GEORGIA KIDNEY CONSULTANTS

René B. Mackay, MD • Julio E. Pena, MD

Emily Waldron, NP-C

1360 Caduceus Way
Building 400, Suite 104
Watkinsville, GA 30677

225 Plaza Drive
Monroe, GA 30655

119 Harmony Crossing
Suite 1
Eatonton, GA 31024

Demographic Information:

First Name:_____ Middle:_____ Last Name:_____

Prefix:_____ Suffix:_____ Nickname:_____ Maiden Name:_____

DOB: _____/_____/_____ Age:_____ Sex:_____ SSN:_____

Marital Status:_____ Race:_____ Are you Hispanic or Latino? YES or NO

Contact Information:

Mailing Address:_____

City:_____ State:_____ Zip:_____ Email:_____

Phone Numbers: (Please check the box next to the best number to reach you on)

☐ Home:_____ ☐ Cell:_____ ☐ Work:_____

Employer:_____ Phone Number:_____

Spouse/Parent:_____ Phone Number:_____

Emergency Contact:_____ Phone Number:_____

Primary Care Physician:_____ Referring Physician: _____

Preferred Pharmacy:_____ Phone Number:_____

Mail Order Pharmacy:_____ Phone Number:_____

Billing Information: *(Please present your insurance card and photo ID to the front office)*

Primary Insurance:_____ Referral Needed: YES or NO

Address:_____ Phone Number:_____

Policy #:_____ Group #:_____

Policy Holder:_____ Relationship:_____ DOB: ___/___/_____

Secondary Insurance:_____ Referral Needed: YES or NO

Address:_____ Phone Number:_____

Policy #:_____ Group #:_____

Policy Holder:_____ Relationship:_____ DOB: ___/___/_____

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Medical History

Date_____

Full Name_____ Date of Birth:_____

Primary Doctor:_____Referring Doctor:_____

Reason for Referral:_____

Medication: Please list all of the medications you are currently taking.

Name of Medication	Mg/Mcg	How many Pills/Tablets?	How often do you take it?

Social History

Allergies:_____

_____

Pharmacy:_____

_____

Caffeine ( ) Never ( ) Current --How many per day?_____

Tobacco ( ) Never ( ) Current ( ) Past --Year you quit:_____

How many per day:_____

Alcohol ( ) Never ( ) Current ( ) Past --Year you quit:_____

How many per day:_____

Do you have any family members with Kidney Disease?_____ If so, what stage?_____

Surgical History

Date	Type of Surgery and Hospital

Hospitilization History

Date	Reason and Hospital

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Past Medical History

Date_____

Please check(√) conditions you currently have or have had in the past years.

	Year Diagnosed	Doctor
( ) Kidney Disease (If so, what stage?)		
( ) Diabetic Nephropathy (Progressive Kidney Disease in people with Diabetes)		
( ) Diabetes Mellitus Type I (Insulin Dependent/High Levels of Sugar)		
( ) Diabetes Mellitus Type II (Non-Insulin Dependent/Resistance)		
( ) Diabetic Neuropathy (Peripheral Nerves Damage)		
( ) Hypertension (High Blood Pressure)		
( ) Proteinuria (Protein in Urine)		
( )Hematuria (Blood in Urine)		
( ) Hyperlipidemia (Elevated evel of any kind of lipids in the blood)		
( ) Hypercholesterolemia (High Blood Cholesterol(fats) in the blood stream)		
( ) Hypertryglyceridemia (Elevated Triglycerides)		
( ) Hyperparathyroidism (Over activity of the Thyroid Gland)		
( )Peptic Ulcer Disease (Gastric Ulcer)		
( ) Anemia ( )Asthma (Respiratory condition causing difficult breathing)		
( ) Gout (Uric Acid builds up causing inflammation in one joint)		
( ) Arthritis (Inflammation in the joints)		
( ) Edema (Enlargement of organs, skin or other body parts)		
( ) Cirrhosis (Poor Live function)		

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Past Medical History

Date_____

Please check(√) conditions you currently have or have had in the past years.

