Charleston Nephrology, Hypertension and Transplant, PLLC

Abdul R. Zanabli, MD, Medical Director
Gayatri Lessey, MD
Muhammad Saleem, MD

4825 MacCorkle Ave SW, Ste A, South Charleston, WV 25309
Tel: **304.400.4700** Fax: **304.400.4635**
nephrologyaz@yahoo.com
www.wvkidney.org

Patient's Name:____ Age:________
Last First Middle Initial

Date of Birth: _____/_____/_____ Social Security Number: ______-____-______ Sex: M F
Month Day Year

Street Address: ____ Apt#________

City:____________________________________ State:____________ Zip:________________

Home Phone:______________________________ Cell Phone:__________________________

Employer:________________________________ Work Phone:__________________________

Marital Status: □Married □Divorced □Single □Widowed

Spouse's Name:_____________________________________ Cell Phone:________________
Last First Middle Initial

Date of Birth_____/______/_______ Social Security Number__________________________

Spouse's Employer:______________________________ Work Phone:____________________

Primary Insurance Carrier:____

Secondary Insurance Carrier:____

Emergency Contact:_________________________________ Relationship:________________

City:_________________________________ State:_________ Phone:__________________

Family Doctor:_____________________________________ Number:__________________

Please be advised that this practice does not provide any family practice related service and/or treatment. It is the patients responsibility to maintain a relationship with their family provider while under the care of Charleston Nephrology Hypertension and Transplant, PLLC.

Signature:____ Date:___________

Who referred you to our office today?____

Why are you here today?____

INSURANCE AUTHORIZATION AND ASSIGNMENT

Patient's or authorized person's signature. I agree that the above information is correct. I authorize the release of any medical or insurance information to be used by Charleston Nephrology Hypertension and Transplant, PLLC in order to process insurance claims for the services provided by Dr. Zanabli. I authorize payment of medical benefits to Charleston Nephrology Hypertension and Transplant. If patient is a minor I authorize treatment.

Signed:___________________________________ Date:_____________________

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PATIENT NAME:____________________________

Medical History

☐ Kidney Disease
☐ Diabetes
☐ High blood pressure
☐ Ischemic heart disease
☐ Cancer
☐ Stroke
☐ Gout

EENT

☐ Blindness
☐ Cataracts
☐ Hearing Problems
☐ Glaucoma

Cardiovascular

☐ Atrial Fibrillation
☐ Pacemaker
☐ High Cholesterol
☐ AICD
☐ Valvular Heart Disease
☐ Congestive Heart Failure
☐ Mitral Valve Prolapse

Respiratory

☐ COPD
☐ Chronic bronchitis
☐ Asthma
☐ Emphysema
☐ Pneumonia
☐ Tuberculosis
☐ Sleep Apnea

Gastrointestinal

☐ GERD
☐ Stomach/Bowel Ulcers
☐ Gall bladder disease
☐ Hepatitis
☐ Inflammatory bowel disease
☐ Irritable Bowel Syndrome
☐ Gluten intolerance
☐ Lactose intolerance

Genitourinary

☐ Enlarged prostate
☐ Kidney Stones
☐ Frequent UTIs

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PATIENT NAME:______________________________

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Osteoporosis

Neurological

- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Seizures
- ☐ Dementia

Psychiatric

- ☐ Depression
- ☐ Anxiety Disorder

Endocrine

- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hyperparathyroidism
- ☐ Adrenal Insufficiency

Hematology

- ☐ Anemia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Blood Transfusion
- ☐ Thalassemia

Immuno/Allergy

- ☐ HIV
- ☐ Rheumatoid arthritis
- ☐ AIDS
- ☐ Lupus

Surgery History

- ☐ Appendectomy
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Cataract surgery
- ☐ Gall bladder removal
- ☐ Gastric bypass
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Prostatectomy
- ☐ Nephrectomy
- ☐ Renal Transplant
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Valve replacement
- ☐ AV Fistula
- ☐ AV graft
- ☐ PD catheter
- ☐ Other

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Review of Systems: Please Circle if Positive **Check here if all negative** ☐

Constitutional: Fever Fatigue Weight gain Chills
Weight loss Weakness

HEENT: Vision Impaired Sinus problems Eye pain Sore throat
Redness Nose bleeds Color blindness Headache
Double vision Hoarseness Hearing loss Tinnitus
Ear pain Vertigo

Respiratory: Shortness of breath Cough Shortness of breath at rest
Wheezing Shortness of breath with activity
Blood in sputum Pain with breathing
Pain with breathing Night sweats

