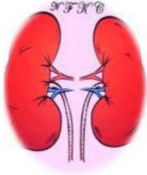

NORTH FLORIDA KIDNEY CARE

MELVIN SEEK, MD
DON HENRY ESPRIT, MD, FASN

RONALD WENDT, APRN, FNP-BC
TARA GETTINS, APRN, FNP-C

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FAX: 386-530-7690

Patient Information

Last Name	First Name	MI	Date Of Birth
Address	City	State	Zip
Primary Phone	Home Phone □	Work Phone □	Cell Phone □
E-mail Address	Gender □ M □ F	SSN - -	Preferred Language

Marital Status	Preferred Contact	Ethnicity	Race
□ Married	□ Home Phone	□ Hispanic/Latino	□ American Indian
□ Single	□ Work Phone	□ Non-Hispanic	□ Asian
□ Divorced	□ Cell Phone	□ Filipino	□ Black or African American
□ Separated	□ ***Opt out*** of Reminder Calls	□ Other	□ White
□ Widow ed	□ ***Opt out*** of Patient Satisfaction Mailings	□ Decline	□ Other
□ Life Partner			□ Decline

Primary Care Provider	Referring Provider

Primary Insurance Information

Insurance Company	ID#	Group #

Policy Holder Information ☐ Same As Patient

Insured Full Name	Date of Birth	Subscriber's SSN - -	Effective Date
Relationship to Patient			

Secondary Insurance Information

Insurance Company	ID#	Group #

Policy Holder Information ☐ Same As Patient

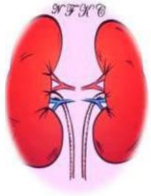
Insured Full Name	Date of Birth	Subscriber's SSN - -	Effective Date
Relationship to Patient			

Emergency Contact

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please Check Primary Phone	Home Phone □	Work Phone □	Cell Phone □

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Florida Kidney Care, LLC or insurance company to release any information required to process my claims.

Patient signature	**Date**



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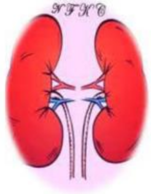
Patient name:____________________

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Medications – *List all medications you take, prescriptions and non-prescription, and the dosage*			
□ I do not take any medications			
Medication Name	Dosage	Medication Name	Dosage

Allergies - *List all know allergies*	
□ No Known Allergies	

Medical History – *Check (✓) if you have ever experienced the following conditions*		
□ None	□ Deep Venous Thrombosis	□ Kidney Stones
□ Anemia	□ Ey e Disease	□ Neuromuscular Disease
□ Asthma	□ GI Disorders	□ Neuropathy
□ Bleeding Problems	□ Gout	□ Peripheral Vascular Disease
□ Broken Bones	□ Hearing Problems	□ Retinopathy
□ Coronary Artery Disease	□ Heart Disease	□ Sleep Apnea
□ Cancer - Ty pe	□ Hepatitis - Ty pe	□ Stroke
□ Congestive Heart Failure	□ High Blood Pressure	□ Thyroid
□ Depression	□ Hyperlipidemia	□ UTI's
□ Diabetes	□ Kidney Disease	□ Other________________________________



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Patient name:____________________

Surgical History - *Check (✓) if you have received the following procedures, and year preformed*			
Surgical Procedure	Year	Surgical Procedure	Year
☐ None		☐ Hernia Repair	
☐ Angioplasty		☐ Hip Replacement	
☐ Angioplasty w /Stent		☐ Knee Replacement	
☐ Appendectomy		☐ LASIK	
☐ Arthroscopy Knee		☐ Liv er Biopsy	
☐ Back Surgery		☐ Kidney Biopsy	
☐ CABG (Heart By pass		☐ Pacemaker	
☐ Carpal Tunnel Release		☐ Small Bowel Resection	
☐ Cataract Ex traction		☐ Thyroidectomy	
☐ Cholecystectomy		☐ Tonsillectomy	
☐ Colostomy		☐ Other	
☐ Gastric By pass		☐ Other________________________________	

Hospitalizations		
Ty pe of hospitalization & reason	Hospital	Year

Immunization History - *Check (✓) if you have received the following*	
Immunization	Date/Year
☐ Influenza	
☐ Pneumonia	
☐ Hepatitis	
☐ Tetanus	
☐ Chickenpox	
☐ MMR (Measles, Mumps, Rubella)	

Personal and Social History	
Personal	What is your Occupation?
	Who do you live with? ☐ Alone ☐ Spouse ☐ Partner ☐ Child(ren) ☐ Other__________________
Children	Do you have Children? ☐ Yes ☐ No Number of Sons_______Daughters_______

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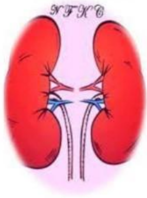
Patient name:____________________

