HYPERTENSION & KIDNEY Associates of Middle GA

Iyad Barakat, MD
Mohammad A Aslam, MD
Deep Adhikari, MD

105 Tommy Stalnaker Dr. Suite 1
Warner Robins, GA 31088
TEL: (478)-333-3612 FAX: 478-333-3631

Welcome to Hypertension & Kidney Associates!

This packet contains important information to ensure a productive and thorough visit with your Hypertension and Kidney provider. Please take the time to complete these forms in as much detail as possible. Please bring with you to your appointment all your **medication bottles,** including vitamins and herbal supplements, and a **list of medication allergies, a photo id, or proof of residency** and your **insurance card.** If you are a **self-pay patient** please contact our office **prior to your appointment**, to determine what will be due at initial date of service

Upon your arrival, also please be prepared to supply us with a urine specimen.

This packet of information includes **"review of systems form"** which is a brief medical history for you. Remember; please be as detailed as possible as this will ensure a thorough visit. Also included is the **Statement of Payment Policy** as well as other important forms. Please complete the forms and mail the packet back to us, so we receive it at least **1 week prior** to your appointment. You can also download the package at **www.htnkidney.com**

It is important that you arrive **at least 30 minutes** early since we have a lot of information to exchange. Please note that patients arriving late for scheduled appointments may need to be rescheduled per the physician's discretion. We accept credit cards, checks, and cash for payment and your co-payment is required to be paid at the time of service. We do not keep change on site so please bring the correct amount. If for any reason you need to reschedule or cancel your appointment, please give us at least 24 hour notice so we can accommodate other patients. Please note that due to the fact that missed appointments or cancellations/reschedules within less than 24 hours notice cause us financial loss, we will not be able to reschedule your appointment in the following situations:

1. If you have not shown up for your initial appt. with us on 2 separate occasions.
2. You have cancelled or rescheduled your initial appt. with us 3 different times with less than 24 hour notice.

These situations do not allow us enough time to schedule another patient in your place and therefore the physician's time is lost. Thank you for your understanding of this policy and for giving us ample notice if you need to change your appointment time. We look forward to meeting you.
If you have any question or concerns prior to your visit, please contact our office at **(478)-333-3612.**

Thanking You,

Hypertension & Kidney Associates Team
TEL: (478)-333-3612
FAX: (478)-333-3631
www.htnkidney.com

OFFICE LOCATIONS

WARNER ROBINS	PERRY	FORT VALLEY	HAWINSVILLE
105 Tommy Stalnaker Dr. Suite 1 Warner Robins, GA 31088	118 Morningside Drive Perry, GA 31069	701 Blue Bird Blvd, Fort Valley, GA 31030	222 Perry Hwy. Professional Bld B.Hawkinsville GA 31036

HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA, LLC.
PATIENT INFORMATION

LAST NAME_____**FIRST NAME** _____**DOB:**_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE (HOME): _____(CELL):_____ (WORK):_____ MARITAL STATUS S M D W SEP

EMAIL ADDRESS _____AGE_____ SOCIAL SECURITY #_____

EMPLOYER_____ OCCUPATION_____

EMPLOYMENT STATUS: ☐CURRENTLY EMPLOYED ☐UNEMPLOYED ☐RETIRED ☐DISABLED

RACE: BLACK-WHITE-HISPANIC-ASIAN-OTHER LANGUAGE PREFERANCE: ENGLISH-SPANISH OTHER_____

INSURANCE HOLDER/GARUNTOR NAME _____DOB_____

RELATIONSHIP _____ TEL#_____ SSN:_____

ADDRESS_____CITY_____STATE_____ZIP_____

EMERGENCY CONTACT_____ ADDRESS_____:_____

RELATIONSHIP TO PATIENT_____ TEL# _____

PRIMARY	**SECONDARY**
INSURANCE COMPANY _____	**INSURANCE COMPANY** _____
POLICY #_____ GROUP # _____	POLICY #_____ GROUP # _____
NAME OF INSURED_____	NAME OF INSURED_____
RELATIONSHIP_____	RELATIONSHIP_____

NAME OF PRIMARY CARE PHYSICIAN _____ TEL #_____

NAME OF REFFERING PHYSICIAN _____ TEL #_____

NAME OF PREFERRED PHARMACY _____FAX#_____

ADDRESS_____ TEL#_____

WHO REFERRED YOU TO OUR PRACTICE: ☐INTERNET ☐HOSPITAL ☐FRIEND ☐PHYSICIAN:_____

CIRCLE OF CARE: ARE THERE ANY PROVIDERS YOU SEE ROUTINELY (FOR EXAMPLE CARDIOLOGIST, ENDOCRINOLOGIST, ETC) THAT ARE NOT LISTED ABOVE THAT YOU FEEL WE SHOULD OBTAIN RECORDS FOR YOUR VISIT; If so list their names and phone numbers below

