Include: supplements / over the counter medications

(NAME, DOSAGE, HOW OFTEN TAKEN)

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: FOODS, ENVIRONMENTAL, etc.

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INITIAL ENCOUNTER QUESTIONNAIRE

PLEASE PLACE A CHECK MARK BY ALL THAT APPLY. IF CHECKED, EXPLAIN IN THE SPACE PROVIDED.

HEAD

HISTORY OF STROKES ______
- IF YES, WHEN ______
- ANY RESIDUAL WEAKNESS ______

HEAD ACHES ______
EXPLAIN: ______

DIABETES

TYPE I OR TYPE II
- WHEN WAS IT DIAGNOSED ______

DO YOU HAVE NEUROPATHY ______
PAIN, TINGLING, NUMBNESS IN YOUR LEGS DUE TO DIABETES ______

EARS

DIFFICULTY HEARING ______
DEAFNESS ______
HEARING AIDS ______
EXPLAIN: ______

MOUTH

DIFFICULTY CHEWING ______
DIFFICULTY SWALLOWING ______
MOUTH ULCERS ______
EXPLAIN: ______

EYES

DO YOU SEE AN EYE DOCTOR REGULARLY? ______
TROUBLE SEEING ______
BLINDNESS ______
DIABETIC RETINOPATHY ______
WEAR GLASSES ______
EYE SURGERY ______
CATARACTS ______
EXPLAIN: ______

NOSE

NOSE BLEEDS ______
EXPLAIN: ______

BLOOD

ANEMIA
DO YOU RECEIVE INJECTIONS ______
EPOGEN, ARANESP, PROCRIT ______
LEUKEMIA ______
LOW PLATELETS ______
DISEASES ______
EXPLAIN: ______

URINARY

KIDNEY STONES ______
- *IF YES, HOW MANY TIMES* ______
- *LEFT, RIGHT OR BOTH KIDNEYS* ______
- *WHEN WAS THE LAST TIME YOU HAD PAIN DUE TO KIDNEY STONES* ______
- *COMPOSITION: CALCIUM OXALATE, URIC ACID, STRUVITE, STAGHOURN, CYSTEINE* ______

NIGHT TIME URINATING ______
HESITANCY ______
FREQUENCY ______
BLOODY URINE ______
FOAMY URINE ______
EXPLAIN: ______

MUSCULOSKELETAL

WEAKNESS ______
LETHARGY ______
JOINT PAIN/SWELLING ______
EXPLAIN: ______

OTHER

SKIN RASH
NIGHT SWEATS ______
PRESISTENT FEVERS ______
THYROID DISEASE ______
WEIGHT LOSS ______
WEIGHT GAIN ______
USE OF NSAID'S ______
ex. Ibuprofen, Celebrex, Vioxx, Aleve Motrin, Naproxen, Meloxicam, Advil Celecoxib, Diclofenac, Mobic, ect.
HOW OFTEN______ HOW LONG ______
NON-PRESCRIPTION DRUGS ______
EXPLAIN: ______

NECK

SWOLLEN GLANDS ______
EXPLAIN: ______

PULMONARY

COPD
SHORT OF BREATH ______
COUGH ______
ASTHMA ______
SMOKING ______
TUBERCILOSIS ______
EXPLAIN: ______

CARDIAC/HEART

HYPERTENSION ______
- *WHEN WAS IT DIAGNOSTED* ______
- *DO YOU HAVE ANY SIDE EFFECTS FROM ANTI-HYPERTENSIVE MEDICATIONS* ______
- *WHAT IS YOUR AVERAGE AT HOME BLOOD PRESSURE* ______

CHEST PAIN ______
PALPITATIONS ______
ANGINA ______
HEART ATTACK ______
CATHETERIZATION ______
BYPASS ______
DEFIBRILLATOR ______
PACEMAKER ______
STENT PLACEMENT ______
EJECTION FRACTION ______
EXPLAIN: ______

GASTROINTESTIONAL

GERD
ULCER
NAUSEA/VOMITING
DIARRHEA
CONSTIPATION
BLOOD STOOLS
DARK STOOLS
EXPLAIN: ______

- HAVE YOU HAD ANY CT SCANS WITH IV CONTRAST DONE RECENTLY? ______

PLEASE LIST ANY SURGERIES: ______

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.