	Year Diagnosed	Doctor
( ) Obstructive Sleep Apnea (Repetitive pauses in breathing during sleep)		
( ) Depression (Feelings of hopelessness and inadequacy)		
( ) Fibromyalgia (Long-term body wide pain)		
( ) Vitamin D Deficiency (Lacking Vitamin D)		
( ) Coronary Artery Disease (Narrowing of the small blood vessels)		
( ) Cancer (If so, what type?)		
( )Tuberculosis (Infection in the lungs)		
( )Hepatitis (If so, what type?)		
( )Stroke (Brain attack)		
( ) Pacemaker (Device for stimulating the heart muscle)		

Family History

Father ( )Alive ( )Deceased ( ) Unknown	( ) Arthritis ( ) High Blood Pressure ( ) Gout ( ) Stroke ( ) Hay Fever ( ) Asthma ( ) Chemical Dependency ( )Diabetes ( )Tuberculosis ( ) Kidney Disease ( ) Heart Disease ( ) Cancer
Mother ( )Alive ( )Deceased ( ) Unknown	( ) Arthritis ( ) High Blood Pressure ( ) Gout ( ) Stroke ( ) Hay Fever ( ) Asthma ( ) Chemical Dependency ( )Diabetes ( )Tuberculosis ( ) Kidney Disease ( ) Heart Disease ( ) Cancer
Brothers ( )Alive ( )Deceased ( ) Unknown	( ) Arthritis ( ) High Blood Pressure ( ) Gout ( ) Stroke ( ) Hay Fever ( ) Asthma ( ) Chemical Dependency ( )Diabetes ( )Tuberculosis ( ) Kidney Disease ( ) Heart Disease ( ) Cancer
Sisters ( )Alive ( )Deceased ( ) Unknown	( ) Arthritis ( ) High Blood Pressure ( ) Gout ( ) Stroke ( ) Hay Fever ( ) Asthma ( ) Chemical Dependency ( )Diabetes ( )Tuberculosis ( ) Kidney Disease ( ) Heart Disease ( ) Cancer

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General Consent for Care and Treatment

TO THE PATIENT: ***You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedure are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Patient Name (PRINT)	Date
_____	_____
Patient/Designee Signature	Relationship to Patient
_____	_____
Printed Name/Signature of Witness	Job Title

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

☐ Do Not Release Information

I, _____, authorize Georgia Kidney Consultants, LLC and its representatives to use the additional contact information listed below to discuss information regarding any matters relating to my appointments, billing information, and/or medical care. This authorization will remain in effect until I provide written notification to Georgia Kidney Consultants, LLC of changes or updates.

Name:_____

Relationship:_____

Phone:_____

You may release the following information to the person named above:
☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

Name:_____

Relationship:_____

Phone:_____

You may release the following information to the person named above:
☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

If you wish to restrict use/disclosure to TPO in other ways, please request a form.
Under the terms of the consent, I can ask GKC to limit how my personal health information is used or disclosed to carry out treatment, payment or health care options. I understand that GKC does not have to agree to my request. If GKC does agree to my request, I understand that they would follow the agreed limits. If I revoke consent, GKC does not have to provide any further health care services to me.

_____ _____
Patient Name (PRINT) Date

_____ _____
Patient/Designee Signature Relationship to Patient

GEORGIA KIDNEY CONSULTANTS

"eRx" CONSENT FORM

Georgia Kidney Consultants is implementing ePrescribing in each of our offices. It is a federally mandated initiative that requires all physicians to prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by the credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your provider see important information like drug interaction and your prescription history.

The benefit to you is:

- Less confusion over hand written prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescription filled.

"Patient Consent:

I agree that Georgia Kidney Consultants may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Name (PRINT) Date

_____ _____

Patient/Designee Signature Relationship to Patient

Financial Policy

WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OFSOME OF OUR FINANCIAL POLICIES.

INFORMATION REGARTING YOUR INSURANCE COVERAGE

You must be informed of and understand the details of your health insurance coverage and fulfill any associated requirements (e.g., pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc.) It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services. You have the responsibility to provide us with the necessary information for any Worker's Compensation you may be receiving.

