renalus | Center for Kidney Care

Account # _____

Payment Policy

Thank you for choosing Renalus Center for Kidney Care. We are committed to providing you with quality and affordable health care. Please read our payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Missed appointments.** At this time we currently do not charge for missed appointments. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Print Name of Patient or Responsible Party Date

_____

Signature of Patient or Responsible Party

Humam Humeda, M.D. Edward L. Friedland, M.D. Ronnie Wiles, M.D. Christopher S. Reid, M.D. Nicholas Nagrani, M.D.
Maged Nashed, M.D. Derek Jimenez, M.D. Haitham O. Qader, M.D. Douglas Bunting, M.D. James P. Martin, D.O.
Mark Vannorsdall, M.D.

renalus.com

renalus | Center for Kidney Care

1619 Creighton Road
Pensacola, FL 32504

o 850.444.4700
f 850.444.9766

Patient Information: This Section refers to the PATIENT ONLY.

Social Security Number: _____

Last Name: _____ Jr., II, _____

First Name: _____ MI _____

Nickname/ Alias: _____

Address: _____

City: _____ State _____ Zip code: _____

Home phone: ( ) _____.

Cell phone: ( ) _____.

Birth Date (mm/dd/yy): _____ Sex: ( ) Male ( )Female

Marital Status: Married Single Divorced Widowed

Race: □ African American □ American Indian □ Asian
□ Caucasian □ Hispanic □ Pacific Islander □ Other: _____

Personal Email: _____

If Employed, Company : _____

Work Phone: _____

Occupation: _____

Address: _____

_____

If Student: ( ) Full Time ( ) Part Time

Name of School: _____

Responsible Party: This section refers to the PERSON/PARTY WHO SHOULD RECEIVE THE BILL.

Relationship to Patient: ( ) Self (skip to next section) ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Social Security Number: _____

Last Name: _____ Jr., II, _____

First Name: _____ MI _____

Address: _____

City: _____ State _____ Zip code: _____

Home phone: ( ) _____.

Work phone: ( ) _____.

Birth Date (mm/dd/yy): _____ Sex: ( ) Male ( )Female

Marital Status: Married Single Divorced Widowed

Race: African American American Indian Asian
Caucasian Hispanic Pacific Islander Other:

If Employed, Company : _____

_____

Address: _____

_____

City, State: _____

Zip Code: _____

If Student: ( ) Full Time ( ) Part Time

Name of School: _____

Subscriber Information: This section refers to the PERSON IN WHOSE NAME THE INSURANCE IS LISTED.

Relationship to Patient: ( ) Self (skip to next section) ( ) Parent ( ) Spouse ( ) Employer ( ) Other: _____

Social Security Number: _____

Last Name: _____ Jr., II, _____

First Name: _____ MI _____

Address: _____

City: _____ State _____ Zip code: _____

Home phone : ( ) _____.

Work phone : ( ) _____.

Birth Date (mm/dd/yy): _____ Sex: ( ) Male ( )Female

Marital Status: Married Single Divorced Widowed

Race: African American American Indian Asian
Caucasian Hispanic Pacific Islander Other

If Employed, Company : _____

_____

Address: _____

_____

City, State: _____

Zip Code: _____

If Student: ( ) Full Time ( ) Part Time

Name of School: _____

Please make sure the office has a copy of your most recent insurance card(s).

Please ensure the office has a copy of your current Drivers License.

INSURANCE COVERAGE INFORMATION: PLEASE SHOW ALL NUMBERS ON YOUR CARD(s).

PRIMARY INSURANCE COVERAGE:

Insured (Name on card): _____ Insured ID Number: _____

Insurance Co. Name: _____ Group/Member/Policy Number: _____

Address: _____ Effective Date: _____

SECONDARY INSURANCE COVERAGE:

Insured (Name on card): _____ Insured ID Number: _____

Insurance Co. Name: _____ Group/Member/Policy Number: _____

Address: _____ Effective Date: _____

THIRD INSURANCE COVERAGE:

Insured (Name on card): _____ Insured ID Number: _____

Insurance Co. Name: _____ Group/Member/Policy Number: _____

Address: _____ Effective Date: _____

WHO IS THE PATIENT'S PRIMARY CARE PHYSICIAN (PCP):

IN CASE OF EMERGENCY

Name and Phone number of nearest relative NOT living with you (include relationship):

_____ _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize the office of Renalus Center for Kidney Care to release any medical information required during the course
of examination and treatment and permit payment directly to them of any benefits due for their services rendered. I recognize
and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible, and non-covered services.

