Nephrology Associates of Dayton Inc. *Patient Information*

Dr. Klein Dr. Oxman Dr. Doerr Dr. Kaufhold Dr. Colao Dr. Jackson Dr. Eze Dr. Ammula Dr. Lovekar

PATIENT INFORMATION – PLEASE FILL OUT ALL INFORMATION COMPLETELY

Patient Name First Middle Last			**Home Phone ( )**
Home Address			**Cell Phone ( )**
City **State** **Zip**			**Work Phone ( )**
DOB _____/_____/_____	**SSN - -**	**Race**	**Marital Status**
Employer			**Business Phone ( )**
Spouse's Name			**Spouse's Employer**
Spouse's DOB _____/_____/_____			**Spouse's SS # - -**
Emergency Contact Other than Home Number: **Name:**			**Phone Number ( )**
Family Physician			**Phone number ( )**
Referring Physician			**Phone Number ( )**

INSURANCE INFORMATION – MUST BE FILLED OUT COMPLETELY

Primary Insurance	**Effective Date**	
Policy Holders Name	**ID #**	**Group #**
Secondary Insurance	**Effective Date**	
Policy Holders Name	**ID #**	**Group #**
Tertiary Insurance	**Effective Date**	
Policy Holders Name	**ID #**	**Group #**

I consent to treatment necessary for the care of the above named patient. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY Nephrology Associates of Dayton, Inc.

I understand that payment of charges is due at the time of service unless other definite arrangements have been made prior to treatment. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES. I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO Nephrology Associates of Dayton, Inc. SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

_____ _____

SIGNATURE DATE

***** FOR FUTURE USE ONLY *****

I AGREE THAT THE ABOVE INFORMATION IS CURRENT AND ACCURATE, AND THAT I HAVE REVIEWED IT COMPLETELY!

INITIAL	DATE	INITIAL	DATE	INITIAL	DATE
INITIAL	DATE	INITIAL	DATE	INITIAL	DATE
INITIAL	DATE	INITIAL	DATE	INITIAL	DATE

OVER

Nephrology Associates of Dayton, Inc.
Payment and Dismissal Policy

Thank you for choosing us as your specialty care provider. We are committed to providing you with the highest quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed these policies. Please read this carefully, ask us any questions you may have, sign and date in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans including Medicare and Medicaid. Please check with your insurance company if you are unsure if we are providers under your plan. Knowing your insurance benefits is your responsibility.
2. **Co-payment.** All co-payments 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 from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. A $15.00 fee will be assessed to your account if we have to bill you for your copay, unless prior arrangements have been made with the billing department.
3. **Proof of Insurance.** You must complete our patient information form before seeing the doctor. You must also provide us with your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all charges incurred.
4. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claim paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Failure to do so will result in you being 100% responsible for charges incurred. 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.
5. **Coverage Changes.** If your insurance changes, please notify us immediately so we can make appropriate changes to help you receive your maximum benefits.
6. **Referrals.** It is your responsibility to know if you need a referral from your primary care physician to see a specialist. You must obtain and bring the referral with you to your visit or make arrangements with your primary care physician to have it faxed to our office. If your visit is denied due to lack of referral, you will be responsible for charges incurred.
7. **Dismissal from practice.** There are several reasons we may dismiss you as a patient from our practice.
   A) **Non-payment.** If your account is over 90 days past due, you will receive a final statement giving you 15 days to pay your account or to arrange payment. Failure to do so will result in your account being turned over to a collection agency and possible dismissal from the practice.
   B) **Non-compliancy.** If you fail to comply with a recommended plan of care, including subsequent appointments.
   C) **Abuse.** If you, a family member or other display any verbal abuse, disruptive or violent behavior towards any staff member or physician.

If you are dismissed from the practice, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis. You will NOT be dismissed based on ethnicity, gender, religion or age. Our practice is committed to providing the best treatment to our patients. Thank you for reviewing our payment policy. If you have any questions, do not hesitate to ask one of our staff.

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

_____ _____

Signature of patient or responsible party **Date**

Patient Name:_____ **Date of Birth:**_____ **Today's Date:**_____

IT IS VERY IMPORTANT TO BRING YOUR MEDICATION LIST TO EVERY VISIT!

1. **Please list any allergies, adverse reactions, or side effects to medications/latex/dyes/shellfish/etc and the type of reaction you have to these items:** _____

2. **List all medications (including over-the-counter) that you are currently taking:**

Name of Medication	Strength (ex: mg)	How often do you take this medication?