Cardiovascular: Chest Pain Orthopnea Palpitations
Edema Claudication PND

GI: Abdominal Pain Constipation Nausea Anorexia Diarrhea

Trouble swallowing Heartburn Indigestion Vomiting

GU: Urinary urgency Urinary hesitancy Urinary burning/pain

Foamy urine Blood in urine Incontinence

Urinary frequency Nocturia

Musculoskeletal: Back Pain Muscle Aches Neck pain Arm weakness

Joint pain Leg weakness

Skin: Rash Dryness Itching Color change Scaling

Neurological: Numbness Tingling Tremors Fainting Seizures

Psychological: Depression Anxiety Insomnia

Endocrine: Heat Intolerance Excessive thirst Cold Intolerance Excessive urination

Hematological: Bleeding gums Easy bruising

Immuno/Allergy: Seasonal allergies Hives

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PATIENT NAME:__________________________

Family History

Kidney Disease	☐ Father	☐ Sibling
☐ None	☐ Mother	☐ Child
Diabetes	☐ Father	☐ Sibling
☐ None	☐ Mother	☐ Child
High Blood Pressure	☐ Father	☐ Sibling
☐ None	☐ Mother	☐ Child

Tobacco Use	☐ Current user	☐ Former user	☐ Never used
Alcohol Use	☐ Current user	☐ Former user	☐ Never used
Recreational Drug Use	☐ Current user	☐ Former user	☐ Never used

Do you take over the counter pain medication like: Motrin, Advil, Aleve, Naproxen, Ibuprofen?

☐Yes ☐No ☐Other:______________________________________

Have you ever had kidney stones?	☐Yes	☐No
Do you get urinary tract infections?	☐Yes	☐No
Do you have family history of kidney disease?	☐Yes	☐No
Any of your family members on dialysis or had a kidney transplant?	☐Yes	☐No
Do you have burning or blood when passing urine?	☐Yes	☐No
Do you urinate frequently during the day or night?	☐Yes	☐No
Have you ever had a kidney problem in the past?	☐Yes	☐No
Have your kidneys shut down in the past or received dialysis?	☐Yes	☐No
Did you have kidney ultrasound, dopplar, ct scan or mri in the past?	☐Yes	☐No
Were you ever told you have protein or blood in your urine?	☐Yes	☐No

For females: Have you ever had preeclampsia, high blood pressure, or protein in the urine during pregnancy?

☐Yes ☐No

For males: Did you have prostate enlargement or surgery in the past?

☐Yes ☐No

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Do your ankles swell? □Yes □No

Do you have high blood pressure? □Yes □No
If yes, for how long?____________________
Is it treated and under control?____________________

Do you have heart disease? □Yes □No
If yes, what kind?____________________
Who is your cardiologist?____________________
Have you had a echo or stress test in past?____________________

Do you have diabetes? □Yes □No
If yes, for how long?____________________
Is it treated and controlled?____________________

Flu Immunization □Yes □No If Yes, Date & Location: ____________________

Pneumonia Immunization □Yes □ No If Yes, Date & Location: ____________________

Do you have an Advanced Care Plan (Living will, medical power of attorney or DNR) Yes/No

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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.

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

1. **Our Duties**

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). We must also provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our Privacy Officer, at our current address.

2. **Your Complaints**

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, stating what PHI you believe has been used or disclosed improperly. You will not be retaliated against for making a complaint. For further information you may contact our Privacy Officer, at telephone number 304-400-4700.

3. **Description and Examples of Uses and Disclosures of Protected Health Information.**

By signing our Consent form regarding the use and disclosure of your PHI, you agreed that we may use and disclose your PHI to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of our use of your PHI. In connection with treatment, we will, for example, allow a physician associated with us to use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your PHI to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with Health Care Operations, we will, for example, allow our auditors, consultants, or attorneys access to your PHI to determine if we billed you accurately for the services we provided to you.

4. **Description of Uses and Disclosures We May Make Without Your Consent**

You previously signed a Consent form allowing us to use your PHI for the reasons stated in the Consent. Therefore, we are allowed to use your PHI for all purposes stated in the consent. Even without your consent, the privacy regulations, gives us the right to use and disclose your PHI: (i) if you are an inmate in a correctional institution; (ii) if we have an indirect treatment relationship

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with you, (iii) if, in an emergency treatment situation, we attempt to obtain consent as soon as reasonably practicable after we delivered such emergency treatment; (iv) if we are required by law to treat you, and we try but are unable to obtain such consent; or (v) if we attempt to obtain consent from an individual who has substantial barriers to communicating, but we determine in our professional judgment, that your consent to receive treatment is clearly inferred from the circumstances. The purposes for which we might use your PHI would be to carry out treatment, payment, and health care operations similar to those described in Paragraph 1.

