ADVANCED KIDNEY CARE OF CENTRAL FLORIDA

3175 Citrus Tower Blvd Clermont, FL 34711 PH: (352) 240-3812 | FAX: (888) 716-2003
131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

Welcome.....

Thank you for choosing Advanced Kidney Care of Central FL, PA for your health care needs. On behalf of the entire staff, we are delighted you placed your confidence in us.

To better serve you, we request your cooperation in completing the following forms ***prior*** to arriving to your appointment. Please fill out these forms completely in blue or black ink.

In order to better serve you, we ask that you bring all your medications, insurance cards, enclosed forms, and other documents you feel are important for your visit. Please plan to arrive 15 minutes prior to appointment.

Checklist to bring to your appointment:

- Fill out Patient Registration Form
- Fill out New Patient Health History Form
- Read and Sign Financial Policy
- Read and Sign Assignment of Benefits
- Fill out Authorization for Release of Medical Information
- Fill out Consent to Disclose Medical Information
- Bring your current Insurance Card(s)
- Bring a form of photo ID (Driver's License, Passport)
- Bring your copayment or coinsurance (cash, check, credit card)
- Bring in ALL current medication bottles
- Bring any pertinent lab work, medical records

If for any reason you cannot keep appointment, please give us 24 hours notice so we may use that appointment to attend to another patient.

If you have any questions regarding your appointment or our office policy please feel free to contact our office.

Thank you,
The Staff of Advanced Kidney Care of Central Florida,PA

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PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name	**Sex: M F**	**DOB _____/_____/_____ Age:**	**Social Security #**	**Marital Status** []Single []Married[]Divorced[]Widowed
Address **City**		**State Zip**	**Phone (Home)**	**Phone (Cell)**
Email:		**How Did You Hear About Us? Family/Friend Internet Advertisement Other**		
Employer	**Employer Address**	**Occupation**	**Phone (Work)**	
Spouse's Name	**Spouse's Phone #**	**Spouse's Employer**		
Referring Provider				

PERSON RESPONSIBLE FOR PAYMENT

Name	**Relationship**	**Social Security #**	**Driver's License #**
Address **City**	**State Zip**		
Employer	**Employer Address**	**Phone (Work)**	
Credit Card Visa MC Discover Amex	**Name on Card**	**Exp**	

PRIMARY INSURANCE (Please Have Insurance Card(s) & Photo ID for Copying)

Ins Company Name & Address			
Policy Holder Name	**Relationship**	**DOB**	**Social Security #**
ID #	**Group #**		

SECONDARY INSURANCE (Please Have Insurance Card(s) & Photo ID for Copying)

Ins Company Name & Address			
Policy Holder Name	**Relationship**	**DOB**	**Social Security #**
ID #	**Group #**		

EMERGENCY CONTACT

Name	**Relationship**	**Phone (Home)**	**Phone (Cell)**	**Phone (Work)**

ADVANCED DIRECTIVE

1. Do you have a living will? Yes ___ No ___
A copy may be needed for your chart. A copy was received by this office (Date _____)

2. Have you given anyone Power of Attorney? Yes ___ No ___
A copy may be needed for your chart. A copy was received by this office (Date _____)
Name _____ Relationship _____ Date _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign my insurance benefits to be made directly to Advanced Kidney Care of Central FL, PA and its associates, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges NOT covered by my insurance company. I also agree to paying all co-payments, co-insurances and/or elective service fees at the time of service. If there are problems collecting payments, attorney's fees, collection agency costs and any related fees will be added to my bill.

I authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician.

I grant permission to Advanced Kidney Care of Central Fl, PA physicians to perform such examinations and medical/therapeutic procedures as may be deemed professionally necessary for my/the patient's diagnosis and treatment.

I acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____

Patient Name _____ DOB _____

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NEW PATIENT HEALTH HISTORY

DEMOGRAPHICS				
Last Name	**First Name**		**DOB**	**Sex M F**
Address	**City**	**State**	**Zip**	
Phone (H)	**(W)**	**(C)**		
Referred By		**Primary Care Physician**		
Emergency Contact Name		**Phone**	**Relationship**	
Date of Last Physical Exam	**Doctor**			

CURRENT MEDICATIONS (List Strength, Frequency)	

ALLERGIES
Medication Allergies
Other Allergies (Food, Environmental)

PAST MEDICAL HISTORY - Do you have or have you ever had?				
[ ] High Blood Pressure	[ ] Rheumatic fever	[ ] Cancer (type)	[ ] Headaches	[ ] Gallstones
[ ] Heart Disease	[ ] Anemia (low blood)		[ ] Seizures	[ ] Gallstones
[ ] Heart Attack	[ ] Blood transfusions	[ ] Breast masses	[ ] Glaucoma	
[ ] Heart Failure	[ ] Excessive bleeding	[ ] Sexually transmitted disease	[ ] Osteoporosis	[ ] Liver Disease/Hepatitis
[ ] Stroke	[ ] Blood clots	[ ] HIV testing	[ ] Kidney stones	[ ] Stomach ulcers
[ ] Blocked arteries	[ ] Splenectomy	[ ] HIV/AIDS	[ ] Urinary infections	[ ] Colon Disease
[ ] Diabetes	[ ] Asthma/Allergy	[ ] Arthritis	[ ] Kidney disease	[ ] Anxiety
[ ] High cholesterol	[ ] Emphysema/COPD	[ ] Lupus	[ ] Prostate disease	[ ] Depression
[ ] Thyroid Disease	[ ] Pneumonia or TB	[ ] Gout	[ ] Esophageal reflux	[ ] Other

PREVIOUS HOSPITALIZATIONS (Date, Reason, Hospital)

SURGERIES/OPERATIONS (Date, Type, Reason, Hospital)

Patient Name _____ DOB _____

IMMUNIZATIONS/VACCINES (Include Dates)				
[ ] Pneumonia	[ ] Tetanus	[ ] Influenza	[ ] Zostavax (Shingles)	[ ] HPV (Gardisil)
[ ] Hepatitis B	[ ] 2nd MMR Vaccine (If born after 1956)	[ ] TB Skin Test		

HEALTH SCREENING (Include Dates)			
[ ] Mammogram	[ ] PAP Smear	[ ] Colonoscopy	[ ] Prostate Exam

FAMILY HISTORY	Sex	Living	Deceased	Age	Diseases (Include Diabetes, Stroke, Cancer, Blood disease, Heart Disease/Heart Attack, Thyroid disorders, Seizures, Bleeding disorders, Kidney disease, Kidney stones, High blood pressure, Cancers, Psychiatric disorders)
Father	M				
Mother	F				
Brothers/Sisters (circle sex)	M F				
	M F				
	M F				
	M F				
	M F				
Sons/Daughters (circle sex)	M F				
	M F				
	M F				
	M F				
	M F				
Aunts/Uncles (circle sex)	M F				
	M F				
	M F				
Grandmother/Grandfather	M F				
	M F				

LIFESTYLE/SOCIAL HISTORY		
Occupation	**Highest Education Level:** [ ] Middle school [ ] High school [ ] College [ ] Post Graduate [ ] Other	**Marital Status** S M D W
Exercise (Type & Frequency per week)		
Caffeine on a regular basis? [ ] Yes [ ] No How many cups/cans per day?		
Smoking History [ ] Never [ ] Age started [ ] Age stopped	Packs per day: Currently	In the past
Alcohol Use [ ] Daily [ ] Occasional [ ] Rare [ ] None		
Recreational Drug (Now or In the Past) [ ] Marijuana [ ] Cocaine [ ] IV drugs [ ] Other		
Who lives with you at home? [ ] Alone [ ]Spouse/Partner [ ]Children [ ]Boyfriend/Girlfriend [ ]Nephews/Nieces [ ]Grandchildren		
Religious preference if any		
Sexual preference: [ ] Heterosexual [ ] Homosexual [ ] Bisexual	**Hobbies/Interests**	

REVIEW OF SYSTEMS (Circle any symptoms you experienced recently)				
General	**Ears**	**Eyes**	**Nose**	**Throat**
Weight gain	Hearing loss	Vision loss	Nosebleeds	Hoarseness
Weight loss	Ringing in ears	Blurry vision	Nasal congestion	Sore throat
Loss of appetite	Wax problems	Double vision	Snoring	Itchy throat
Night sweats	Ear pain	Painful eyes	Post nasal drip	Difficulty swallowing
Weakness		Redness	Decreased smell	Painful swallowing
Fatigue		Drainage		
Swollen glands				
Cardiovascular	**Respiratory**	**Gastrointestinal**	**Urinary**	**Allergy**
Chest pain/tightness	Persistent cough	Nausea/Vomiting	Painful urination	Sinus congestion
Irregular heartbeat	Bloody sputum	Abdominal pain	Flank pain	Hives
Palpitations	Difficulty breathing	Heartburn	Frequent Nighttime urination	Itchy eyes
Swollen legs	Wheezing	Diarrhea	Urine leakage	Runny nose
Leg pain/cramps	Painful breathing	Constipation	Difficulty urinating	
		Bloody stools	Frequent urination	
		Black tarry stools	Blood in urine	
		Mucous in stool	Foamy urine	
		Rectal pain	Recurrent UTI's	
			Penile/Vaginal discharge	

