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

Regional Nephrology Associates, P.A.

ABOUT YOU Date ____________

NAME: ____________

Home Address: ____________

____

Date of Birth: ____________ Age: ________ SS#: ____________

Driver License #: ____________

Phone # Home: ____________ Work: ____________ Cell: ____________

Employer: ____________

Employer's Address: ____________

____

REFERRED BY: ____________

What You Prefer To Be Called: ____________

Marital Status: S M D W Male Female Smoker Y N

ABOUT YOUR SPOUSE

Name: ____________ Date of Birth ____________

Phone # Home: ____________ Work: ____________ Cell: ____________

Employer: ____________ SS#: ____________

PRIMARY INSURANCE COMPANY Identification No: ____________

Co. Name: ____________

Address: ____________

____________ Phone #: ____________

Group # (Plan, Local, or Policy #): ____________ Effective Date: ____________

Insured's Name: ____________ Relationship: ____________

SECONDARY INSURANCE COMPANY Identification No: ____________

Co. Name: ____________

Address: ____________

____________ Phone #: ____________

Group # (Plan, Local, or Policy #): ____________ Effective Date: ____________

Insured's Name: ____________ Relationship: ____________

...over...

IN THE EVENT OF AN EMERGENCY

Who would we contact? ______________________________

Relationship: ______________________________

Home Number ______________________ Cell Number ______________________

Work Number ______________________________

MEDICAL HISTORY

List of allergies you have: ______________________________

List of any Prescription/over the counter medications you're taking: ______________________________

____

____

List previous surgeries/treatments with dates: ______________________________

____

List any serious accidents/illness with dates: ______________________________

____

For women:

Are you taking birth control? ______________________________

Are you pregnant? __________ If yes, how long? __________ Are you nursing? __________

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 any information required to process insurance claim.

I hereby acknowledge that 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 patients 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 a the time of your appointment. Failure to provide co-payment may result in your appointment being rescheduled, unless prior arrangements with the practice administrator has been made.

If your insurance company requires referrals, 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 this office of any changes in any address, phone number and insurance status.

Signature of Patient ______________________________ **Date** ______________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_________________________________ Date of Birth____________

I hereby authorize the use and disclosure ,as appropriate,of my individually indentifiabl e health information by Regional Nephrology associatesP.A as described below.

Authorization requested by:______________________or at the request of patient.

Person/organization receiving the information___________________________

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

____

Purpose of the use or disclosure:_____________________________________

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

______I understand that this authorization is voluntary and my treatment is not conditioned on my 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 the authorization may be revoked by me in writing, as explained in Regional Nephrology Associates P.A.'s Notice of Privacy Practices, but the revocation won't have ant effect on uses or disclosures prior to revocation.

______I understand that I will receive a copy of this Authorization upon request.

____________________________________ ____________________

Signature of patient or patient's representative ** Date

____

Printed Name of representative
OTHER THAN PATIENT

You may refuse to sign this Authorization

MEDICATION LIST

Patient's Name: ______________________________ Date: ____________

Date of Birth: ________________ Pharmacy: ____________________

PLEASE LIST ALLERGIES TO MEDICATIONS: ________________________

____

MEDICATION NAME	DOSE	FREQUENCY DIRECTIONS	PRESCRIBING DOCTOR