5. **Other Uses and Disclosures Require Your Authorization**

Uses and disclosures other than those allowing us to carry out treatment, payment, and health care operations, and other than those for which you consent is not required by law, will only by made by obtaining a written authorization from you. You may revoke such an authorization in writing at any time, except to the extent that we have taken action in reliance of you authorization.

6. **Uses of Protected Health Information to Contact You**

We may use your PHI to contact you regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations.

7. **Disclosures of Protected Health Information for Billing Purposes**

We may disclose your billing information to any person that calls our billing company with billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

8. **Individual Rights**

(i) You may request us to restrict the uses and disclosures of your PHI, but we do not have to agree to your request. (ii) You have the right to request that we communicate with you regarding your PHI in a confidential manner or pursuant to an alternative means, such as by a sealed envelope rather than a postcard, or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your PHI

(ii) as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs to make arrangements to have the records inspected and copied.

Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R. § 164.524. (iv) You have the right to request us to amend your PHI for as long as the PHI is maintained in the designated record set. We may deny your request for an amendment if the PHI was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R. § 164.524, or if the PHI is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive, an accounting of the disclosures of your PHI for six years before the date on which you request the accounting. An exception to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

9. **Effective Date**

The effective date of this Notice is August 27, 2013.

PATIENT CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION, AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

1. **Patient Consent for Use and Disclosure of Protected Health Information ("PHI")**

I, the undersigned patient, give my consent to Charleston Nephrology, Hypertension, and Transplant, PLLC and its providers, staff, and agents (collectively, "the Group") to use or disclose my protected health information ("PHI") to carry out my treatment, payment, or health care operations. The Group can release, use, or disclose my PHI to other physicians, certified
registered nurse anesthetists, staff, nursing staff, nurse practitioners, physician assistants, students and residents in each of the above disciplines, and other such entities or persons as are related to my treatment, payment, and health care operations, as determined by the Group.

2. **Permission to Release Medical Record to Providers**

If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical record maintained by the Group to those other providers.

3. **Permission to Release Billing Information Over the Telephone**

I agree, as part of this consent for payment operations, that the Group and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

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4. **Permission to Call and Leave Voice Mail Messages**

   I agree that the Group or its agents or representatives may call and leave a voice mail message at my home or other number I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

5. **Permission to Discuss Protected Health Information With Third Persons**

   I agree that the Group may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The Group may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the Group may discuss my PHI with any person that identifies him or herself as active in my mental, physical, emotional, or spiritual care, including, but not limited to family, friends, clergy, and patient advocates. I also agree that the Group, and its agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

6. **Permission to Discuss Protected Health Information Regarding Minors**

   I agree that if the Group treats my child, that the Group and its agents may discuss my child's PHI with the person accompanying the child. I agree that the Group may discuss PHI with both natural parents and stepparents.

7. **Permission to Discuss Protected Health Information With Public Agencies**

   I agree the Group and its agents may, upon request, disclose my PHI to public health agencies, law enforcement, and the FDA.

8. **Notice to Employee to Disclosure to Employer of Work-Related Illnesses/Injuries**

   I agree that the Group may disclose my PHI to any of my current, prior or future employers relating to medical surveillance of the workplace and any of my work-related illnesses and injuries.

9. **Acknowledgment of Receipt of Notice of Privacy Practices**

   I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my PHI.

10. **Duration of Consent**

    I agree that my consent for release of my PHI shall apply all past, present, and future medical records maintained by Group, without new consents being signed by me, and shall last until I provide written notice of termination of my consent to the Group.

Signed:__________________________________ Date:____________________

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Request for Limitations and Restrictions of Protected Health Information (PHI)

PATIENT PLEASE NOTE: The practice is not required to agree with your request. Please refer to our Notice of Privacy Practices for more information regarding your procedure in following the HIPPA rules and regulations concerning patient's privacy. I agree that I have received a copy of HIPPA rules and regulations.

Patient Name:____DOB:______________________

I give the following person permission to have access to my medical history and to be involved in discussions that the physician may have with me during my office visits. The following person may also be advised of test results, etc. that have been performed.