PRINTED NAME: ______ SIGNATURE: ______ DATE: ______

Records Release Form

NAME: ______________________________ DOB: ______________________________

LIST OF DOCTORS/HOSPITALS WHO HAVE MY MEDICAL RECORDS AND CAN RELEASE THEM TO NAPLES NEPHROLOGY, P.A.

NAME: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________ FAX: ______________________________

LIST OF PEOPLE ALLOWED ACCESS TO ALL MY HEALTH INFORMATION:

______________________________ RELATIONSHIP ______________________________

______________________________ RELATIONSHIP ______________________________

______________________________ RELATIONSHIP ______________________________

MESSAGES CAN BE LEFT ON MY VOICE MAIL YES NO

MESSAGES CAN BE LEFT ON MY CELL PHONE YES NO

COMMUNICATION BY PATIENT EMAIL YES NO

____

SIGN DATE

THIS MESSAGE IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS MEDICALLY PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURES UNDER APPLICABLE LAW. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN THIS ORIGINAL MESSAGE TO US AT THE ADDRESS BELOW; THANK YOU,

NAPLES NEPHROLOGY, PA, 878 109TH AVENUE NO., NAPLES , FL 34108

PHONE: 239-513-1002 FAX: 239-513-1915

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FINANCIAL AGREEMENT

In consideration of the patient receiving services from NAPLES NEPHROLOGY, PA, I agree:

- I am responsible for all expenses for treating the patient.
- Payment of charges is due at the time of the appointment
- If NAPLES NEPHROLOGY, PA files my insurance claims for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays and deductibles.
- I authorize my insurance company to make payments directly to Naples Nephrology, PA for covered services.
- I will be responsible for costs of collections, including court costs and attorney fees and any late fees incurred.
- Past due balances are subject to a late fee and/or monthly statement fee If not paid In-full within 30 days of receipt of bill.

Acknowledged and Agreed:

Signature-Responsible Party-Patient, Parent, Guardian: ______________________________

Print Name:______________________________ Date:______________________

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MARK S. RUSSO, M.D., Ph. D
VERA M. STRICEVIC, M.D.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and you may get access to this information.
PLEASE REVIEW IT CAREFULLY.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we use it and disclose your protected health information for treatment, payment, and for healthcare operations as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we will describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describes different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exclusive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. We will disclose your health information to other physicians who may be treating you. Additionally, we made from time to time disclose your health information to other physicians whom we have requested to be involved in your care. For example – we may disclose your healthcare information to an outside treatment provider; such as a pathologist to whom we have used to determine a diagnosis to help in your treatment.

Payment: We will use and disclose your protected health information to obtain payment for health care services we provided you. For example – we may include information with a bill to a third-party pair that identifies you, your diagnosis procedures performed and supplies used in rendering services.

Healthcare Operations: We will use and disclose your protected health information to support the business activities of our practice. For example – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third-party business associates who perform in billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information

Appointment Reminders: We will use and disclose your protected health information to contact to you as a reminder about a scheduled appointment or treatment.

Treatment Alternatives: We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved In Your Care: We will use and disclose your protected health information to a family member, a relative, a close friend or other person you identified that is involved in your medical care or payment for your care.

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has been reviewed. The research proposal and establish protocols to ensure privacy of your health information.

As Required by Law: We will use and disclosure protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety: We will use and disclosure protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by the health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation: We will use and disclosure protected health information for Worker's Compensation or similar programs that provide benefits for work related injuries or illness.

For Law Enforcement Purposes: We may disclose your protected health information to a law enforcement official for law-enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court ordered warrant, subpoenas, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are a victim of a crime.
- To a law enforcement official if the facility has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

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ACKNOWLEDGENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have reviewed Naples Nephrology, P.A.'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:___________

Print Name:________________________________ Relationship:_________________________

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

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Naples Nephrology

DEAR PATIENT,

The doctors at Naples Nephrology, P.A. would like to make you aware that if you are admitted to a hospital, you have the RIGHT to ask to be seen by doctors of Naples Nephrology, P.A.

