Rockford Nephrology Associates
PATIENT REGISTRATION FORM

Patient Information

Patient Name: ______________________ (Last Name and Suffix - i.e. Sr, Jr) ______________________ (First Name) ______ (M.I.) Date of Birth: ____/____/____

Social Security # ____-____-____ Gender: Male ____ Female ____ Marital Status: S M D W Other____

Ethnicity: ☐ African-American ☐ Alaska Native ☐ Asian ☐ American Indian ☐ Hispanic / Latino
☐ Native Hawaiian ☐ White/Caucasian ☐ Other Pacific Islander ☐ Other: ____________

Physical Address: ____

City: ______________________ State: ____________ Zip: ____________

Billing Address: ☐ Same as above -or- ____
If home address and billing address differ, please write billing address on the line provided.

Home Phone: (____) ____________ Work: (____) ____________ Cell: (____) ____________

Email Address: ______________________ Primary Care Provider: ______________________

Spouse's Name: ______________________ Preferred Hospital: ______________________

Spouse's Date of Birth: ____/____/____ Preferred Pharmacy: ______________________

Pharmacy History Consent: Yes ______ No ______

Employment Status

☐ Working Full-Time Employer Name/Occupation: ______________________

☐ Working Part-Time Employer Name/Occupation: ______________________

☐ Retired Date ________ Employer Name/Occupation: ______________________

☐ Unemployed, Currently not working -or- ☐ Disabled, as of ______________ (date)

Insurance / Guarantor Information

Do you have health insurance ? Yes ☐ No ☐ Insurance Name: ______________________

Is the patient the policyholder? Yes ☐ No ☐ – the policy belongs to my Spouse ☐ Parent ☐ ________ (Other) ☐

If the Guarantor (individual responsible for payment) is NOT the patient, please complete the following:

Guarantor Name: ______________________ Date of Birth: ____/____/____

SSN: ____-____-____ Gender: Male _____ Female _____ Relationship to Patient: ____________

Address: ______________________ City: ____________ State: ________ Zip: ________

Home Phone: (____) ____________ Work: (____) ____________ Cell: (____) ____________

Emergency Contacts

Emergency Contact 1: ______________________ Relationship: ____________ Phone: (____) ____________

Emergency Contact 2: ______________________ Relationship: ____________ Phone: (____) ____________

RNA
Rockford Nephrology Associates

Patient:

Patient DOB:

Health History

Have you ever had the following? Please Circle all that apply.

	NO	YES		NO	YES
Anemia	N	Y	Hyperlipidemia	N	Y
Arthritis	N	Y	Hyperparathyroidism	N	Y
Asthma/COPD	N	Y	Hypertension	N	Y
Atrial Fibrillation (AFIB)	N	Y	Kidney Cyst	N	Y
Congestive Heart Failure (CHF)	N	Y	Kidney Failure	N	Y
Cancer	N	Y	Kidney Stones	N	Y
Cancer within Last 5 Years	N	Y	Lupus	N	Y
Coronary Artery Disease	N	Y	Polycystic Kidney Disease	N	Y
Diabetes Type 2	N	Y	Protein in Urine - Proteinuria	N	Y
Diabetes Type 1	N	Y	Recurrent Urinary Tract Infections	N	Y
Blood in Urine - Hematuria	N	Y	Stroke	N	Y
Hepatitis A	N	Y	Thyroid Disorder	N	Y
Hepatitis B	N	Y	Transplant	N	Y
Hepatitis C	N	Y	Vitamin D Deficiency	N	Y
Anxiety	N	Y	Peripheral Vascular Disease (PVD	N	Y
Depression	N	Y	Gout	N	Y
Sleep Apnea	N	Y			

Other

____

Previous Hospitalizations and Surgeries (Please include dates)

____

____

____

____

Family Medical History

Has anyone in your family had any of the following:

Kidney Disease	Yes	No	If yes, list family member(s)______________
Protein in urine	Yes	No	If yes, list family member(s)______________
Blood in urine	Yes	No	If yes, list family member(s)______________

Dialysis	Yes	No	If yes, list family member(s)________________
Diabetes Type I	Yes	No	If yes, list family member(s)________________
Diabetes Type II	Yes	No	If yes, list family member(s)________________
Hypertension	Yes	No	If yes, list family member(s)________________
SLE	Yes	No	If yes, list family member(s)________________
Kidney Stones	Yes	No	If yes, list family member(s)________________
Polycystic Kidney Disease	Yes	No	If yes, list family member(s)________________
Cancer	Yes	No	If yes, list family member(s)________________
Deafness	Yes	No	If yes, list family member(s)________________
Other	Yes	No	If yes, list family member(s)________________

