Nephrology and Hypertension Consultants, P.A.

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8401 UNIVERSITY EXECUTIVE PARK DR SUITE 123
CHARLOTTE, NC 28262
PHONE (704) 503-4400 **FAX (704) 503-4030**

We would like to welcome you to ***Nephrology & Hypertension Consultants, PA****.*

Enclosed are our patient registration forms, office policies, map, and a patient questionnaire, to assist us in getting to know you better.
Please complete the forms, and bring them with you on the day of your appointment, which is scheduled for _______________________ at ______________ AM/PM with the nurse for your initial work-up, then you will meet with Dr. _____________.

Please arrive 15 minutes prior to your scheduled visit with the nurse.

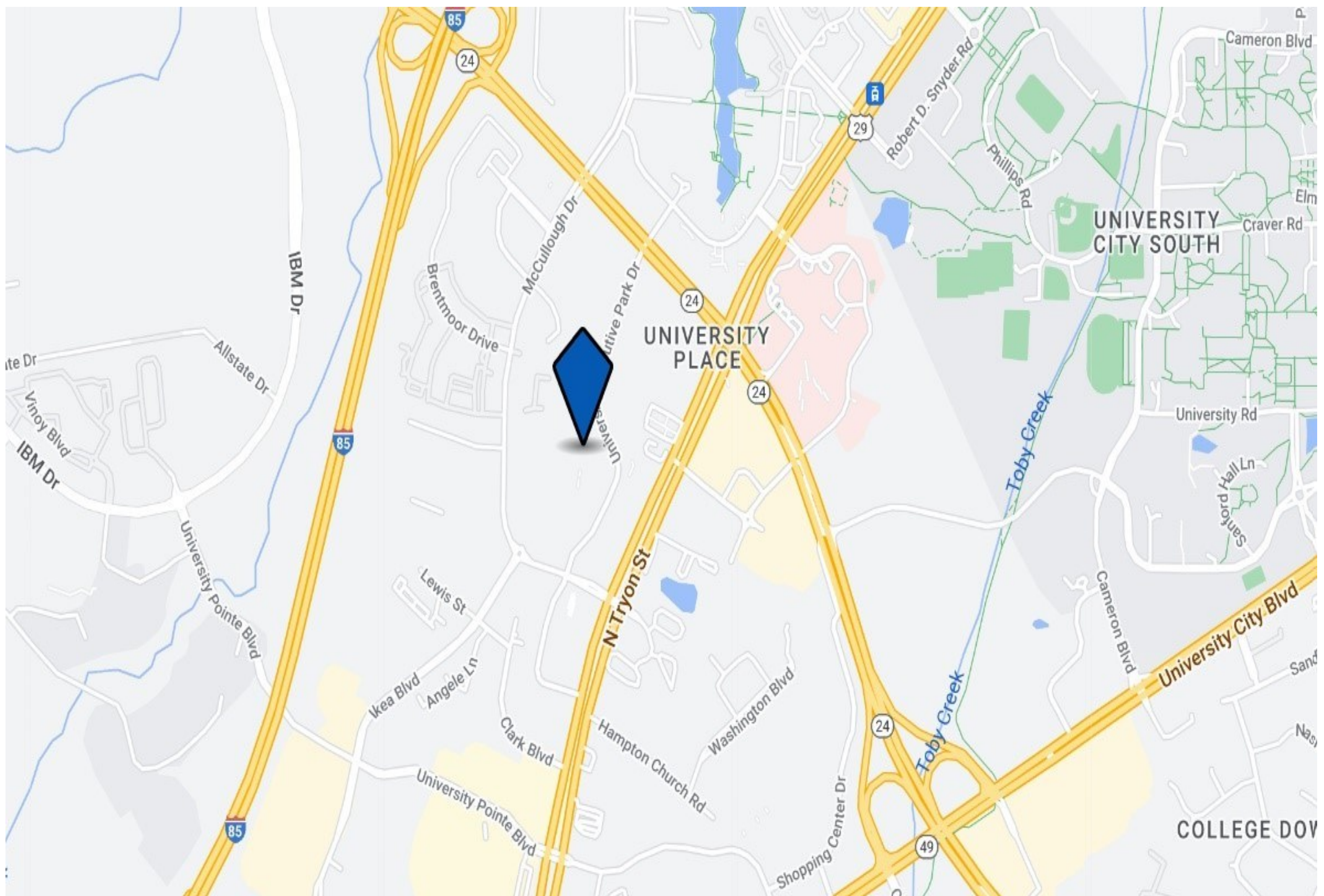
Please Remember to bring your **Insurance Card(s), Your Co-payment (if applicable), and a list of all medications you are taking.** Payment is expected prior to being seen.

