East Bay Nephrology Medical Group

Patient Policy

Welcome to our office. We promise to provide you with the highest quality of medical care. However, we must ask that in return you help us by accepting the following conditions. Please review and sign below to acknowledge that you have read and understand these policies.

You will be responsible for informing us of any address, phone or insurance changes. Please advise us of your status every time you visit our office. This helps keep our records current.

New patient, we need a 48 hour notice to cancel your appointment with the doctor. If you do not show for your appointment you may be subjected to a $50.00 charge that your insurance will not cover.

Follow up patient, we need a 24 hour notice to cancel your appointment with the doctor. If you do not show for your appointment you may be subjected to a $25.00 charge that your insurance will not cover.

All co-payments, deductibles, share of cost payments are due at the time of your office visit. We accept payments, in cash, check or credit cards (MasterCard or Visa). You will be responsible for $25.00 plus bank charges if your payment does not clear.

Thank you,

Physicians at East Bay Nephrology Medical Group, INC.

I understand and agree to the conditions listed above.

____

Signature Date

____

Print Name

2013

PATIENT MEDICATION INFORMATION

PATIENT NAME:
NAME OF PHARMACY:
ADDRESS OF PHARMACY:
PHONE NUMBER OF PHARMACY:

NAME OF MEDICATION	STRENGTH	DIRECTIONS

New Patient Questionnaire **Patient Name:**

Review of Systems

Constitutional

Fever	□ Yes □ No
Chills / Sweats	□ Yes □ No
Headaches	□ Yes □ No

Eyes

Blurred Vision	□ Yes □ No
Double Vision	□ Yes □ No

Ears/Nose/Throat/Mouth

Ear Infection	□ Yes □ No
Sore Throat	□ Yes □ No
Sinus Problems	□ Yes □ No

Respiratory

Wheezing	□ Yes □ No
CoughSore	□ Yes □ No
Short of Breath	□ Yes □ No

Cardiovascular

Chest Pain	□ Yes □ No
High Blood Pressure	□ Yes □ No

Gastrointestinal

Abdominal Pain	□ Yes □ No
Nausea / Vomiting	□ Yes □ No
Heartburn / Indigestion	□ Yes □ No
Constipation / Diarrhea	□ Yes □ No

Genitourinary

Urine Retention	□ Yes □ No
Painful Urination	□ Yes □ No
Urinary Frequency	□ Yes □ No
Sexual Dysfunction	□ Yes □ No
Flank Pain	□ Yes □ No

Skin

Skin Rash	□ Yes □ No
Boils	□ Yes □ No
Persistent Itch	□ Yes □ No

Allergies

Hay Fever	□ Yes □ No
Drug Allergies	□ Yes □ No

Musculoskeletal

Joint Pain	□ Yes □ No
Neck Pain	□ Yes □ No
Back Pain	□ Yes □ No

Hematologic / Lymphatic

Swollen Glands	□ Yes □ No
Blood Clot Problems	□ Yes □ No

Neurological

Tremors	□ Yes □ No
Dizzy Spells	□ Yes □ No
Numbness / Tingling	□ Yes □ No

Endocrine

Excessive Thirst	□ Yes □ No
Too Hot / Cold	□ Yes □ No
Tired / Sluggish	□ Yes □ No

Psychological

Are you generally satisfied with your life?	□ Yes □ No
Do you feel depressed?	□ Yes □ No
Have you considered suicide?	□ Yes □ No

Other complaints?

Past Medical History: (Patients personal history of medical illness)

High blood pressure	□ Yes □ No	Kidney Stones	□ Yes □ No
Diabetes	□ Yes □ No	Arthritis	□ Yes □ No
Kidney Disease	□ Yes □ No	Hypothryoidism	□ Yes □ No
Heart Attack	□ Yes □ No	Lupus	□ Yes □ No
Heart Failure	□ Yes □ No	Leg Swelling	□ Yes □ No
Stroke	□ Yes □ No	Cancer	□ Yes □ No
Asthma	□ Yes □ No	Migraines	□ Yes □ No
Tuberculosis	□ Yes □ No	Hepatitis B	□ Yes □ No
Ulcers	□ Yes □ No	Hepatitis C	□ Yes □ No

Additional Medical History: (Hospitalizations, Serious Illnesses, Other)

Surgical History: (Please include surgery and date)

Family History: (Family member's history of medical illnesses)

Mother's Age _____ Father's Age ______

	No History	Father	Mother	Brother	Sister	Son	Daughter	Other
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
CAD	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

Marital Status ☐ Married ☐ Single ☐Divorced ☐Widowed

Profession____________________________

Personal Habits:

Smoking ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe/ Cigar ☐ Other
Years Smoking __________ Packs per day __________ Pipes/cigars per day ______
Years quit ____________

Alcohol: ☐ Yes ☐ No Cups per day __________

Exercise: ☐ Yes ☐ No How often_______________

Do you use herbal medicines? ☐ Yes ☐ No How often? _______________

Allergies: (Please list all medication allergies and sensitivities)

East Bay Nephrology Medical Group

AUTHORIZATION / ASSISNMENT OF BENEFITS STATEMENT / NOTICE AND ACKNOWLEDGEMENT

Patient Name____

Social Security #____

I authorize the physicians of *EAST BAY NEPHROLOGY MEDICAL GROUP, INC.* to treat me. I also request that my insurance carrier make payment of authorized Medicare or other Insurance benefits on my behalf to *EAST BAY NEPHROLOGY MEDICAL GROUP, INC.,* for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or my insurance company and its agents any information needed to determine benefits payable.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am financially responsible for any charges not covered by insurance benefits. In Medicare assigned cases, *EAST BAY NEPHROLOGY MEDICAL GROUP, INC.* agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

I acknowledge that I have received East Bay Nephology's attached Notice of Privacy Practices.

A Photostat of this authorization shall be as valid as the original.

____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

Return Form To:
East Bay Nephrology Medical Group
2905 Telegraph Ave.
Berkeley, CA. 94705

If any questions, please contact:
East Bay Nephrology Billing Department
(510) 841-0411