_____ _____

Date Signature of Patient and / or Guardian, if patient is a Minor

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Renalus Center for Kidney Care for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Date Signature of Patient and / or Guardian, if patient is a Minor

How were you referred to the practice?

☐ Dr. _____ ☐ Friend/Relative ☐ Radio ☐ Newspaper

☐ Other: _____

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1619 Creighton Road
Pensacola, FL 32504

o 850.444.4700
f 850.434.8144

HIPAA Form

Patient Name:	
Patient Date of Birth:	
Patient Social Security#	

I have received Renalus Center for Kidney Care Privacy Policies and Practices booklet on how my Protected Health Information will be used and disclosed.

Patient Signature: *Date:*

Witness Signature: *Date:*

Persons Authorized to Receive Information:
Health information Renalus Center for Kidney Care collects or receives about you may be disclosed to the following persons:

Name	Relationship	Phone Number

Emergency Contact Information:
In the event of a medical emergency at one of our facilities, Renalus Center for Kidney Care can contact the following persons:

Name	Relationship	Phone Number

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1619 Creighton Road STE 1
Pensacola, FL 32504

o 850.444.4700
f 850.434.8144

Patient Consent for Photographing

Policy & Procedure

The undersigned, a patient of Renalus Center for Kidney Care, does hereby consent to having their photograph taken by an employee of Renalus Center for Kidney Care. The photograph will be entered into the patient's medical file and will be used only by members of our staff for the purpose of assisting in identifying our patients and thereby providing the best possible care.

*DATE:*_____

*PATIENT SIGNATURE:*_____

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Pensacola, FL 32504

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f 850.434.8144

Authorization for Release of Confidential Information

Patient Name: _____
Last *First* *Middle*

_____
Maiden / Previous Name

Patient Date of Birth: _____ *Telephone No.:* _____

I Hereby Authorize and Request

_____
Name of Releaser

_____
Address

_____
City *State* *Zip*

To Release To:

Renalus Center for Kidney Care
1619 CREIGHTON ROAD STE 1
PENSACOLA, FLORIDA 32504
TEL: (850) 444-4700
FAX: (850) 434-8144

A copy of the medical records of the above-named patient pertaining to *(check appropriate box and list the date)*:

☐ Emergency Care Date(s): _____

☐ Hospitalization Date(s): From: _____ To: _____ From: _____ To: _____

☐ Outpatient Care Date(s): _____

Check appropriate box, as needed:

☐ History & Physical ☐ Discharge Summary ☐ Operative Report ☐ Pathology

☐ Occupational Therapy Notes ☐ Physical Therapy Notes ☐ Lab ☐ X-Ray

☐ Abstract(s) (H&P, Discharge Summary, Consult, OP Report, etc.) ☐ Other:_____

I HAVE READ AND I UNDERSTAND THE NATURE OF THIS AUTHORIZATION. THIS AUTHORIZATION SHALL BE VAILD FOR A PERIOD OF TEN (10) YEARS FROM THE DATE THE AUTHORIZATION IS SIGNED. {IF PRESENT, HIV ANTIBODY TEST RESULTS HAVE BEEN DISCLOSED FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FLORIDA LAW AND FEDERAL REGULATIONS [FLA. STATE ANN.81.609 (2) (f)] PROHIBIT MAKING AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY STATE LAW.}

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/ Guardian Date

_____ _____
Witness (if possible) Date

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Patient History Form

Date Completed _____

Name _____ Date of Birth _____

Height _____ Weight _____ Primary Language _____

Please list your physicians below:

Primary Care Provider: _____ Hematology/Oncology: _____

Endocrinologist: _____ Gastroenterologist: _____

Urologist: _____ Cardiologist: _____

Pulmonologist: _____ Other Specialists: _____

Pharmacy: _____ Location: _____ Phone: _____

Allergies to Medications: Use the chart below to list all medications that you are allergic to and types of reactions

Medication Name	Type of reaction, such as rash or breathing difficulties

Medications:

Use the chart below to list all medications, both prescription and nonprescription. Please use any additional space on back of page.