_____

_____

_____

******PLEASE PRESENT INSURANCE CARD AND ID TO THE RECEPTIONIST******

FOR FILING OF YOUR INSURANCE

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize payment of medical benefits to Hypertension & Kidney Associates for services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signed _____ DATE _____

CHIEF COMPLAINT: Main reason for your visit today			
HISTORY OF PRESENT ILLNESS			**DATE**
Have you had kidney damage or protein in your urine?	No	Yes	
Have you had a kidney biopsy	No	Yes	
Have you ever been diagnosed with diabetes	No	Yes	
Have you had Eye damage (or laser treatment)	No	Yes	
Have you had nerve damage (numbness, decrease feeling in feet)	No	Yes	
Interim History:			**DATE**
Have you seen a kidney doctor in the past; If Yes: Dr. _____	No	Yes	
Have you ever been on dialysis	No	Yes	
Have you had any of the following procedures or medications in the last 60 days?			**DATE**
Antibiotics	No	Yes	
Radiology studies involving IV contrasts	No	Yes	
Colonoscopy	No	Yes	
Chemotherapy	No	Yes	
PAST MEDICAL HISTORY: Have you ever suffered or been diagnosed with the following Condition:			**DATE**
High Blood Pressure	No	Yes	
Diabetes	No	Yes	
Kidney Disease	No	Yes	
Kidney Stones	No	Yes	
Lung Disease	No	Yes	
Sleep Apnea	No	Yes	
Pneumonia	No	Yes	
Asthma/Shortness of Breath/COPD	No	Yes	
Heart Disease	No	Yes	
High Cholesterol	No	Yes	
Congestive Heart Failure	No	Yes	
Abnormal Heart Rhythm	No	Yes	
Gastric Disease/Reflux	No	Yes	
Arthritis	No	Yes	
Nervous/Anxiety Disorders	No	Yes	
Hepatitis	No	Yes	
Headaches/Dizziness	No	Yes	
HIV/AIDS	No	Yes	
Cancer: If yes, list what type _____	No	Yes	
ALLERGIES: List name of medications, foods, other agents/substances you are allergic to:			
DRUG NAME	**REACTION**		**ACTIVE (Y/N)**

SURGICAL HISTORY	
Type	**Date(MO)(YR)**
☐ AV Fistula, Location:	
☐ AV Graft, Location:	
☐ Peritoneal Catheter	
☐ Prostrate Removal	
☐ Kidney Stone Removal (Lithotripsy)	
☐ Kidney Removal	
☐ Kidney Biopsy	
☐ Kidney Transplant ☐ Left ☐ Right	
Transplant Type: ☐ Living Related ☐ Living Non-Related ☐ Cardaveric Transplant Facility	
Please list any others	

HOSPITALIZATIONS	
Reason for Hospitalization	**Date(MO)(YR)**

FAMILY HISTORY						
	Father	**Mother**	**Brother(s)**	**Sisters(s)**	**Son(s)**	**Daughter(s)**
A-Alive/D-Deceased	A / D	A / D	A / D	A / D	A / D	A / D
Chronic Kidney Disease						
Dialysis						
Diabetes						
Hypertension						
Lupus						
Polycystic Kidney Disease						
Heart Disease						
Stroke						
Cancer						
Mental Illness						
Unknown						

SOCIAL HISTORY - Answer all Sections		
DIET	**TOBACCO**	**ALCOHOLIC BEVERAGES**
Any special diet:	Cigarettes: Packs/day	Never:
	Cigars: Pipe:	Less than 6 drinks/week:
	Age Started smoking	Over 24 drinks/week:
	Age stopped smoking	Treated for alcoholism
EXERCISE	Snuff:	Tested for drug dependency
Type:	Chewing Tobacco:	Outcome of either treatment:
		Recreational drug use:

HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA, LLC.
MEDICATION LIST

Please list ALL your medications, including **Over the Counter medications, Herbals Supplements and vitamins.**
Also list any pain or arthritis medication such as Tylenol, Motrin, Advil, Ibuprofen, Aleve, Naproxen, Asprin, Goody pwdr
(Please bring all your meds for every appointment)

PATIENT NAME:_____ **DOB:**_____

MEDICATION	**DOSAGE** (Mg,mcg, ml,etc)	**PRESCRIBED BY HOW OFTEN** (Daily, twice daily, etc)

REVIEW OF SYSTEMS: **Please indicate ONLY symptoms that you are currently experiencing**

