Physicians
Philip S. Travis, M.D.
Ronald L. Gaines, M.D.
Douglas A. Amare, M.D.
Maryella D. Sirmon, M.D., FACP
J. Michael Nipper, M.D.
M. Craig Kleinmann, D.O.
Stephen P. Wilber, M.D.
W. Bibb Lamar, M.D.
Christopher D. Mire, M.D.
Jonathan B. Cole, M.D.
R. Sellors Meador, M.D.
Jesse M. Corbello, M.D.
Ryan C. Tulowitzki, D.O.
Elizabeth M. Anderson, M.D.

Physician Extenders
Connie Andrews, C.R.N.P.
Christine Avinger, C.R.N.P.
Holli Beall, C.R.N.P.
James Collier, III, C.R.N.P.
Emilija Pflaum, P.A.
Benjamin Kunz, C.R.N.P.
Nakita Milhouse-Cook, C.R.N.P.

Administrator
Andrew Radoszewski,
M.B.A., M.P.H., CMPE

West Mobile Office
124 A South University Blvd.
Mobile, Alabama 36608
Phone: 251.343.5004

Midtown Mobile Office
1551 Old Shell Rd.
Mobile, Alabama 36604
Phone: 251.433.1180

Fairhope Office
917 A. Plantation Blvd.
Fairhope, Alabama 36532
Phone: 251.990.3533

Foley Office
230 E. Fern Ave.
Foley, Alabama 36535
Phone: 251.824.4300

Anemia Clinic
124 A South University Blvd.
Mobile, Alabama 36608
Phone 251.343.5004

Outreach Clinics
Atmore, Alabama
Bay Minette, Alabama
Monroeville, Alabama
Jackson, Alabama
Thomasville, Alabama

Mailing Address
Post Office Box 850849
Mobile, Alabama 36685-0849

Website:
mykidneydoc.net

NEPHROLOGY ASSOCIATES OF MOBILE, P.A.

Dear Patient,

Thank you for entrusting your care to one of the physicians of Nephrology Associates of Mobile, P.A. We are committed to providing you the highest quality of care possible at all times, including insuring that you are able to see your physician at the time of your appointment in a timely manner.

To do that, we will need your assistance. Please take some time to complete these forms before you arrive for your first appointment. By doing so, you will help us to timely complete your chart for your physician. Please also bring the following with you:

- Insurance cards & Picture I.D.
- Co-payment required at time of the visit
- All of your current medications
- If no Insurance, you will be required to pay $75.00 for the visit, at the time of the visit, and $50.00 each visit thereafter.

Failure to bring the items mentioned above will at best delay your appointment or could possibility result in our office having to reschedule your appointment.

According to our records, your appointment is on _____ at _____. We ask that you arrive at _____, (30 minutes prior to your appointment time) so that we can perform a final check on your required paperwork.

Our office is open from 8:00 a.m. to 5:00 p.m., Monday through Friday. Please do not hesitate to contact us with any questions. We ask that you call at least 24 hours in advance of any appointment should you need to reschedule your appointment.

Again, thank you for entrusting your care to us. Our staff is ready to assist you in any way possible to provide you excellent care.

Date: ___/___/___
Age: _____

PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle _____

Address: _____

City: _____ State _____ Zip _____ Phone _____ Cell Phone: _____

Email Address: _____

Sex: ____ Race: _____ Ethnicity _____ Preferred Language: _____ Birth Date: _____ Marital Status: _____

Employer: _____ Phone: _____

Social Security: _____ Driver's License: _____

Spouse Name: _____ Employer: _____ Phone: _____

Person to notify in case of emergency: _____ Phone: _____
(Outside Your Home) (Other Than Your Number)

Referred By: _____

CONSENT FOR TREATMENT

Knowing that I am suffering from a condition requiring diagnosis and/or medical treatment, I do hereby voluntarily consent to such diagnostic procedures, hospital care, examinations, and treatment as are necessary in the judgment of the physician (s) in charge of my care.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me in the results of examination or treatment in the hospital or office. I hereby authorize Nephrology Associates of Mobile, P.A. to retain or dispose of any specimens that may be taken during examination or treatment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I give permission to Nephrology Associates of Mobile, P.A. to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.

_____ _____
Signature Date

_____ _____
Authorized Representative Date

Patient Name: Last _____ First _____ Middle _____

IF YOU ARE INSURED BY AN INSURANCE COMPANY REQUIRING A REFERRAL –
YOU MUST CONTACT YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT.