3. **What is your preferred pharmacy?**

Pharmacy Name: _____ Location (Street/City):_____

4. **Have you been diagnosed with any of the following?**

Diagnosis	Yes or No	What year were you diagnosed?
Diabetes	Y or N	
High Blood Pressure	Y or N	
Protein in Urine	Y or N	
Blood in Urine	Y or N	
Kidney Stones	Y or N	
Cancer (if yes, what part of body?)	Y or N	
Thyroid Problems	Y or N	
Frequent Urinary Infections	Y or N	

Any other medical problems not mentioned above: _____

Please continue on other side...

Patient Name:_____ **Date of Birth:**_____ **Today's Date:**_____

5. **List all surgeries you have had:**

Type of Surgery	Location on Body	Year of Surgery	Surgeon or Facility

6. **Provide a Medical Family History (blood relatives only):**

Relative	Living / Deceased	Age at Death	Health Problems
Mother			
Father			
Sister			
Brother			

7. **Do or did you ever use tobacco (smoke or chew)?** **Yes or No (circle one)**
   If yes, do you currently use tobacco? Yes or No
   If yes, how much do you use per day? _____
   If you do not currently use, when did you quit? _____
   When you used, how much did you use per day? _____

8. **Do you currently drink alcoholic beverages?** **Yes or No (circle one)**
   If yes, how much do you drink per month? _____

9. **Do you have a history or currently use substances or drugs?** **Yes or No (circle one)**
   If yes, what substances or drugs? _____

10. **Please list all doctors you visit on a regular basis:**

Physician Name	Why do you see this doctor?	How long?

Thank you. Please update this information with your physician anytime it changes.

Nephrology Associates of Dayton
Review of Systems

Name: _____
Date: _____
D.O.B. _____

		GENERAL	
YES	NO	Weight Change	
YES	NO	Appetite Change	
YES	NO	Fever	
YES	NO	Chills	
YES	NO	Night Sweats	
YES	NO	Fatigue	
		SKIN	
YES	NO	Rash / Sores	
YES	NO	Itching	
YES	NO	Yellow Jaundice	
YES	NO	Change in Hair / Nails	
		EYES	
YES	NO	Blurred Vision	
YES	NO	Double Vision	
YES	NO	Light Sensitivity	
YES	NO	Blindness	
YES	NO	Glasses	
		EARS	
YES	NO	Ear Infection	
YES	NO	Ringing in Ears	
YES	NO	Hearing Loss	
		NOSE	
YES	NO	Sinus	
YES	NO	Nosebleeds	
YES	NO	Hayfever / Allergies	
		MOUTH	
YES	NO	Bleeding Gums	
YES	NO	Frequent Sore Throats	
YES	NO	Trouble Swallowing	
YES	NO	Hoarseness	
		NECK	
YES	NO	Stiffness	
YES	NO	Pain	
YES	NO	Lumps	
		RESPITORY	
YES	NO	Wheezing	
YES	NO	Chronic Cough / Sputum	
YES	NO	Coughing Up Blood	

Please continue on other side.

CARDIOVASCULAR

YES	NO	Heart Murmur	
YES	NO	Shortness of Breath	
YES	NO	Lying Flat in Bed	
YES	NO	At Rest in a Chair	
YES	NO	With Activity	
YES	NO	Smothering When Asleep	
YES	NO	Chest Pain / Heart Attack	
YES	NO	Palpitations / Skipped Beat	
YES	NO	Leg Pain When Walking	
YES	NO	Leg / Abdominal Swelling	

GASTROINTESTINAL

YES	NO	Nausea / Vomiting	
YES	NO	Diarrhea	
YES	NO	Constipation	
YES	NO	Vomit Blood	
YES	NO	Blood in Stool	
YES	NO	Abdominal Pain	

GENITOURINARY

YES	NO	Pain / Burning with Urination	
YES	NO	Increased Urgency	
YES	NO	Urination at Night	
YES	NO	Problems Initiating Stream	
YES	NO	Problems Stopping Stream	
YES	NO	Urgency	
YES	NO	Incontinence	
YES	NO	Blood in Urine	
YES	NO	Foamy Urine	

MUSCULOSKELETAL

YES	NO	Muscle Pain	
YES	NO	Joint Pain / Arthritis	

ENDOCRINE

YES	NO	Increased Thirst	
YES	NO	Increased Urination	
YES	NO	Increased Appetite	
YES	NO	Temperature Intolerance	

