SOUTH SHORE NEPHROLOGY, P.C.

Please fill out this form along with all the documents included in the patient packet and bring it with you for your upcoming appointment.

Be sure to bring your insurance card(s) and your copayment if applicable. We accept copayments in the form of cash, personal check or credit card.

Please call your primary care physician for a ***referral*** should your insurance plan require a referral for the visit.

Please complete this form by legibly printing all current medications below.

CURRENT MEDICATIONS:

Medication	Strength	How Often Taken

Pharmacy ______________________ Town ______________________

Mail Away Pharmacy ______________________ Phone ______________________

Preferred Lab Drawing Station ______________________ Town ______________________

SOUTH SHORE NEPHROLOGY, P.C.

Patient Registration

Name:______________________________ Gender:__________

Date of Birth______________________

Home Phone______________________ Cell Phone:______________________

Address:____

City:______________________ State:______ Zip:____________

SS#______________________

Email:______________________________ Patient Portal __ Yes __ No

Primary Care Physician:______________________________________

Referring Physician:______________________________________

Emergency Contact:______________________ Relationship:______________________

Emergency Contact Phone:______________________

Which best describes your race? __ White __ Hispanic __ Black or African American __ Asian
__ American Indian/Alaska Native __ Native Hawaiian or other Pacific Islander __ Other

Which best describes your ethnicity? __ Non-Hispanic or Latino __ Hispanic or Latino __ Other

Do you have a language preference? __ English __ Spanish __ Portuguese __ French __ Other

Authorization for Use and Disclosure of Health Information

If I am referred to another physician by this office, I authorize the release of information necessary to the other physician's office and, in turn, I authorize their office to send my reports or results to this office. This authorization also applies to any Hospital or Clinic.
I authorize that my medical records can be faxed to another physician or hospital, if it is in my best interest.
I authorize general messages and appointment notices to be left on my answering machine if I cannot be reached personally.
I authorize that all appointment information can be released to my spouse, partner or significant other.

I authorize the staff of South Shore Nephrology, PC to speak with the following individual regarding my current care and treatment:

Name:______________________________ Phone:______________________

Relationship to Patient:______________________________________

Patient Signature:______________________________ Date:______________________

Notice of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by South Shore Nephrology, P.C. and how I may obtain access to and control of this information. Your medical record is protected under HIPAA federal law.
By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

______________________________ ______________________________
Signature of Patient (or Personal Representative) Date

____
Description of Personal Representative Authority

Financial Policy

I acknowledge that I have read and understand the terms listed in the Financial Policy of South Shore Nephrology, PC.

______________________________ ______________________________
Signature of Patient (or Personal Representative) Date

SOUTH SHORE NEPHROLOGY, PC

Patient History Form

Name ____
Date of Birth ____________________Age__________
Primary Care Physician____________________________

Which doctor referred you here?___________________

What is the reason your doctor sent you to see a Kidney Specialist____
____
____

How long have you known about this problem?
____

What other doctors have you seen for this problem?
____

What other doctors have you seen for this problem?
____
____

Check the following symptoms that you have/had

___ blood in the urine
___ protein in the urine
___ foamy urine
___ waking to urinate
___ bedwetting
___ prostate problems
___ urinate frequently
___ pain on urination
___ urinary infection
___ incontinence
___ kidney stones
___ kidney failure

Past Medical History
Check the following illnesses that you have/had

___ Diabetes
___ High blood pressure
___ Heart disease
___ Heart failure
___ Heart valve problem
___ Heart murmur
___ High cholesterol
___ Asthma
___ COPD
___ GERD
___ Sleep Apnea
___ Tuberculosis
___ Allergies
___ Gout
___ Vascular disease
___ Seizures
___ Stroke
___ Nerve Damage
___ Anemia
___ Bleeding problems
___ Ulcers
___ GI bleeding
___ Hepatitis
___ Gallbladder
___ Cancer
___ Thyroid disease
___ Depression
___ Arthritis
___ Spine disease
___ Osteoporosis

Date__________________________________

List any operations or surgeries

____
____
____

Current Medications (include over-the-counter medicines – tylenol, advil, ibuprofen, aleve, etc.)
____
____
____
____
____

List any medication Allergies
____
____

Family Medical History
Which family members have/had

___ Heart disease______________________________
___ Diabetes__________________________________
___ High blood pressure________________________
___ Kidney disease_____________________________
___ Stroke____________________________________
___ Cancer___ _________________________________
___ Blindness__________________________________
___ Deafness__________________________________
Other_______________________________________
____

Social History
___ Single ___ Married ___ Divorced ___ Widowed
Occupation___________________________________
Previous occupation____________________________
With whom do you live? ________________________
Have you ever smoked? ___ yes ____ no
If so, for how long?______________________
When did you quit?_______________________

Explain any other Medical problems you may have. Include dates and treatments if possible.
____
____
____
____

SOUTH SHORE NEPHROLOGY, P.C.