GENERAL/CONSTITUTIONAL		
Weakness	NO	YES
Fatigue	NO	YES
Change in appetite	NO	YES
Lightheadedness	NO	YES
Night Sweats	NO	YES
Weight gain > 10lbs	NO	YES
Weight loss > 10lbs	NO	YES
ENT		
Drainage/Discharge in Ears	NO	YES
Discharge from Nose	NO	YES
Dry Mouth	NO	YES
Ear Pain	NO	YES
Nose bleeds	NO	YES
Congestion	NO	YES
Sinus pain/pressure	NO	YES
Sore throat	NO	YES
Swollen glands	NO	YES
Sores in mouth	NO	YES
Blocked ear	NO	YES
CARDIOVASCULAR		
Bluish tint to lips/Fingertips	NO	YES
Leg Ulcers	NO	YES
Leg cramps with walking	NO	YES
Leg swelling	NO	YES
Chest pain at rest	NO	YES
Chest pain with exertion	NO	YES
Shortness of breath	NO	YES
Difficulty lying flat	NO	YES
Palpitations	NO	YES
RESPIRATORY		
Coughing up blood	NO	YES
Cough	NO	YES
Pain with inspiration	NO	YES
Sputum production	NO	YES
Wheezing	NO	YES
Snoring	NO	YES
Excessive daytime sleeping	NO	YES
GASTROINTESTINAL		
Abdominal pain	NO	YES
Blood in stool	NO	YES
Constipation	NO	YES
Decreased appetite	NO	YES
Diarrhea	NO	YES
Exposure to hepatitis	NO	YES
Heartburn	NO	YES
Nausea	NO	YES
Vomiting	NO	YES

GENITOURINARY		
Blood in urine	NO	YES
Difficulty urinating	NO	YES
Frequent urination	NO	YES
Pain in lower back	NO	YES
Painful urination	NO	YES
Foamy urine	NO	YES
Decreased urine stream	NO	YES
Incontinence of Bladder	NO	YES
Bladder Pain	NO	YES
MUSCULOSKELETAL		
Joint stiffness	NO	YES
Leg cramps	NO	YES
Muscle Aches	NO	YES
Painful joints	NO	YES
Swollen joints	NO	YES
Weakness	NO	YES
Back or Flank Pain	NO	YES
NEUROLOGICAL		
Paralysis	NO	YES
Weakness of arms or legs	NO	YES
Abnormal Gait	NO	YES
Numbness in hands or feet	NO	YES
Balance difficulty	NO	YES
Dizziness	NO	YES
Lightheadedness	NO	YES
Fainting	NO	YES
Gait abnormality	NO	YES
Headache	NO	YES
Loss of use of extremity	NO	YES
Seizures	NO	YES
Tingling/Numbness	NO	YES
Transient loss of vision	NO	YES
Tremor	NO	YES
ENDOCRINE		
Frequent Urination	NO	YES
Excessive thirst	NO	YES
Heat Intolerance	NO	YES
Cold Intolerance	NO	YES
Excessive sweating	NO	YES
Weight gain > 10lbs	NO	YES
Weight loss > 10lbs	NO	YES
HEMATOLOGY		
Dizziness	NO	YES
Easy Bruising	NO	YES
Prolonged Bleeding	NO	YES
Recent transfusion	NO	YES
Swollen glands	NO	YES

HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA, LLC.
PAYMENT POLICY AS OF JAN 2015

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Insurance Coverage

We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first. Also note, that Insurance Companies have agreements with certain laboratories, It is your responsibility to know which laboratory your insurance authorizes, and to inform the staff at Hypertension and Kidney.

Copays We have a contractual obligation (with your insurance company) to **collect** your copay at the time of service, and you have a contractual obligation (with your insurance company) to **pay** your copay at the time of service. Because of these contractual obligations, **our office does not bill copays. Copays are the patient's responsibility and are due at the time of service.** We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care you will be expected to pay this amount at the time of service. If you are unable to pay your copay at the time of your appointment, we may require that you reschedule your appointment.

Accepted Forms of Payment

We accept payment by cash, check, Visa, MasterCard, and Discover.

Patient Outstanding Balances

If you have an outstanding balance with our company we will send a "Billing Statement" monthly to your home. We expect that you will pay your full balance upon receipt of our billing statement. If you are unable to pay the outstanding balance in full in a single payment, please contact our Billing Office. Our billing office is available Monday – Friday from 8:00am to 5:00pm to assist you in satisfying your financial obligation. Please call us to discuss payment plans, patient financial evaluations and discounts available..

Unpaid Accounts

In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee in order to continue receiving medical care from our physicians. Once your account has been sent to collections, you will need to make payment arrangements with the collection agency.