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____

Policy Holder's Name: _____ Birthdate: ____/____/____

Employer: _____

Contract or Group: _____

Relationship of Patient to Policy Holder: _____

Insurance Company (Secondary): _____

Policy Holder's Name: _____ Birthdate: ____/____/____

Employer: _____

Contract or Group: _____

Relationship of Patient to Policy Holder: _____

ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize payment of all benefits, basic and major medical, to be made directly to Nephrology Associates of Mobile, P.A. I also agree to pay for services I receive that are not covered by my medical insurance as well as for any deductible or co-payment due at the time of service.

FINANCIAL OBLIGATION:

The undersigned, in consideration of the services to be provided, jointly and severally, agrees to pay all charges for such services, including without limitation any deductibles and/or co-insurance amounts, and any other charges not covered or allowed by health insurance payors (and if applicable, any amounts not covered or allowed by Home Health Agencies, where patient is under a current episode of care). Physician charges will be according to their usual and customary rates. The undersigned agree to pay the Financial Obligation according to the physician's credit terms, and agree that any payments made by or on behalf of the patient may be applied to any open account(s) the patient may have with the physician and/or their affiliated entities. If the undersigned fails to pay the Financial Obligation according to the physician's credit terms and if the physician(s) files suit or takes other steps to collect any unpaid amount due, the undersigned agrees to pay the reasonable costs of collection activities, which costs may include a collection fee and/or a reasonable attorney's fee. Collection activities may include civil legal action, wage garnishment and/or credit reporting to consumer credit reporting agencies. The undersigned is on notice that collection activity may include forwarding any unpaid, delinquent balances to Armstrong and Associates, Inc, and or an attorney for collection. The undersigned agrees and gives prior express consent that the undersigned may be contacted regarding the Financial Obligation by telephone at any telephone number associated with his accounts(s), including wireless telephone numbers, by the physician or their collection agent. The undersigned further gives prior express consent to be contacted by text messages, e-mails (using any email address associated with his accounts(s)), pre-recorded/artificial voice messages, and/or automatic dialing devices. If the undersigned is a family member or other representative of the patient, the undersigned is agreeing to all the terms of this document on behalf of the patient and also guarantees payment of the Financial Obligation.

_____ _____

Signature Date

_____ _____

Authorized Representative Date

Medicare Part B

Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE – Please print or type

Provider's Name *(If you are a DMA supplier, please complete certification at bottom of page)*	Provider's I.D.Code
Provider's Address *(Street, City, State, ZIP Code)*	

Beneficiary's Name	Medicare HI number	Applicable MEDIGAP Group Number

TO BE COMPLETED BY BENEFICIARY OR AGENT – Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICAL BENEFITS	*I request that payment of authorized Medicare benefits be made on my behalf to Dr. H,B,T,G,A, S,N,K,W,L,M, DS or to Nephrology Associates of Mobile, P.A. (the Supplier) for any services or items furnished to me by the physician or supplier, I authorize any holder of medical information about me to release to Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.*
********** STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS	*I request that payment of authorized MEDIGAP benefits be made on my behalf to Nephrology Associates of Mobile, P.A. for any services furnished to me by the physician/ supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP Insurer)_____ any information needed to determine these benefits or the benefits payable.*

_____ Signature of Beneficiary or Person Signing for Beneficiary

_____ Date Signed

Address of Person Signing for Beneficiary *(Street, City, State, ZIP Code)*	Relationship of Agent to Beneficiary

Reason Beneficiary Is Unable To Sign

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment – even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patient from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use this extended patient signature request for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement. "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNED CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.

_____ Signature of Durable Medical Equipment Supplier

_____ Date Signed

Patient Name: _____ **Date of Birth:** _____ **Visit Date:**_____

List the names of any doctors you regularly see.

_____

_____

_____

_____

Do you have any of the following conditions?

- o Seizures
- o Stroke
- o Thyroid problems
- o Diabetes type I or II
  Since what age _____
- o Diabetic retinopathy or eye damage
- o Diabetic nerve damage or neuropathy
- o High blood pressure
  Since what age _____
  Have you ever been in the hospital for high blood pressure _____
- o Atrial fibrillation or flutter
- o Congestive heart failure
- o Coronary artery disease
- o Heart valve problems
- o COPD or asthma
- o Sleep Apnea
- o Gastroparesis
- o Hepatitis B or C
- o Liver cirrhosis
- o Bleeding stomach ulcers or other bleeding in the gut
- o Kidney Stones
- o Enlarged prostate
- o Overactive bladder
- o Urinary tract infections
- o Lupus
- o Rheumatoid arthritis
- o Gout
- o Cancer
- o Sickle cell anemia or sickle cell trait
- o Anemia (low red blood cell count)
- o DVT or blood clot
- o HIV or AIDs
- o Do you take any prescription or over-the-counter NSAIDs? (Examples: meloxicam, Mobic, diclofenac, Voltaren, ibuprofen, advil, aleve, motrin, BC powder, Goody's powder, naproxen, Naprosyn.