Financial Policy

The physicians of South Shore Nephrology, PC are interested in maintaining a long and healthy relationship with all of our patients. Should you have any questions regarding a bill please call (508) 747-4883 x12.

Patient Responsibility:

It is the responsibility of the patient to know your insurance benefits and confirm with your insurance carrier that we participate within your plan. Should your insurance be denied due to inaccurate information or cancellation of coverage, payment in full will be expected for services rendered.

Should your insurance require a referral, it is the responsibility of the patient to obtain the referral from your primary care provider prior to each appointment to ensure our services will be covered. All patients who do not have a referral will be asked to sign a waiver accepting financial responsibility or we reserve the right to reschedule your appointment until a valid referral is on file.

Appointment Cancellations:

For patients who are unable to keep an appointment, please call the office within 24 hours of the scheduled visit. A fee of $50.00 will be charged for missing an appointment without prior notice.

Copays, Coinsurance and Deductibles:

In accordance with the requirements of your insurance carrier, copayments are due at the time of your visit. Each missed copayment will be assessed a Copayment Billing Fee of $5.00.

If you have a deductible as part of your plan, which applies to visits with our providers, you are responsible for paying this within 90 days. If you have Medicare and you do not have a supplemental insurance policy, the 20% coinsurance will be your responsibility. There is a $25.00 Non-Sufficient Funds Fee due for each check payment returned to us by your bank. The bank automatically charges us for each bounced check.

Collections and Billing:

One balance billing statement will be mailed to the patient after insurance payments have been received by our office. Patients who have an outstanding balance over 90 days will incur an additional $30.00 Collection Fee. The fee will automatically be applied to the patient account following 90 days from the date of service.

Records:

An Administrative Fee of $15.00 will be charged for forms which must be completed by our staff (medical records copies, disability, family medical leave, medical equipment forms, etc.). The patient requesting the forms will be responsible for this fee.

Non-Covered Charges:

All charges not paid by your insurance carrier will require payment in full upon notice of insurance claim denial. This practice is not responsible for services provided that are deemed non-covered. It is your responsibility to know what your insurance covers.

Insurance/Medicare Patient:

Medicare patients are responsible for deductible, co-insurance and all non-covered services at the time of service. Medicare assigns a reimbursement determination and the practice agrees to accept this determination allowed by Medicare. As a Medicare patient, I authorize payment of Medicare benefits to be made on my behalf to South Shore Nephrology, P.C. for any services furnished to me by South Shore Nephrology, P.C.

Please sign below to indicate that you have read and understand all of the above statements.

________________________________ ________________________________

Name of Patient (please print full name) Date

____

Signature

South Shore Nephrology, PC (Medical Care Provider)
A Member of New England Quality Care Alliance, Inc.

HEALTH INFORMATION EXCHANGE AUTHORIZATION

This Medical Care Provider, its affiliated entities, and other clinical providers involved in your care, participate in Health Information Exchanges (HIEs). An HIE is a secure electronic solution that allows health care providers in different places to access information about you so that each provider has a more complete picture of your health. HIEs can also avoid the need for you to undergo duplicative tests conducted elsewhere.

The information that may be provided to an HIE includes both historical medical and demographic information about you, which may consist of sensitive information, including, but not limited to: HIV, sexually transmitted disease, psychiatric treatment, substance use disorder (alcohol or drug), abortion, domestic violence, rape, adoption, and genetic conditions. **As part of this Authorization, you specifically consent to the release of this and other sensitive health information and you acknowledge that you are waiving your legal rights under Massachusetts law to specifically authorize disclosure of this information.**

This Authorization does not expire. In the event that you decide to "opt out" of the HIE at a future date, you should contact your Tufts Medical Center clinic to request a new form, check the form's "OPT OUT" box, sign and date the form ("revocation"), and return it to your clinic. Your revocation will be effective when your provider receives it.

Check one box below:

- ☐ **OPT IN/ALLOW OTHER PROVIDERS TO VIEW CLINICAL DATA**
- ☐ **OPT OUT/DO NOT ALLOW OTHER PROVIDERS TO VIEW CLINICAL DATA**

I have read this Authorization form and I understand what it says. All of my questions have been answered to my satisfaction in a language that I understand. I agree with the information on this form. By signing this form, I authorize my health care provider to use or disclose my health information in order to participate in the HIE.

Signature of Patient or Authorized Representative________________________ Date ______________

Representative's Relationship to Patient ______________________________________