Please kindly give 48 hour notice if you are unable to keep your appointment. To learn more about our practice, you can find us at www.nephrology-htnconsultants.com.

If you have any questions, or we can further assist you in any way, please do not hesitate to call our office. Thank you for allowing us to participate in your healthcare. We look forward to seeing you.

Sincerely,
Nephrology & Hypertension Consultants, PA

Enclosures: Patient Registration
Contact Information Sheet
HIPAA statement
Financial Policy
Patient Questionnaire
Medical Records Request
Map



NEPHROLOGY AND HYPERTENSION CONSULTANTS

8401 UNIVERSITY EXECUTIVE PARK DR SUITE, 123 CHARLOTTE, NC 28262

PHONE (704) 503-4400

FROM: HARRISBURG, NC– TAKE HWY 49 SOUTH 5 1/2 MILES. TURN RIGHT ONTO WT HARRIS BLVD., TRAVELING WEST. TURN LEFT AT THE FIRST TRAFFIC SIGNAL, ONTO NORTH TRYON STREET, GOING SOUTH. AT THE 2ND TRAFFIC SIGNAL, TURN RIGHT ONTO MCCULLOUGH DR. TURN RIGHT, ON UNIVERSITY EXECUTIVE PARK DR. TURN LEFT AT BUILDING 8401. DRIVE AROUND TO THE BACK OF THE BUILDING. WE ARE LOCATED IN SUITE 123

FROM: CONCORD/KANNAPOLIS, NC– TAKE I-85 SOUTH 13 MILES TO WT HARRIS BLVD. EXIT 45 A ONTO WT HARRIS BLVD TRAVELING EAST. THEN SEE (*) BELOW.

FROM: MATTHEWS/MONROE, NC– TAKE HWY 74 WEST TO I-485. CONTINUE EAST AND NORTH ONTO I-485 FOR 18 MILES. EXIT ONTO I-85 GOING SOUTH. GO 3 MILES AND TAKE EXIT 45A ONTO WT HARRIS BLVD. TRAVELING EAST. THEN SEE (*) BELOW.

FROM: WEST CHARLOTTE– TAKE I-85 NORTH. CONTINUE TO EXIT 45 A, WT HARRIS BLVD. GO EAST ON WT HARRIS BLVD. 1/2 MILE. THEN SEE (*) BELOW

FROM: I-77 SOUTH– TRAVEL I77 NORTH TO I-85 EXIT. TAKE I85 NORTH TO EXIT 45 A. TRAVEL EAST ON WT HARRIS BLVE 1/2 MILE. THEN SEE (*) BELOW

FROM I-77 NORTH, CORNELIUS, NC– TAKE I 77 SOUTH TO WT HARRIS BLVD. GO EAST ON WT HARRIS BLVD APPROIMATELY 9 MILES (CROSS OVER I-85). THEN SEE (*) BELOW.

***TURN RIGHT ONTO NORTH TRYON STREET, GOING SOUTH. AT THE 2ND TRAFFIC SIGNAL, TURN RIGHT ONTO MCCULLOUGH DR. TURN RIGHT, ON UNIVERSITY EXECUTIVE PARK DR. TURN LEFT AT BUILDING 8401. DRIVE AROUND TO THE BACK OF THE BUILDING. WE ARE LOCATED IN SUITE 123.

Nephrology & Hypertension Consultants, PA

PATIENT REGISTRATION FORM

DATE ________________ 20________
Signatures must be updated annually

PATIENT ACCOUNT NUMBER: ________________________ ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

Name ____ D.O.B. ________________________ AGE _______ ☐ MALE ☐ FEMALE

Address ____ Soc. Sec. No.____________________________

City ____State _________ Zip Code ______________ E-Mail ____________________________

Home Phone ________________________________ Cell Phone __________________________________ Employer Phone ______________________________