Other Possible Fees Missed Appointment Fee - A missed appointment is a scheduled appointment that you miss without notifying us in advance. An appointment that is cancelled or rescheduled with less than 24 hours notice is also considered a missed appointment. Our policy is that the first time you miss or cancel an appointment with less than 24-hours notice, a letter will be sent to you. The 2nd time you miss or cancel an appointment with less than 24-hours notice a $25.00 fee will be charged to your account. Insurance companies do not cover this charge, and you will be responsible for paying this fee prior to being seen again by our physicians. **Disclaimer:** The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

Returned Check Fee - It is the policy of Hypertension and Kidney Associates to charge $35.00 to patients whose checks are returned by our bank for non-sufficient funds. If a patient puts a stop payment on a check, the amount we will charge is $25.00. This is the amount our bank charges for these items.

Patient Name PRINTED: _____ **DOB:** _____

Patient Signature: _____ **Date**: _____

HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA
AUTHORIZATION FOR RELEASE OF INFORMATION

In general the HIPPA privacy rule, gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the patients office instead of the patients home.

I wish to be contacted in the following manner (check all that apply)

☐ **Home Telephone**: _____ ☐ **Written Communication**

☐ Ok to leave a message with information ☐ Ok to mail to home address

☐ Leave message with call back number only ☐ Ok to mail to work

☐ **Work Telephone**: _____

☐ Ok to leave a message with information

☐ Leave message with call back number only

I authorize the Release of medical info and appointments to: (check all that apply)

☐ Spouse, Name:_____ Phone number:_____

☐ Parent, Name:_____Phone number:_____

☐ Employer/school:_____ Phone number:_____

☐ DO NOT DISCUSS WITH ANYONE

☐ Other:_____

_____ _____
Patient or Legal Representative Printed Name **Patient or Legal Representative Signature**

_____
Date

Please notify the office if you would like to make any changes to the form in the future

The privacy rule generally requires healthcare providers to take responsible steps to limit use or disclosure of, and requests for PHI, **Uses and disclosures for PHI may be permitted without prior consent only In an emergency**.

HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA
MEDICAL CARE DIRECTIVE

At Hypertension and Kidney Associates, we strive to comply with patient wishes concerning the extent of care that they would like to receive

We recognize the patients right to execute living wills, to enter advanced directives concerning the extent of care that they receive and to designate a surrogate as their agent should they become unavailable to make decisions concerning their own care

To help us comply with your wishes concerning the extent of care that you would like to receive, it is necessary that we be informed of any advance directives that you may have prepared and executed. Please provide us the following information so we can do so.

1. Have you executed a living will?

☐**YES** ☐**NO**

If yes, please provide a copy of the living will.

2. Have you executed a power of attorney for healthcare?

☐**YES** ☐**NO**

If **YES**, please provide a copy of your power of attorney for healthcare to the nurse upon completion of this form

Please state Date executed _____

3. IF **NO,** information on living will was requested and given**,**
Please refer to the website **http://georgialegalaid.com** for additional details

_____ _____

Patient or Legal Representative Printed Name **Patient or Legal Representative Signature**

_____

Date

HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA, LLC.
NOTICE OF INFORMATION PRACTICES

The privacy of your health information is important to us this notice describes how your health information is used and disclosed and how you may access this information

OUR LEGAL DUTY:
We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect 09/01/2007 and will remain in effect until it's replaced

USES AND DISCLOSURES OF HEALTH INFORMATION

1. The practice may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples of these include, but are not limited to, referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims, including coordination of benefits with other insurers. Healthcare operations examples include internal quality control of records, etc.

2. The practice will not make, use or disclose, protected health information about the individuals written consent or authorization. Such authorization may be revoked at any time. Revocation must be in writing. Two exceptions to this would include public health requirements and court orders.

3. The practice reserves the right to change the terms of this notice and make new provisions effective for all the protected health information it maintains. The practice will provide each patient with a copy of any revisions of this notice at the time of the next visit, or at the last known address. A copy can be obtained at the office at any time during business hours.

4. Any patient, guardian of personal representative has the right to:

    a. Object to the use of their health information for directory purposes.
    b. Inspect and obtain copies of the record.
    c. Request amendments be made to their record.
    d. Request a six-year accounting of all disclosures of the record. The history will be provided within 60 days and a reasonable charge maybe assessed.
    e. Request restrictions to how their information may be used or disclosed. The practice is not required to agree to these restrictions, but if the practice does agree, it must comply.

5. Any person or patient may file a complaint to the practice and to the secretary of Health and Human Services if they believe their privacy rights have been might violated. To file a complaint with the practice, please contact our office manager at the office or phone number. All complaints will be addressed and the results will be reported. It is the policy of the practice that no retaliatory action will be made against any individual who submits a complaint.

CONSENT TO USE AND DISCLOSURE
I _____have had the opportunity to read the notice and consent to the use and disclosure of my protected information to carry out treatment, payment activities and healthcare operations. Name of patient date signature relationship to patient

NAME OF PATIENT_____ **DATE**_____

SIGNATURE _____ **RELATION TO PATIENT**_____