NEUROPSYCHIATRIC

YES	NO	Seizures	
YES	NO	Paralysis	
YES	NO	Numbness / Tingling	
YES	NO	Depression / Anxiety	

HEMATOLOGIC

YES	NO	Low Blood Count	
YES	NO	Easy Bruising	
YES	NO	Excessive Bleeding	
YES	NO	Blood Transfustions	

Reviewed with Patient

Physician Signature:_____ **Date:** _____

Lawrence W. Klein, D.O., FACOI
Mark D. Oxman, D.O., FACOI
Barbara M. Doerr, PhD., D.O., FACOI
Jeffrey J. Kaufhold, M.D., FACP
Dominic J. Colao, D.O., FACOI

Nephrology Associates of Dayton INC.

Jennifer L. Jackson, D.O., FACOI
Chukwuma E. Eze, M.D.
Ashok K. Ammula, M.D.
Shachi S. Lovekar, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

Nephrology Associates of Dayton, Inc. respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our Notice of Privacy Practices describes all potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

I have been provided with a Notice of Privacy Practices (available in the medical office waiting area), which provides a more complete description of how my protected health information may be used or disclosed.

I understand that Nephrology Associates of Dayton reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the medical office.

_____

Please Print Name Date of Birth

_____

Patient (or patient rep) Signature Date

Please list anyone that you wish to release health information or medical records to (i.e.family member, friend, etc.)

_____

Name Relationship Phone

_____

Name Relationship Phone

_____

Name Relationship Phone

If we are unable to reach you, may we leave a message on your **home** phone number? Yes_____ No_____
If we are unable to reach you, may we leave a message on your **cell** phone number? Yes_____ No_____
May send you update or reminder emails? If yes, please provide your email: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained.

_____ _____

Reason Date

_____ _____

Employee Signature Employee witness (2nd person)

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Nephrology Associates of Dayton INC

Jennifer L. Jackson, D.O., FACOI
Chukwuma E. Eze, M.D.
Ashok K. Ammula, M.D.
Shachi S. Lovekar, M.D.

Authorization of Release for Medical Information

I hereby grant permission to release the following records and/or information with no limitations, including any treatments for psychiatric illness, alcohol and drug abuse, to:

Nephrology Associates of Dayton, Inc.,
7700 Washington Village Drive, Suite 230
Dayton, Ohio 45459
Phone: (937) 438-3132
Fax: (937) 438-8707

Nephrology Associates of Dayton, Inc.
7231 Shull Road
Huber Heights, Ohio 45424
Phone: (937) 235-2757
Fax: (937) 235-2851

_____
Name of Patient

_____
Address of Patient

_____
Date of Birth

_____
Social Security Number

_____
Signature of Patient or Legal Representative

For Office Use Only:

Information Requested

- ☐ **Discharge Summary**
- ☐ **Final Diagnosis**
- ☐ **X-Ray Interpretation**
- ☐ **ER Report**
- ☐ **Renal Notes**
- ☐ **EKG Interpretation**
- ☐ **Laboratory Findings**
- ☐ **Nursing Notes**
- ☐ **Tissue / Biopsy Report**
- ☐ **Other**
- ☐ **History and Physical**
- ☐ **Operative Report**
- ☐ **X-Ray Films**
- ☐ **Renal Consult**

Remarks: _____

_____

_____

Sign up for 'MyChart'

MyChart is an online tool that gives you access to review the medical information in your Electronic Medical Record (EMR). MyChart gives you more control over your health care experience by giving you the ability to access personal medical information when you need it. You will now have 24-hour access to your information and the ability to change personal contact information such as address, phone number, and email. You will have any and all information at your fingertips.

Features

My Medical Records

- View your health summary with your current health issues
- Review medication you are currently using as well as immunizations you have completed
- View current allergies
- Review test results
- View preventative care programs completed
- Access to your family's records (proxy account if patient is a minor or an adult who allows access)

Message Center

- Send and receive an email message to your doctor or the office
- Ask medical questions or advice
- Request prescription renewal

Appointments

- Review list of past and upcoming appointments

Administrative

- Wallet version of convenient, printable summaries of your medical records and insurance information
- Customer service line if you have an issue with the website

Enjoy and appreciate this new technology…it gives you better access, convenience, and control of your health care!

I have been offered access to 'MyChart' and I choose to:

☐ Accept access to this new health care tool **☐ Decline access at this time**

Signature **Date**