Employer ____ Occupation ____

EMERGENCY CONTACT

Name ____ Emp. ____

Address ____ Emp. Phone ___________________________________

Phone ____ Relationship ____

Authorized person(s) to release patient's medical information to: ____

REFERRING M.D. _______________________________________ **PRIMARY CARE M.D.** ____

PRIMARY INS. **COPAY** _______________

Ins. Co. ___________________________________

Employer Name _____________________________

Insured's Name ____

Insured's D.O.B. ____

Cert. or I.D. No. ____

Group No. ____

Coverage Info. Tel. No. _____________________________________

Hospital Preference or Required by this Insurance: _______________

Mail Claims to ____

Is this an Employer Plan? __________ If yes: You or Spouse? _____

Are you Retired? _________ Disabled? _________ Cobra? ________

PRIMARY INS. **COPAY** _______________

Ins. Co. ___________________________________

Employer Name _____________________________

Insured's Name ____

Insured's D.O.B. ____

Cert. or I.D. No. ____

Group No. ____

Coverage Info. Tel. No. _____________________________________

Hospital Preference or Required by this Insurance: _______________

Mail Claims to ____

Is this an Employer Plan? __________ If yes: You or Spouse? _____

I acknowledge the opportunity to review NHC's Notice of Privacy Practices.

AUTHORIZATION FOR TREATMENT: I hereby authorize such examinations, treatments, and medications, as may be prescribed by the Nephrology & Hypertension Consultants, P.A. physician in charge of my care. AUTHORIZATION TO RELEASE INFORMATION: I authorize the physicians of NHC, PA to release any information required in the course of my treatment for insurance purposes. AUTHORIZATION OF PAYMENT POLICY: I understand that I am responsible for all medical expenses regardless of insurance coverage. ASSIGNMENT OF BENEFITS: I authorize payment directly to Nephrology & Hypertension Consultants, PA for any medical or Medicare benefits payable to me for services rendered.

____ ____
Patient's Signature Date

NEPHROLOGY AND HYPERTENSION CONSULTANTS, P.A.

PATIENT QUESTIONAIRE

Today's date ____________

Patient Name: ____________

Primary Physician: ____________ Phone #: ____________

Other physicians: ____________

Pharmacy Name/Address/Phone: ____________

PAST MEDICAL HISTORY

Check (√) conditions you have or have had.

O Diabetes
O High Blood Pressure
O Kidney Disease
O Kidney Stones
O Kidney Transplant
O Diabetic Eye Disease
O Hepatitis
O Protein In Urine
O High Cholesterol
If yes, Date: ____________
O Cancer
O Gout
O Heart Disease
O Lupus

List other conditions or illnesses you have: ____________

YOUR FAMILY HISTORY

Check (√) medical conditions that run in your family (besides yourself):

O Diabetes
O Kidney Disease
O Heart Disease
O Bleeding Problems
O High Blood Pressure
O Cancer

List other conditions that run in your family: ____________

MEDICATION

List the name, dosage, frequency and reason of all medications you are currently taking.
Please list all over-the-counter medications also. Use back of this form if you need more space.

Medication Name	**Dosage** (mg, units?)	**Frequency**	Reason

List all allergies (including environmental, food, and medications) with your reaction to exposure.

____

Patient Name ______________________

Place a check (√) in circle of any symptoms you have had in the past 3 weeks:

Constitutional		**Vascular**		**Metabolic/Endocrine**	
Change in appetite	O	Blue/gray skin	O	Excessive thirst	O
Chills and fever	O	Cold extremities	O	Insulin reaction	O
Fatigue / weakness	O	Ulcers	O	Low blood sugar	O
Irritability	O	Varicose veins	O	Numbness/tingling	O
Night sweats	O			Problems with cold	O
Sleep Problems	O	**GI**		Problems with heat	O
Weight Loss	O	Abdominal pain	O	Weight gain	O
		Blood in stool	O		
HEENT		Constipation	O	**Neurological/Psych**	
Headache	O	Diarrhea	O	Tremors	O
Hearing problems	O	Heartburn	O	Seizures	O
Mouth problems	O	Hemorrhoids	O	Difficult speech	O
Nasal problems	O	Nausea	O	Difficult walking	O
Throat problems	O	Swallowing issues	O	Memory problems	O
Visual problems	O	Vomiting	O		
				Dermatological	
Respiratory		**GU**		Rash	O
Cough	O	Blood in urine	O	Itching	O
Difficult breathing	O	Decreased urine	O	Skin eruptions	O
Shortness of breath	O	Foul urine odor	O	Skin infection	O
		Frequent urination	O	Unusual sweating	O
Cardiovascular		Leaking urine	O		
Chest pain	O	Painful urination	O	**Musculoskeletal**	
Fainting	O	Slow urine stream	O	Back pain	O
Irregular heart beat	O	Urination at night	O	Muscle cramps	O
Swelling	O			Muscle weakness	O
		Reproductive		Neck Stiffness	O
Hematologic		Last menstruation	______	Painful joints	O
Bleeding	O	Difficult period	O		
Bruising easily	O	Impotence	O	**Immunological**	
		Other	O	Allergies	O

Comments: ____

____

____

List reasons for hospitalizations, dates of admission, name of hospital.