  _____

  _____

  _____

Please list any other medical conditions you have.

_____

_____

_____

Patient Name: _____ **Date of Birth:** _____ **Visit Date:**_____

Have you had any of the following surgeries?

- o Pacemaker or defibrillator placement
- o Coronary stent placement
- o Coronary bypass surgery
- o Heart valve surgery
- o Abdominal surgery
  What kind? _____

  _____
- o Prostate or bladder surgery
- o Kidney surgery
- o Port placement
- o Stent placement or bypass surgery in the legs
- o Kidney stone surgery

Please list any other surgeries you have had. _____

_____

Please indicate if anyone in your family has the following medical conditions.

- o High blood pressure
- o Cancer
- o Diabetes
- o Polycystic kidney disease
- o Is anyone in your family on kidney dialysis or had a kidney transplant? If so, who? _____
- o Any other medical conditions that run in your family? _____

Current marital status _____

Current occupation _____

If retired, previous occupation

_____

Do you currently use tobacco products? _____
If so, how much daily?_____
What age did you start?_____

Are you a former tobacco user? ____
If so, what year did you quit? _____
How many years did you use tobacco? _____ How much? _____

Do you currently drink alcohol _____
If so, how often? ____ How much on average?_____

Have you quit using alcohol? If so, what year _____

Do you currently use any recreational/street drugs? Which ones?

_____

Have you previously used any recreational/street drugs? Which ones?

_____

Patient Name: _____ **Date of Birth:** _____ **Visit Date:**_____

Please indicate if you are having any of the following.

- Unintentional weight loss
- Poor vision
- Dry eyes
- Hearing loss
- Sinus infections
- Heart palpitations
- Difficult breathing when lying down
- Difficult breathing with activity
- Swelling in the legs or feet
- Cough
- Coughing up blood
- Diarrhea
- Constipation
- Bloody or dark-colored urine
- Foamy urine
- Pain during urination
- Frequent urination
- Trouble emptying bladder
- Slow urine stream
- Muscle pain
- Joint pain
- Rash
- Dry skin
- Tremor or shaking
- Weakness
- Easy bruising

Name _____ Date of Birth _____

Primary Care Doctor _____ Referring Doctor _____

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE

Medication Name	mg / mcg	How Often You Take It

DRUG ALLERGIES OR MEDICATIONS THAT YOU CANNOT TAKE

Medication Name	Reaction

	Pharmacy Name	Address	Phone Number
Local			
Mail Order			
Other			

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Nephrology Associates of Mobile, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nephrology Associates of Mobile, P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received the practice's Notice of Privacy Practices prior to signing this consent. Nephrology Associates of Mobile, P.A., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nephrology Associates of Mobile, P.A., Privacy Officer at 124-A South University Blvd., Mobile, Alabama 36608.

With my consent, Nephrology Associates of Mobile, P.A. may share my protected health information (PHI) with the following individuals: Please list names, numbers & relationship.

_____

_____

With my consent, Nephrology Associates of Mobile, P.A. may use my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third-parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

With my consent, Nephrology Associates of Mobile, P.A. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Nephrology Associates of Mobile, P.A. may decline to provide treatment to me.

_____ _____

Signature Date Signed

Privacy Notice

NEPHROLOGY ASSOCIATES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share -You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information - You can ask for a list (an accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within a 12 month period.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated - You can complain if you feel we have violated your rights by contacting Nephrology Associates' Privacy Officer using the information on the signature page. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- ☐ Share information with your family, close friends, or others involved in your care;
- ☐ Share information in a disaster relief situation
- ☐ Include your information in a hospital directory

(If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.)

In these cases, we never share your information unless you give us written permission:

- ☐ Marketing purposes ☐ sale of your information ☐ most sharing of psychotherapy notes.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you - We can use your health information **and share it with other professionals who are treating you.** *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues - We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests - We can use or share health information about you:

- for workers' compensation claims
- for law enforcement purposes or with a law enforcement official
- with health oversight agencies for activities authorized by law
- for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and posted in our offices.

If you have any questions about this notice, you may contact the Nephrology Associates Privacy Officer:

- Email: Privacy.Officer@Mykidneydoc.net
- Mail: **Privacy Officer**- Nephrology Associates, P.A. P.O. Box 850849 Mobile, Alabama 36685-0849

Privacy Notice

☐ I acknowledge having received a copy of the Nephrology Associates, PA Privacy Notice which became effective April 10, 2017.

_____ Date: _____

Signature of the Patient or the Patient's Guardian

Instructions:

Patient retains pages 1 and 2. The signature page (page 3), once signed, is scanned and added to the patient's paper chart and to the electronic medical record.