Patient Name _____ DOB _____

Neuro	Skin	Musculoskeletal	Hematologic	Psychiatric
Headache	Rash	Joint pain	Easy bruising	Difficulties with sleep
Numbness/tingling	Itchy skin	Joint swelling	Varicose veins	Stress
Memory difficulties	Dry skin	Joint redness	Excessive bleeding	Feeling depressed
Speech problems	Change in moles	Joint stiffness		Feeling anxious
Tremors	New mole	Muscle pain		Changes in mood
Difficulty walking	Hair loss	Back pain		Changes in behavior
Lightheaded	Heat intolerance			Suicidal thoughts
Dizzy/Vertigo	Cold intolerance			Eating disorder
Fainting				Domestic abuse

_____ _____ _____

Patient/Guardian Signature Relationship Date

_____ _____

Review by Date

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FINANCIAL POLICY

Thank you for choosing Advanced Kidney Care of Central FL (AKCCF), PA for your medical needs. The following patient financial responsibilities and policies have been established to assist us in providing the highest quality of medical care.

Insurance:
It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security name, and relationship to the patient to file all claims. Patients are responsible for all fees at the time of service that are not covered by insurance, including co-payments, coinsurance, deductibles, and non-covered services or items received. **At every visit, please make sure you have all insurance card(s) and photo ID as well as any other forms that may assist us in processing your claim correctly.**

No Insurance:
If you are not covered at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. We ask that you pay at least 50% of the charges at the time of service. The remainder of this balance must be paid in 3 equal monthly payments. Cash, check, or credit card is accepted.

Worker's Compensation:
Worker's compensation will be filed if the patient notifies AKCCF upon scheduling an appointment and supplies billing information upon check-in. Details of the accident will be required and verified with your employer.

Returned Check:
There will be a $30 charge assessed for any check returned by your bank for any reason.

Past Due Balances:
Accounts that are not paid within 60 days from the date of service may be sent to our inhouse collections department. A collection fee may be added to the balance. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records:
If you request a copy of your medical records, you will be required to (1) sign a medical record release form and (2) pay a medical record fee prior to having your records copied. Please allow up to 7 days for this request to be processed.

Upon your written request, AKCCF will copy your medical record for the purpose of transferring your care to another provider or for your personal use. The fee for copies of your medical record is $1.00/page for 0-10 pages, $0.50/page for pages 11-50, and $0.25/page for pages 51 and up.

All request for medical records from an attorney, insurance company, or any other outside source will be charged $20.00 labor fee. There will be no charge for pages 0-10. Pages 11-50 will be charged $0.50/page and pages 51 and up will be $0.25/page.

Cancellation/No Show Policy:
We understand there may be times when you miss an appointment due to emergencies. We urge you to call 24 hours prior to canceling your appointment so another patient may utilize this time.

You may be dismissed from the practice after 3 or more no shows in a 12 month period.

Service Charges:
If 60 days after billing, you fail to pay any balance due on your account or fail to honor your established financial agreement, your account is subject to $5.00/month rebilling fee and/or may be sent to a collection agency. Handling charge up to 50% of your account balance if it must be sent to collection.
A fee of $30 will be assessed to your account for any check returned by your bank for any reason.

Billing Questions:
We outsource out medical billing to Practice Management. Please call (800) 395-7780 with any billing questions.

Dismissal Process:
There are several reasons that a person may be dismissed from our practice. A few reasons are as follows:

* Failure to keep scheduled appointments
* Being verbally or physically abusive to staff
* Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within 30 days of the date of the letter, one of our providers will be available for advice. After the 30 days, you will no longer be seen at our practice by any provider. A copy of your medical record may be forwarded to your new doctor after a formal request is made and applicable fees (if any) are paid.