Name of Person you give permission to__________________________Relationship to Patient______________________

Name of person you give permission to__________________________Relationship to Patient______________________

Name of person you give permission to__________________________Relationship to Patient______________________

I <u>do not</u> give the following permission to have access to my medical history or to be involved in discussions with the physician. The following person <u>may not</u> be advised of test results, etc. that have been performed.

___________________________________	______________________
Name of Person to WITHHOLD information	Relationship to Patient
___________________________________	______________________
Name of Person to WITHHOLD information	Relationship to Patient

The office staff/physician has my permission to discuss my health information (test results, surgery information, etc.) in the following ways:

- ☐ Home Phone (a message may be left on my machine)
- ☐ Work Phone (a message may be left on __voice mail or ___with a coworker)
- ☐ Cell Phone (a message may be left on voice mail)
- ☐ Mail Only
- ☐ Any Of the Above

Signature:____

Date:______________________

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MEDICAL RECORDS RELEASE

Patient Name:____________________________________

Date of Birth:____________________________________

Social Security Number:______________________________

I hereby authorize Charleston Nephrology, Hypertension and Transplant/Abdul Zanabli, MD to obtain my information from my medical record.

________ Lab results, x-rays, ultrasounds, and office notes

________ Entire Record

You may withdraw this authorization, which must be signed and dated, by written notification. To obtain information on how to withdraw your authorization, or to receive a copy of your withdrawal, you may contact the Health Information Management Department at this facility. Your withdrawal will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

I have had the opportunity to review the contents of this authorization and my rights in relation to this form. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

____________________________ ____________
Signature of Patient Date

____________________________ ____________
Signature of Guardian (If patient is under 18) Date

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Financial Policy

We recognize the need for a clear understanding between patients and this office regarding financial arrangements for medical care. The following Financial Policy s provided for your information.

PAYMENTS: Office visits are to be paid at the time of service. We accept cash, checks or credit/debit cards. Exclusions to this policy will be those patients whose primary insurance carrier is Medicare, Medicaid, Preferred Provider or Managed Care Organization with which we participate. **COPAYMENTS AND DEDUCTIBLES ARE DUE AND PAYABLE AT THE TIME THE SERVICE IS RENDERED.** We have a contract with your insurance company that obligates us to collect the deductible and the copay at the time of service.

MEDICARE patients with no secondary insurance company will be expected to pay their 20% coinsurance at the time of the service. We are "participating providers" with Medicare and will accept assignment for all services covered by Medicare. This means we accept the approved amount and write off the non-approved portion. However, you are responsible for the 20% coinsurance and yearly deductible. If you provide us with supplemental or secondary insurance, we will bill them as well.

COMMERCIAL INSURANCE patients will be expected to pay any portion not covered by their insurance company as well as any copays and deductible amounts. It is the patient's responsibility to know what services are not covered by their insurance company.

AUTHORIZATIONS: If you are insured by managed care and do not have authorization for your office visit or procedure, you will be required to sign a Patient Responsibility Statement. This states that you agree to pay for your office visit/procedure if we are unable to obtain an authorization for you. IT IS YOUR RESPONSIBILITY TO OBTAIN AN AUTHORIZATION FOR YOUR OFFICE VISIT.

DIVORCED PARENTS/PATIENTS: The responsibility of payment of services provided to a patient or dependent child rests with the parent who seeks treatment.

BILLING: The receptionist will provide you with a receipt for your copayments and deductibles when you make your payment at each visit. Payment in full is expected within 30 days, unless prior arrangements are made to make monthly payments.

INSURANCE: When we agree to bill your insurance for changes incurred, it is extremely important that we have COMPLETE information on your insurance. We require that you present us with valid insurance cards, if you do not have your insurance card, your account will be private pay until you produce a valid insurance card. If should be understood that your insurance policy is an agreement between you and the insurance company. Your doctor bill is an agreement between you and your doctor. You are responsible for payment of your doctor bill regardless of the status of your insurance claim. If we do not receive payment in full from your insurance company within 60 days, you will be billed for the services.

It is our hope that the above policy will allow us to provide quality care to our valued patients. If you have any questions, or need clarification on any of our policies, please do not hesitate to contact our office.

SIGNATURE: ______________________________ **DATE:** ______________

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MEDICATION LIST

DATE	DRUG	MG	HOW OFTEN	START	STOP

Allergies: ______________________________
____

Pharmacy: ______________________________
Phone: ______________________________

Patient Name: ______________________________ DOB: ______________________________