UNINSURED PATIENTS

If you do not have current health insurance coverage and/or we determine that period insurance is no longer valid, the entire payment for any services performed shall be paid at the time of service.

NON-PARTICIPATING PROVIDER OR NON-COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes. (Please note: In certain rare circumstances- and in our sole discretion- we may directly bill your insurance carrier as an out-of-network provider in lieu of accepting payment directly from you and if we do so, you agree to assign your payment rights to our office and forward us any checks you receive relative to the services we have provided you.)

PARTICIPATED PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., co-payments, deductibles and fees for non-covered services), which are due at the time of service.

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TYPES OF PAYMENT; DISHONORED CHECKS

For your convenience, our office accepts cash, personal checks, MasterCard, Visa, and American Express. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional $25.00 which shall be due and owing immediately.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

RELEASE OF MEDICAL RECORDS

Medical records created by our office shall only be released pursuant to your express written authorization in accordance with HIPAA or other controlling laws (or under circumstances as required by law). In accordance with Georgia law, we charge a photocopying fee of $0.90 per page, with a minimum fee of $15 and have up to 30 days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records.

MISCELLANEOUS FEES

Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. Prior to requesting any such services, you should request a copy of our miscellaneous services fee schedule.

By signing below, patient or responsible party acknowledges that he or she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

_____ _____

Patient Name (PRINT) Date

_____ _____

Patient/Designee Signature Relationship to Patient

GEORGIA KIDNEY CONSULTANTS

APPOINTMENT, CANCELLATION, and NO-SHOW GUIDELINES

SCHEDULED APPOINTMENTS

We understand that delays happen; however, we must keep the other patients and providers on time.

If a patient is 15 minutes past the scheduled time for a regular office visit or a physical exam, we reserve the right to reschedule the appointment.

CANCELLATION or NO-SHOW

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel the appointment, you may be preventing another patient from obtaining needed treatment**. If you cannot make your scheduled appointment time, please call 706-850-8135 to reschedule.**

We request that you give our office 24-hour notice in the event you need to cancel or reschedule your appointment. If you do not contact our office, we consider this to be a No-Show appointment. Excessive cancelled appointments may result in you being dismissed from the practice.

As a courtesy, we provide an appointment card/ a reminder call and/ or email for appointments. If you do not receive your reminder call or message, the cancellation guideline will remain in effect. You are responsible for remembering your appointment.

If you have any questions regarding these guidelines, please let our staff know and we will be glad to provide clarification.

I have read and understand the Appointment/Cancellation/No-Show Guidelines and agree to be bound by the terms.

_____ _____

Patient Name (PRINT) Date

_____ _____

Patient/Designee Signature Relationship to Patient

GEORGIA KIDNEY CONSULTANTS

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I authorize _____ to disclose the following information from the medical records of:

Patient Name:_____ Date of Birth:_____

Mailing Address: _____

Phone Number:_____

Covering the period(s) of health care from:_____ **to** _____.

Information to be disclosed:

( ) Complete Health Records, including:

( ) Discharge Summary ( ) History and Physical Examination ( ) Consultation Report
( ) Progress Note ( ) Pharmacy/Prescription Records ( ) Radiology Reports
( ) Laboratory Tests ( ) AIDS or HIV Infection ( ) Biopsy Reports
( ) Treatment for Alcohol and/or Drug Abuse ( ) Photographs/Images

This information is to be disclosed to the following individual or entity for the purpose of:

( ) Transfer to a New Provider ( ) Personal Use ( ) Consultation ( ) Treatments ( ) Other

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Send Records to:

GEORGIA KIDNEY CONSULTANTS

1360 Caduceus Way, Building 400, Suite 104, Watkinsville, GA 30677
Phone: 706-850-8135 Fax: 706-548-9101

The Patient or Patient's Designee must read and sign the following statements:

I understand that unless earlier revoked, this authorization will expire on _____.

_____ _____
Patient Name (PRINT) Patient/Designee Signature