Current Social History (circle)

Exercise: Yes No

Alcohol Intake: None Occasionally Moderate Heavy

Tobacco: None 1 per day 2-4 per day 5+ per day

Tobacco - years of use: ________

Smoking Status: Never Smoked / Former Smoker / Current Every Day / Current Some Days / Smoker Current status / Unknown if ever smoked

Has smoked since age: ____________________ Quit Date:________________

Illicit drugs: ____________________________

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner

Occupation: ____________________________ Status: Full Time Part Time

Retired Date: __________ Disabled: ____________

Level of Education: ________________________

Advanced Directives________________________

Patient:
Patient DOB:

Medication List

Name of Medication	Strength	Directions (i.e. 1 per day, 2 every 6 hours)

Have you ever taken any anti-inflammatory medications such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.?
Yes_ No _ . If YES, please list medications:

___

___

___

___

Medication allergies:

___

___

___

___

Patient:
Patient DOB:

REVIEW OF SYSTEMS
Please circle and describe how you are feeling today

Constitutional: Fever Fatigue Weight gain _ lbs) Weight loss _ lbs)

Eyes: Dry eyes Vision change

Nose: Frequent nosebleeds

Mouth/Throat: Sore throat Snoring Dry mouth

Cardiovascular: Chest pain on exertion Known heart murmur Shortness of breath when walking Light-headed on standing Palpitations Swelling in the extremities

Respiratory: Cough Wheezing Shortness of breath Coughing up blood Sleep apnea

Gastrointestinal: Abdominal pain Vomiting Change in appetite Frequent diarrhea Nausea

Genitourinary: Urinary loss of control Difficulty urinating Increased urinary frequency Blood in urine

Musculoskeletal: Muscle aches Arthralgias/joint pain Back pain

Skin: Jaundice Rash Itching

Psychiatric Depression Restless sleep

Endocrine: Increased thirst Heat intolerance Cold intolerance

Hematologic/Lymphatic: Swollen glands Easy bruising Excessive bleeding

Allergy/Immunologic: Runny nose Itching Hives

Release of Information/Financial Policy

Thank you for choosing Rockford Nephrology Associates as your nephrology healthcare provider. The following is a statement of our Release of Information/financial Policy which we require you read and sign prior to any treatment. All patients must also complete and sign our Patient Registration Form.

RELEASE OF INFORMATION/MEDICAL RECORDS
By signing this form, you authorize Rockford Nephrology Associates or its designee(s) to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You also authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse date that may be protected by Federal Regulations – 42CFR Part 2. You agree that a photocopy your original authorization shall be considered equally authentic.

REGARDING INSURANCE
We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to Rockford Nephrology Associates for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays, co-insurance and deductibles at the time of service. Your insurance policy is a contract between you and your insurance company. Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be responsible for an additional 30% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.

Those Insurance Plans in which we are a Participating Provider.
All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment, the event that your insurance coverage changes to a plan in which we are not a participating provider, refer to the paragraph below.

Those Insurance Plans in which we are NOT a Participating Provider.
If your insurance company has not paid your account in full within 45 days of the billed date, the balance is you responsibility. Your assistance in collection from your insurance company may be required.

WE ACCEPT PAYMENT IN THE FORM OF CASH, PERSONAL CHECK, VISA OR MASTERCARD

>>>CONTINUED ON NEXT PAGE

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waving of a patient's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefit plans offered by other third party payers. You are responsible for payment unless we are a participating provider for your insurance company.

PATIENT BALANCES

Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private Insurance.

REFUNDS

Refunds will be issued on a quarterly basis unless a specific request is made.

CASES INVOLVING AN ATTORNEY

If you are receiving services for an auto accident, worker's compensation case or personal injury and you are working with an attorney, we expect a minimum monthly payment of $25 in order to continue treatment. We also require information relating to your group health coverage. Both your group health and the appropriate auto carrier will be billed at the same time. This procedure is necessary in order to have a claim on file with the group health in case the auto carrier does not pay or is exhausted at some point during your treatment. This procedure not only protects Rockford Nephrology Associates, but you as the patient.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are not able to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you consistently miss scheduled appointments, our policy is to charge $25.00 for missed appointments and you will be held responsible for payment.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996.