Medication Name	Prescribing Physician	Reason for medication	Dose (such as 2mg, 1tsp)	How often?(daily or twice daily, etc)

Medical History: (select "yes" with a "X" beside each item below that you have been diagnosed with)

Acute kidney injury	□ Yes	Gout	□ Yes	Myocardial infarction	□ Yes
Anemia	□ Yes	Hematuria	□ Yes	Nephrotic syndrome	□ Yes
Atrial fibrillation	□ Yes	Hepatitis B	□ Yes	Osteoarthritis	□ Yes
Cancer	□ Yes	Hepatitis C	□ Yes	Osteoporosis	□ Yes
CHF	□ Yes	HIV/AIDS	□ Yes	Polycystic kidney	□ Yes
Chronic kidney disease	□ Yes	Hyperkalemia	□ Yes	Proteinuria	□ Yes
Clotting disorder	□ Yes	Hyperlipidemia	□ Yes	Pyelonephritis	□ Yes
COPD	□ Yes	Hyperparathyroidism	□ Yes	Renal cyst	□ Yes
Coronary artery disease	□ Yes	Hypertension	□ Yes	Sleep apnea	□ Yes
Diabetes mellitus	□ Yes	Hyponatremia	□ Yes	Stroke	□ Yes
Diabetic nephropathy	□ Yes	Hypothyroidism	□ Yes	TIA	□ Yes
ESRD	□ Yes	Kidney stones	□ Yes	UTI	□ Yes
GERD	□ Yes	Lupus	□ Yes	Other: _____	

Surgical History: (select "yes" with a "X" beside each surgery listed below that you have had)

Abdomen surgery	□ Yes	Gallbladder surgery	□ Yes	Kidney transplant recipient deceased donor	□ Yes
Bladder surgery	□ Yes	Hysterectomy	□ Yes	Kidney transplant recipient living related donor	□ Yes
CABG	□ Yes	Kidney biopsy	□ Yes	Kidney transplant recipient living unrelated donor	□ Yes
Cardiac stent	□ Yes	Kidney removal	□ Yes	Lithotripsy	□ Yes
Cystectomy (bladder removal)	□Yes	Kidney stone surgery	□ Yes	Parathyroid surgery	□ Yes
Dialysis access surgery	□Yes	Kidney transplant	□ Yes	Thyroid surgery	□ Yes

Other surgical history: _____

Family History: (Place a "X" in the box □ in front of each item below that family members have been diagnosed with)

Mother: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Father: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Sister: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Brother: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Maternal Aunt: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Maternal Uncle: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Paternal Aunt: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Paternal Uncle: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Mat.Grandma: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Mat.Grandpa: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Pat.Grandma: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Pat.Grandpa: □Anemia □Autoimmune Disease □Cancer □Diabetes □HTN □Kidney Disease □Stroke □Heart disease □Dementia □Gout □Autosomal Dominant Disease

Add family member health information: _____

□ **Adopted** □**Family history unknown**

Social History: (select with a "X" applicable items below regarding your social history)

Tobacco Use: □ Current Every Day Smoker
□ Current Some Day Smoker
□ Former Smoker
□ Heavy Tobacco Smoker
□ Light Tobacco Smoker
□ Never Smoker
□ Passive Smoke Exposure – Never Smoker

Start Date: _____
Quit Date: _____
Types: □ Cigarettes □ Pipe □ Cigars
Packs/day: □0.25 □ 0.50 □ 1 □ 1.5 □ 2 □ 3
Years: □ 0.5 □ 1 □ 2 □3 □ 4 □ 5 □ 10 □15

Smokeless Tobacco Use: □ Current □ Former □ Never
Type: □ Snuff □ Chew
Smokeless Tobacco Quit Date: _____

Alcohol Use: □ Yes □ Not Currently □ Never □ Defer
Drinks/Week: _____ Glasses of wine
_____ Cans of beer
_____ Shots of liquor
_____ Standard drinks or equivalent
Alcohol/Week: _____

Substance Use: Drug Use: □ Yes □ Not Currently □Never □ Defer
Types:□Amphetamines □ Amyl nitrate □ Anabolic steroids
□Barbiturates □Benzodiazepines □ "Crack" cocaine
□Cocaine □Codeine □Fentanyl □ Flunitrazepam □GHB
□Hashish □ Heroin □ Hydrocodone □ Hydromorphone
□Ketamine □LSD □ Marijuana □MDMA (ecstacy)
□Mescaline □ Methamphetamines □ Methaqualone
□Methylphenidate □Morphine □Nitrous oxide □ Opium
□Oxycodone □ PCP □ Psilocybin □Solvent inhalants □ Other
Use/week: _____ Comments:_____

Living Arrangement: (select with a "X" in front of the accurate choice regarding your living arrangement below)

□Lives Alone
□Spouse
□Significant Other
□Family Member
□In Home Caregiver
□Assisted Living Facility (ALF or nursing home)

Functional/Cognitive: (select with a "X" in front of the accurate item(s) below)

□Impairment
□Memory Deficit
□Hearing Loss
□Poor Vision or Blindness
□Limited Mobility
□Transportation Challenges
□ No concerns noted regarding list above for functional/cognitive items