Thank you,

Dr. Mark S. Russo. M.D, Ph.D.

Dr. Vera M. Stricevic, M.D.

NAPLES NEPHROLOGY, P.A.

ATTENTION TO ALL PATIENTS

AS OF MAY 1, 2022 NAPLES NEPHROLOGY PROVIDERS WILL BE CHARGING $100.00 FOR ANY PATIENT WHO DOES NOT SHOW UP FOR A SCHEDULED APPOINTMENT OR CANCEL AT LEAST 24 HOURS PRIOR.

A NEW APPOINTMENT WILL NOT BE APPROVED UNTIL FULL PAYMENT IS MADE.

THANK YOU

ACKNOWLEDGED: ______________________________

PLEASE PRINT NAME: ______________________________

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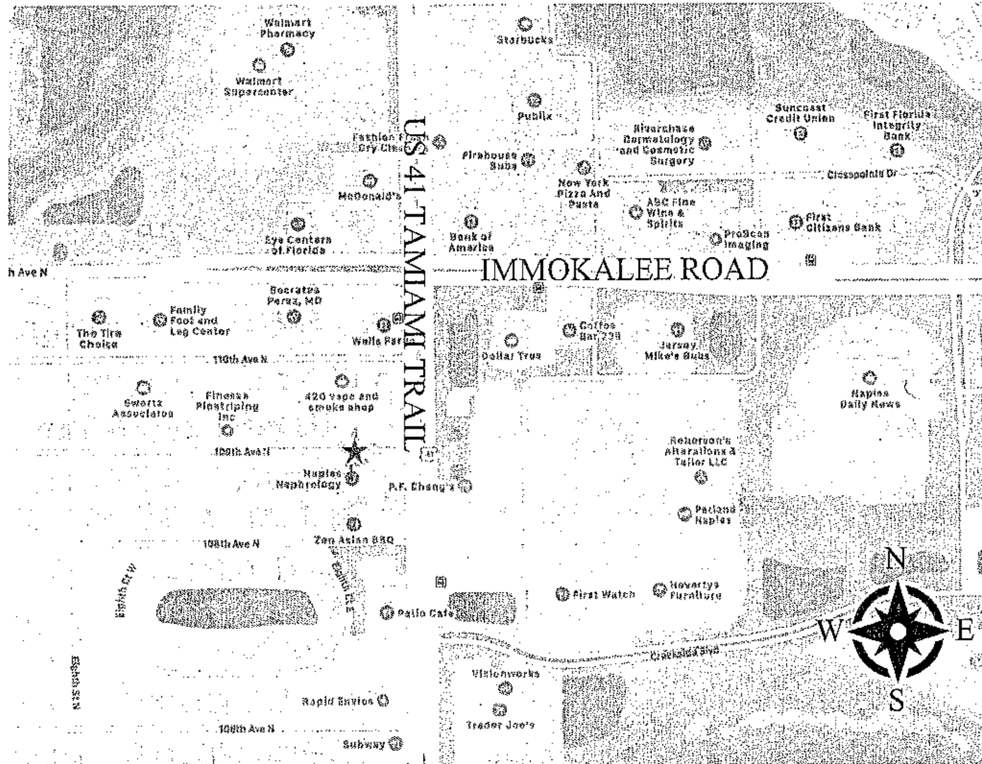
DIRECTIONS TO NAPLES NEPHROLOGY, P.A.



DIRECTIONS FROM I-75
Take Exit 111 (Immokalee Road)
Head West on Immokalee Road until you reach US 41 (Tamiami Trail)
Stay in the Right-hand turn lane and turn Left
Go South two (2) blocks
Make a Right hand turn on 109th Avenue North
We are the second building on the Left in Mango Square

FROM US 41 HEADING SOUTH (Bonita Spring, Estero)
Cross over Immokalee Road
Go South two (2) blocks
Make a Right hand turn on 109th Avenue North
We are the second building on the Left in Mango Square

FROM US 41 HEADING NORTH (Marco Island, East Naples)
Approach Immokalee Road in the Left Turn Lane
Make a U-Turn
Go South two (2) blocks
Make a Right hand turn on 109th Avenue North
We are the second building on the Left in Mango Square

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