____

____

____

Use back of this form if more space is needed.

Patient Name ______________________

SOCIAL HISTORY

Race: ______________________ Ethnicity: O Hispanic/Latino O Not Hispanic/Latino O Other

Primary language spoken: ________________ Language spoken at home: ________________

Birthplace: ______________________ Hand dominance (right/left) ____________

List any social issues you would like to discuss: ______________________________

Family / Social Support

Do you have children? Yes / No Number of girls: _____ boys: _____

Who lives with you? ______________________ Relationship? ______________________

Who comprises your support network? ______________________________

Education / Military Experience

Highest level of education obtained: 9 10 11 12 GED AA/AS BA/BS MA/MS Ph.D. MD ________

Occupational hazards: ______________________ Military experience: ________ Branch: ________

Tobacco

Do you use tobacco? Yes / No

What kind? ________________ Amount per day: ____________ How many years? ________

Have you ever tried to quit? ______________________________

Passive smoke exposure: ______________________ How: ______________________

Alcohol

Do you consume alcohol? Yes / No

Type: ________________ Frequency: ________________ Amount: ________________

When was you last drink? ______________________________

Caffeine

Do you consume caffeine? Yes / No

Type (check all that apply): O chocolate O coffee O soda O tea O ____________

Amount per day: ______________________________

Lifestyle

Have you had sleep pattern changes? Yes / No Explain: ______________________

Activity level: O inactive O moderate O vigorous O ______________________

Type of exercise: ______________________ Frequency: ________________

Hobbies/Activities: ______________________________

Diet History: ______________________________

Do you have animals in your home? Yes / No What kind:

Within the past 2 years, have you traveled out of state? Yes / No Out of country? Yes / No

Where? ______________________________

If necessary, would you agree to a blood transfusion? Yes / No

Advance Directives In Place (Check all that apply)

O None O Healthcare Proxy O Living Will O DNR O Durable Power of Attorney

NEPHROLOGY AND HYPERTENSION CONSULTANTS, P.A.

FINANCIAL POLICY

It is the goal of Nephrology and Hypertension Consultants to provide you with the finest of medical care available at a cost that is both fair and reasonable. Your understanding of our financial policy is essential.

The following is our Financial Policy, which we require that you read and sign prior to treatment.

- Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician.
- We cannot file your insurance if you do not have a copy of your insurance card or the necessary insurance information. You will need to present your current insurance card/s at each visit. Errors and changes in policy coverage prevent us from filling insurance with only a policy number and company name. Without a copy of your insurance card, we must have the insurance company's name and phone number to verify benefits, policyholder's name, and insurance identification number. Without this information, your account will be treated as self-pay. (see above)
- If your health plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physician. If we have not received an authorization prior to your arrival at our office, you will be considered self-pay. We will refund you when we receive proper authorization for those services.
- As a courtesy to you, we will file charges with your insurance company. Charges not paid by your insurance company within 90 days will become due and payable you unless you have Medicare, Medicaid, or insurance policy in which we participate.
- All co-payment, co-insurance, and deductible amounts are due at the time of service. This is an insurance requirement. We accept cash, check, and participating check and major credit cards when possible.
- In the event your health insurance determines a service is "not covered", you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand his/her policy limitations.
- In order for us to accept and file Medicaid, we must have a CURRENT Medicaid card on file for each visit.
- We will bill for workers compensation services that have been pre-authorized by your employer or work comp insurance carrier. You will receive a statement from this office to keep you informed. After 90 days, these charges become your responsibility. It is important to follow closely with your employer to make certain these charges are paid in a timely manner.
- A $25.00 service charge plus any and all bank charges will be applied to your account for any returned check. Once a check has been returned, we can only accept cash.

Please be aware that any unpaid balance over 90 days is subject to intensive collection procedures.

We understand that financial problems arise from time to time. Please let us know if you need to arrange a payment plan that allows you to pay off your balance in installments. Our billing staff can assist you with these arrangements.

Effective date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force.

Name of patient: ________________________________Date of Birth: __________________

Signature of Patient / Guardian: ____________________________________ Date: _____________________