

Regional Nephrology Associates, P.A.

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Specialists in the Treatment of Hypertension & Kidney Disease

510 Jackson Avenue • Northfield, NJ 08225 • Telephone: (609) 383-0200 • Fax: (609) 383-8352

Dear New Patient,

Enclosed is your appointment card indicating the day, date and time of your scheduled appointment in this office. **We have also enclosed a copy of our patient information sheet which we request you complete and bring with you to the office on the day of your appointment.**

If you have any medical records which you feel would be beneficial to us in evaluating you, please bring them with you. We would also appreciate you bringing your medications to the office on your initial visit, so that we may have the opportunity to review them with you. This should include over the counter medications as well as prescription medications.

If for any reason you are unable to keep this appointment, please notify this office as soon as possible. This will allow us to assist another patient in obtaining an appointment. **We request at least 24 hours notice if you must cancel. There is a fifty dollar charge if you do not cancel within the 24 hours or do not keep the appointment. Please note, insurance companies do not cover this fee. Three consecutive missed appointments without cancelling could prompt your physician to discharge you from his care.** Every effort will be made to confirm your appointment two (2) days prior to your visit.

The charge for your initial office visit will vary depending upon any special procedures or studies the doctor may request. We participate in most health insurance plans as "specialists" for the treatment of high blood pressure and kidney disease. If your insurance plan requires a referral from your primary care physician, you must bring this with you at the time of your visit. It is your responsibility to know your insurance companies requirements. Patient appointments will be rescheduled if a referral or copayment is missing at the time of your appointment.

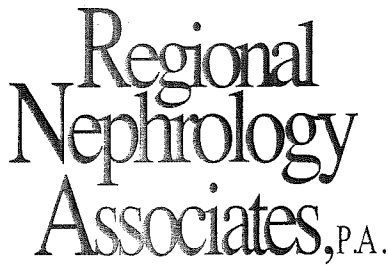
Please bring the following with you to your visit: photo ID, insurance cards, copay and referral if needed, your new patient information sheet and your medications.

You will be receiving a call from our automated system confirming your appointment 2 days prior. Please listen to the entire message as it will ask you about bloodwork.

We look forward to seeing you in the office

Sincerely,

Medical Receptionist



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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I Hereby authorize the use and disclosure by initialing the following, as appropriate, of my individually identifiable health information by Regional Nephrology Associates P.A as described below.

Authorization requested by: _____ or at the request of a patient.

Person/organization receiving the information: _____

Specific description of information to be released (including dates if applicable):

Purchase of the use or disclosure: _____

The patient or the patient's representative must read and initial each of the following statements:

_____ I understand that this authorization is voluntary, and my treatment is not conditioned on signing this authorization.

_____ I understand that if the entity listed to receive this information is not a health plan or health care provider, the information released may no longer be protected by federal privacy regulations.

_____ I understand that this authorization may be revoked by me in writing, as explained in Regional Nephrology Associates P.A Notice of Privacy Practices, but the revocation will not have any effect on uses or disclosures prior to revocation.

_____ I understand that I will receive a copy of this authorization upon request.

 SIGNATURE OF PATIENT

 DATE

 NAME OF EMERGENCY CONTACT OR REPRESENTATIVE

Regional Nephrology Associates, P. A.

ABOUT YOU

DATE: _____

NAME: _____ SS #: _____

Home Address: _____ Date of Birth: _____

Email: _____

Phone #: Home: _____ Work: _____ Cell: _____

REFERRED BY: _____ What you preferred to be called: _____

Marital Status: S M D W Gender: _____ Smoker: Y N Preferred Language: _____

Ethnicity: Not Hispanic / Hispanic / Other / Decline to answer

PRIMARY INSURANCE INFORMATION

GROUP #: _____

INSURANCE Name: _____ ID #: _____

SUBSCRIBER: Self / Spouse / Other

IF OTHER THAN SELF: SUBSCRIBER NAME: _____ DOB: _____

SECONDARY INSURANCE INFORMATION

INSURANCE Name: _____ ID #: _____

SUBSCRIBER: Self / Spouse / Other

IF OTHER THAN SELF: SUBSCRIBER NAME: _____ DOB: _____

Are you here for an accident or work-related injury? Please provide workers comp or auto information: _____

IN THE EVENT OF AN EMERGENCY

Who would we contact? _____ Relationship: _____

Phone #: Home: _____ Work: _____ Cell: _____

I hereby authorize payment of medical benefits directly to Regional Nephrology Associates, PA for services rendered. I further authorize the physician and or/supplier to release information required to process insurance claim.

I hereby acknowledge Regional Nephrology Associates, PA reserves the right to charge a "no show fee" for appointment cancellations made less than 24 hours prior to the appointment. These fees are \$30.00 for established patients and \$50.00 for new patients. These no show fees are the patient's responsibility, as they are not payable by insurance carriers and must be paid prior to the scheduling of any future appointments.

Co-payments are collected at the time of the appointment. Failure to provide a co-payment may result in your appointment being rescheduled unless prior arrangements with the practice administrator have been made.

If your insurance company requires a referral, it is your responsibility to obtain the referral from your primary care physician. Failure to provide a valid referral when required may result in your appointment being rescheduled.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office to any changes in any address, phone number, or insurance status.

Signature of Patient: _____ Date: _____

May we send you a link via email to set up MY CHART?**YES****NO**