Personal and Social History Continued

Alcohol and Drug Use	Do you drink alcohol? □ Yes □ No **If yes,** how often? □ Daily □ weekly □ Monthly □ Occasionally
	Recreational or street drug use? □ Yes □ No
	Analgesic/Painkiller drug abuse? □ Yes □ No
Transfusions	Have you ever had a blood transfusion? □ Yes □ No **If Yes,** When
Smoking Status	Current Smoking Sat? □ Current Every Day Smoker □ Current Some Day Smoker □ Heavy Smoker (11 or more cigarettes/day) □ Light Smoker (less than 11 cigarettes/day) □ Former Smoker □ Never Smoker □ Smoking status unknown
	Quantity__________/Per_______ Start Date____________________________Quit Date
Advanced Care Plan	*Do you have a **Surrogate Decision Maker**? □ Yes □ No **If Yes,** Who Do you have a Documented **Advanced Care Plan**? □ Yes □ No **If Yes, please provide copy to the office** Do you have **DNR** or **Living Will**? □ Yes □ No **If Yes, please provide copy to the office** Do you have a **Durable Power of Attorney** or **health care proxy**? □ Yes □ No If **Yes, please provide copy to the office** ***Surrogate Decision Maker:** A surrogate decision maker, also known as a health care proxy or as agent, is an advocate for your healthcare if you become incapacitated. If you are unable to make decisions or decide your personal health care, someone else must provide direction in decision-making, as the surrogate decision-maker.

Family Health History - Check (✓) if any family member(s) has had any of the following conditions

	No History	Father	Mother	Brother	Sister	Son	Daughter	Other
Anemia	□	□	□	□	□	□	□	□
CAD	□	□	□	□	□	□	□	□
Cancer-Type	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□
Hyperlipidemia	□	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□	□	□
Kidney Stones	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□



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PERMISSION TO DISCUSS HEALTH INFORMATION WITH OTHER INDIVIDIUALS

Purpose: The purpose of this document is to provide permission for North Florida Kidney Care, LLC to discuss your healthcare with the other people listed on the form as it relates to their involvement in your care. You must provide the names, relationships and numbers of those individuals you wish to be on the form and you canupdate or revoke itat any time. If youwish for us not to speak with any individuals, please do not complete the form.

Instructions:

1. Write the name of the family members or other individuals who are involved in the patient's health care, and have the patient or the patient's Personal Representative sign and date the form.

2. If the patient's Personal Representative is signing the form on behalf of the patient, the Personal Representative must also sign and date the acknowledgement that he or she has the legal authority to do so.

1. Individuals to whom North Florida Kidney Care, LLC may disclose my PHI for coordination of care purposes

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I hereby grant North Florida Kidney Care, LLC permission to discuss my health information with the people listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

Name	Relationship (friend, relative, etc.)	Phone #
1 .		
2 .		
3 .		
4 .		
5 .		

1. I understand that if I do not list any one and I am not present or is incapacitated, Southern Kidney Care may share my information with family, friends, or others that North Florida Kidney Care, LLC has determined, based on professional judgment, is in my best interest and necessary for coordination of care and/or payment for health care services I have received from North Florida Kidney Care, LLC.
2. I understand that I may revoke or change the list of people with my provider may share my information by notifying the facility in writing.
3. I understand that a revocation is not effective to the extent that any person or entity has acted in reliance on my authorization.
4. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law .
5. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on signing this authorization.
6. This authorization/permission form will remain in effect for ten (10) y ears or the day my treatment relationship with North Florida Kidney Care, LLC ceases or I revoke my permission, except for patients treating in Maine, Mary land, w hose authorization/permission form will remain in effect for one (1) year or Montana w hose authorization/permission form will remain in effect for six (6) months or the day I revoke my permission.

This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

______________________________ __________________

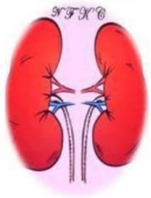
Signature of Patient or Legal Representative Date of Signature

2. Personal Representative Acknowledgement

If the patient is a minor or has a personal representative, I represent that I am the legal Personal Representative of the patient named above and I have the legal authority to act on behalf of the patient in making decisions related to health care.

______________________________ __________________

Signature of Patient or Legal Representative Date of Signature



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NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document a patient's acknowledgement of receipt of our Privacy Practices or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

PATIENTNAME:_______________________________

TO THE INDIVIDUAL: Please complete the following acknowledgement.

❑ I acknowledge that I received the Privacy Practices Notice of this health care provider.

(Please sign in the space indicated below)

TO THE TEAMMATE: Please complete the following if the patient is unable to sign and sign in the space below.

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

❑ The individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

Please provide an explanation of the patient's refusal or inability to sign:____

____

❑ Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are therefore not required to obtain an acknowledgement.