I have read the Financial Policy. I understand my financial responsibilities and agree to the terms of this Policy.

_____
Patient Name

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Person Signing on Behalf of Patient (Print) Relationship to Patient

_____ _____
Witness Signature Date

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ASSIGNMENT OF BENEFITS

Financial Responsibilities
I have read, understand, and agree to Advanced Kidney Care of Central FL (AKCCF), PA's Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable co-payments and deductibles are my responsibility. All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance by either the patient or his/her health insurance carrier. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Private Insurance, and any other health/medical plan, to issue payment check(s) to AKCCF for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize AKCCF to: (1) Release any information necessary to insurance carriers regarding my illness and treatments; (2) To process insurance claims generated in the course of examination or treatment; and (3) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from AKCCF on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Patient Name

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Person Signing on Behalf of Patient (Print) Relationship to Patient

_____ _____
Witness Signature Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____ _____
Patient Name DOB Social Security #

I hereby authorize Advanced Kidney Care of Central FL, PA and its agents/employees to _____ RELEASE or _____ OBTAIN (please initial in appropriate space) information and copies of records pertaining to my medical care and treatment. **By state law you must be advised that the information you authorize for release may include information that could be considered information about communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and HIV (Human Immunodeficiency Virus) or AIDS (Acquired Immune Deficiency Syndrome).** In addition, it may include information about mental health, or drug, substance or alcohol abuse.

Release to:

[ ] Advanced Kidney Care of Central FL, PA
3175 Citrus Tower Blvd
Clermont, FL 34711
Ph: (352) 240-3812
(863) 226-4676
Fax: (888) 716-2003

[ ] _____
Name
_____
Address
_____
City, State Zip
_____
Phone Fax

Obtain from:

_____
Name
_____
Address
_____
City, State Zip
_____
Phone Fax

Information to be Released:

_____ All medical records
_____ Most recent 2 years of pertinent information (Notes, Labs, Imaging, Special Tests)
_____ All medical billing records
_____ Other (specify)

Purpose for which request is being made. Please check one of the following:

___ Physician ___ Medical Claims Processing ___ Self ___ Attorney ___ Other

Drug/Alcohol Abuse Treatment Records:

This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rule prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rule restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

My Rights:

I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that Provider has no control over any information and records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information or records may occur by such other party.

I release Provider, its employees and agents from any liability in connections with the use or disclosure of the information and records released to any party pursuant to this Authorization.

This authorization will expire in 12 months or _____.

_____ _____
Signature of Patient/Patient's Authorized Representative Date

_____ _____
Printed Name Relationship to Patient

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CONSENT TO DISCLOSE MEDICAL INFORMATION

PREFERRED FORM OF COMMUNICATION

It may be necessary to communicate with you regarding a change in your appointment, instructions, and other information regarding your treatment. In the event we are unable to reach you personally, please give us instructions regarding the best way to communicate with you.

I authorize the staff at Advanced Kidney Care of Central FL, PA to contact me by any of the following methods to relay a message:

[ ] Yes [ ] No Home telephone: (_____)
[ ] Yes [ ] No On answering machine
[ ] Yes [ ] No With anyone answering the phone
[ ] Yes [ ] No Authorized persons only: _____ Relationship _____
_____ Relationship _____
_____ Relationship _____
[ ] Yes [ ] No Leave message with call-back number only

[ ] Yes [ ] No Work telephone: (_____)
[ ] Yes [ ] No On answering machine
[ ] Yes [ ] No With anyone answering the phone
[ ] Yes [ ] No Leave message with call-back number only

[ ] Yes [ ] No Cell phone: (_____)
[ ] Yes [ ] No On voicemail
[ ] Yes [ ] No With anyone answering the phone
[ ] Yes [ ] No Leave message with call-back number only

RELEASE OF MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

If you would like to share your medical information with another person, please specify their name(s), phone number, and their relationship to you. If you do not designate someone, we cannot discuss your medical condition or laboratory/test results with anyone other than yourself (HIPAA Regulation).

Their Name	Their Phone #	Relationship
Their Name	Their Phone #	Relationship
Their Name	Their Phone #	Relationship

I hereby release, discharge and agree to hold harmless all parties whom the consent is given from any liability that may arise from the release of information to those authorized above. I realize that I may revoke this consent in writing in the future.

I have received and understand the Notice of Privacy Practices.

_____ _____
Patient/Guardian Signature Date