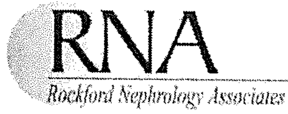
I have read and understand the above statements in the Release of Information/Financial Policy concerning my payment responsibility.

X ______________________________   ____________________   __________

Signature of Patient or Responsible Party   Print Name   Date

X ______________________________   ____________________   __________

Signature of Co-Responsible Party   Print Name   Date



LABORATORY SERVICES PATIENT CONSENT

Rockford Nephrology Associates (RNA) encourages you to use the onsite LabCorp service for the blood and urine tests that are ordered by your nephrologist or nurse practitioner.

The lab that is located within RNA is LabCorp. All lab services are billed separately. It is the patients' responsibility to follow insurance guidelines and to know if LabCorp is within your network.

If you are unable to pay your laboratory bill, please speak with one of RNA's administrators.

____

Signature of Individual (or Legal Representative):

____

Print Individual (or Legal Representative):

____

Relationship:

____

Date:

4-8-2019

PATIENT CONSENT FOR e-PRESCRIBE PROGRAM

ePrescribing is a way for providers to send electronically, an accurate, error free and understandable prescription from the provider's office to the pharmacy. This program also includes:

- Medication History Transactions: provides the healthcare provider with information about your current and past prescriptions. Medication history data can indicate compliance with prescribed regiments, therapeutic interventions, drug-drug and drug-allergy reactions, adverse drug reactions and duplicative therapy.
  The medication history information would include medications prescribed by your healthcare provider at Rockford Nephrology Associates as well as other healthcare providers involved in your care and may include sensitive information regarding any aspect of your health. As part of this consent form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form, you are agreeing that your provider at Rockford Nephrology Associates may request and use your prescription medication history from other healthcare providers and/or third-party benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to receive medical care, payment for your medical care, or your medical care benefits. You also have the right to receive a copy of this form after you have signed it.
This consent form will remain in effect until the day you revoke your consent. You may revoke your consent at any time in writing. Please note, this revocation will not have an effect on any actions taken prior to receipt of the revocation.
Understanding all of the above, I hereby provide informed consent to Rockford Nephrology Associates to enroll me in this e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

____
Signature of Individual (or Legal Representative):

____
Print Individual (or Legal Representative):

____
Relationship:

____
Date:

ROCKFORD NEPHROLOGY ASSOCIATES
RNA of Rockford, LLC
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT INFORMATION

Patient Name (Last, First, Middle) ______________________________

Date of Birth: ____/____/______ ○Male ○Female Primary Nephrologist: ______________

What is the best phone number to use during the day / office hours? ○Home ○Cell ○Work ○Other

Home Phone: (______) ______________ May we leave a message? ○Yes ○No

Cell Phone: (______) ______________ May we leave a message? ○Yes ○No

Work / Other Phone : (______) ______________ May we leave a message? ○Yes ○No

CONSENT

I have read, understand and a copy has been made available to me of RNA's patient privacy notice which describes how medical information about me may be used and disclosed and how I can get access to this information. I understand that the physician has reserved a right to change his or her privacy practices. I understand that a copy of any revised notice will be available to me at the physician's office location.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE LISTED BELOW.

Patient Name (print): ______________________________

Signature: ______________________________ Date: ______________

Sign/Date: ______________________ Sign/Date: ______________________

Sign/Date: ______________________ Sign/Date: ______________________

If you are not the patient, please specify your relationship to the patient: ______________

CONTACT PERSON / PEOPLE

Please list anyone involved with your healthcare that you would like to have access to your medical information here at Rockford Nephrology Associates. This should include any person who may contact our office on your behalf, or accompany you during your visit(s). You may attach a list if more space is necessary.

Name: ______________________________ Phone Number: ______________

May we leave a message? ○Yes ○No Relationship: ______________ Power of Attorney/POA? ________

Grant Full PHI Access? ○Yes ○No If no, explain reason for limited access: ______________

Name: ______________________________ Phone Number: ______________

May we leave a message? ○Yes ○No Relationship: ______________ Power of Attorney/POA? ________

Grant Full PHI Access? ○Yes ○No If no, explain reason for limited access: ______________