THIS FORM HAS BEEN SIGNED BY: (please check one)

❑ PATIENT

❑ PATIENT'S PERSONAL REPRESENTATIVE

❑ TEAMMATE

I attest that the above information is correct.

________________________________ ____________________

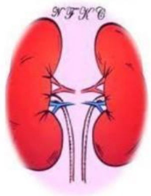
Signature Date

____

Printed name

____

Witness signature



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FINANCIAL POLICY
(PRIVATE INSURANCE AND SELF-PAY PATIENTS)

Patient name: ____DOB:____________________
(Please Print)

Any healthcare insurance policy that you may have is a contract between you and your insurance company and/or employer. North Florida Kidney Care, LLC will assist you in obtaining payment from any healthcare insurance policy for medical serv ices and goods that you receive at our practice; however, you remain primarily responsible to pay for all medical services and goods rendered from North Florida Kidney Care, LLC.

OUR FINANCIAL POLICY	
______ Initial	**You are responsible for any and all applicable co-payments, coinsurance, and unmet deductibles.** It is the patient's responsibility to provide us with current insurance information at each visit. According to your insurance, payment is expected at the time of your visit. Some insurance carriers charge a co-pay for each type of provider seen during one day; therefore, if you are seen by more than one prov ider on the same day you may be responsible for more than one co-payment. You will also be responsible for any past-due balances that may remain on your account. Patients with delinquent accounts will be required to make payment on the date of the visit. If you are unable to make mutually agreeable payment arrangements your appointment may be rescheduled based on the clinical discretion of the provider.
______ Initial	**Payment is Due When Services are Provided.** North Florida Kidney Care, LLC requires that all applicable co-payments, coinsurance, deductibles and any past due amounts on the account be paid on date of visit. In the event that you are not covered by a healthcare plan, full payment is required on the date of visit.
______ Initial	**Assignment of Benefits.** I hereby assign North Florida Kidney Care, LLC any insurance or other third-party benefits available for healthcare services provided to me. I understand that North Florida Kidney Care, LLC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to North Florida Kidney Care, LLC, I agree to forward the Practice all health insurance and other third-party payments I receive for serv ices rendered to meimmediately upon receipt.
______ Initial	**Payment Methods and Returned Check Fee.** North Florida Kidney Care, LLC accepts MasterCard/Visa, personal checks, and cash. If the bank returns your check due to insufficient funds you will be charged a $25.00 serv ice charge which will be due, along with the amount of the returned check, withinthree (3) business days. Your account will be placed on a "cash-only basis."
______ Initial	**Prompt Payment of Mailed Invoices.** In the event that you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 14 days. Amounts for which you are liable may be identified as "*patient balance due*" on the invoice. Patients with an outstanding balance more than 90-day s overdue must make payment arrangements prior to scheduling appointments. Call the billing number provided on your statement to make payment arrangements.
______ Initial	**Non-covered Services.** While the filing of insurance claims is a courtesy that we extend to our patients, not all services provided by North Florida Kidney Care, LLC may be covered by every healthcare plan. Any service determined not to be covered by your plan will be your responsibility. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

ACKNOWLEDGEMENT

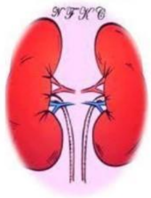
I HAVE READ AND UNDERSTAND the Financial Policy of North Florida Kidney Care, LLC and agree to be bound by it. I understand that healthcare insurance does not cover all medical goods and services and my responsibilities with respect to healthcare insurance as explained above. I under stand that I am ultimately responsible for payment for medical goods and services provided to me by North Florida Kidney Care, LLC. I hereby grant North Florida Kidney Care, LLC the right to bill and collect from my healthcare insurance plan for medical goods and serv ices provided to me. ***If the patient is a minor (younger than 18 years old), the parent or guardian must sign below.***

X ______________________________________ ____________________

Responsible party /Guarantor Printed Name Relationship

X ______________________________________ ____________________

Responsible party /Guarantor Signature Date



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(ONLY SIGN, DO NOT FILL OUT)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's name: ______________________________ DOB: ______________

I hereby authorize ____

(Doctors, Hospital, Facility, Other) to disclose my protected health information to North Florida Kidney Care.

Phone: ___________________ Fax: __________________

Requested documents:

____

The purpose of this release of information is:

Continue care Insurance Process/Legal Reasons

Personal Reasons Other_______________________

I understand that I am not required to sign this authorization, however the information will not be disclosed without it. I understand that if anyone who received my health information is not a healthcare provider or health plan, federal privacy laws may no longer protect my information.
I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending correspondence to the manager of the facility listed above. This authorization will expire 90 days from the date of signature. A photocopy is as valid as the original.

Signature____

(Signature of patient or legal representative) if the patient has a personal representative: I represent that I am the legal guardian/personal representative of the patient names above and I am not prohibited by court order from releasing access to the requested information.