Medication Log

Name

Doctor

Date of Birth

Pharmacy

Medication	Dosage	Frequency	Time of Day

Health History

Anemia	**YES / NO**
Anxiety	**YES / NO**
Arthritis	**YES / NO**
Asthma	**YES / NO**
Auto Immune Disease	**YES / NO**
Bleeding Problems	**YES / NO**
Coronary Artery Disease	**YES / NO**
Cancer	**YES / NO**
Congestive Heart failure	**YES / NO**
Chronic Kidney Disease	**YES / NO**
Depression	**YES / NO**
Diabetes	**YES / NO**
Blood Clots– DVT	**YES / NO**
GI Disorders	**YES / NO**
Gout	**YES / NO**
Hepatitis	**YES / NO**
High Cholesterol	**YES / NO**
High Blood Pressure	**YES / NO**
Nephrolithiasis	**YES / NO**
Neuromuscular disease	**YES / NO**
Neuropathy	**YES / NO**
Polycystic Kidney Disease	**YES / NO**
Retinopathy	**YES / NO**
Sleep Apnea	**YES / NO**
Stroke	**YES / NO**
Thyroid	**YES / NO**
UTI	**YES / NO**
Other	**YES / NO**

Family History

Father, Mother, Brother, Sister

Son, Daughter, or Other

Heart Disease	**YES / NO**	**Who?**
Heart Failure	**YES / NO**	**Who?**

High Blood Pressure	**YES / NO**	**Who?**
High Cholesterol	**YES / NO**	**Who?**
Diabetes Mellitus	**YES / NO**	**Who?**
Anemia	**YES / NO**	**Who?**
Asthma	**YES / NO**	**Who?**
Kidney Disease	**YES / NO**	**Who?**
Kidney Stones	**YES / NO**	**Who?**
Strokes	**YES / NO**	**Who?**
Cancer	**YES / NO**	**Who?**
Autoimmune Disease	**YES / NO**	**Who?**
Arthritis	**YES / NO**	**Who?**
Other		
Personal and Social History		
Marital Status:		**Children**: **YES / NO** **Sons**: _____ **Daughters**: _____
Lives:		**ALONE OR WITH**:
Occupation:		
Alcohol Status: **YES / NO**	**How much?** ____	
Drug Use: **YES / NO**		
Smoking Status: **CHOOSE ONE**		
□ **Never Smoker** □ **Current Someday Smoker**		
□ **Unknown if Ever Smoked** □ **Smoker, Current Status Unknown**		
□ **Current Every Day Smoker** **How long?** _____ □ **Former Smoker** **How Long?** ____ **Quit? When?** ____		

A V NEPHROLOGY MEDICAL GROUP INC.

Welcome to Our Practice

Thank you for choosing our office. We look forward to serving your healthcare concerns. In order to serve you properly, we need the following information. Please print in black ink. All information will be confidential.

PATIENT INFORMATION:

Date:_____ Name:_____ Home Phone:_____
Address _____
SSN:_____ DOB:_____ Male____ Female____ Cell Phone_____
Check One: _____ Married_____ Divorced_____ Widowed_____ Separated_____ Single_____ Minor_____
Patient's employer: _____ Work Phone:_____
Business Address: _____ State_____ Zip_____
Spouse's Name:_____ Employer_____ Work Phone:_____
Emergency Contact: _____ Cell Phone_____ Work Phone:_____
Whom may we thank for referring you?_____
Nearest Relative other than spouse:_____ Phone_____
Email Address:

PRIMARY INSURANCE INFORMATION:

Name of Insured:_____ Relationship to patient:_____
DOB: _____ SSN:_____ Insurance Id#_____ Group#_____
Insurance Carrier:_____ Insurance Phone:_____
Employer:_____ Work Phone:_____ Job Title:_____
Employer Address: _____ City_____ State_____ Zip_____
Do you have any additional insurance?_____ yes_____ no If yes complete the following:

SECONDARY INSURANCE INFORMATION:

Name of Insured:_____ Relationship to patient:_____
DOB: _____ SSN:_____ Insurance Id#_____ Group#_____
Insurance Carrier:_____ Insurance Phone:_____
Employer:_____ Work Phone:_____ Job Title:_____
Employer Address: _____ City_____ State_____ Zip_____

AUTHORIZATION & RELEASE:

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature _____ Date:_____

Medicare Authorization:

A request that payment of authorized Medicare benefits be made on my behalf to A.V.Nephrology Medical Group, Inc. for any services furnished me by this group. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS 1500 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. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare center.

_____ _____

Beneficiary Signature *Date*

PATIENT FINANCIAL RESPONSIBILITIES

POLICY STATEMENT AND RELEASE

Thank you for choosing AV Nephrology for your healthcare needs. Our staff is committed to enhancing the quality of your care and overall health. This policy statement and release has been designed to inform you of our policies and answer questions you may have regarding payment for services rendered at our facilities by members of this group. Please be sure that you have read and understand all the information provided in this statement, in order to sign the release on the reverse side of this page. As our patient, your signature is both required and binding, and upon signing you acknowledge your understanding and compliance with these policies.

PAYMENT FOR SERVICES

For the convenience of our patients, we accept cash and personal checks. **Co-payments and/or deductibles** required by individual plans are due at the time that services are rendered. Return checks are subject to a $40.00 return fee and no further personal checks will be accepted.

MISSED APPOINTMENTS

Patient is responsible for canceling appointments within 24 hours prior to the appointment. Should patient fail to attend scheduled appointment or cancel the appointment within the 24-hour period prior to the appointment, AV Nephrology will charge a **$50.00 fee**. Appointments missed due to illness, adverse weather conditions or other unforeseen events that reasonably prohibit you from canceling the appointment will not be considered missed appointments. AV Nephrology must be notified of such occurrence.

REFERRALS

Should your insurance carrier require a referral, please contact your Primary Care Physician to confirm that the referral has been received prior to your office visit to ensure our ability to render services to you. Without the referral in place, we cannot serve you per our contractual agreement with your carrier.

SELF PAY PATIENTS

We welcome self-paying patients when insurance coverage is not available for our services. Patients without insurance are asked to assume full financial responsibility for the office visit and medical services rendered during the time of service. If, for any reason full payment cannot be rendered at the

time of service, please speak with our Practice Administrator prior to your office visit to determine if reasonable payment arrangements can be established.

DELINQUENT ACCOUNTS

Should your acct become delinquent, after 90 days it will be turned over to a collection agency for action. A service fee of 10% APR will be charged on the outstanding balance until paid in full.

OUTLINE OF INSURANCE COVERAGES

We accept most major insurance plans. Please confirm that we participate with your insurance plan by speaking with Member Services of your plan.

CURRENT INSURANCE AND PATIENT DEMOGRAPHIC INFORMATION

When our Healthcare Providers participate with a patient's insurance plan, we file a claim on behalf of the patient and request payment at the time of service for any co-payments, co-insurance, deductibles or services not covered by the patient's plan. Your coverage must be verified prior to your visit. In order to maintain accurate claim filing, billing and records please keep us abreast of any changes in your insurance coverage, address or telephone numbers.

PATIENT FINANCIAL RESPONSIBILITY FOR NON-COVERED SERVICES

In some cases, a patient's insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. We will expect payment for any known non-covered services at the time of your visit.

MANAGED CARE PATIENTS

Patients with managed care health plans will be expected to follow the payment at the time-of-service requirements of the particular plan under which they are covered. Co-payments, etc. are generally listed on the front of your insurance card. We are considered a "specialist" and co-payments tend to be higher for such services.

MEDICARE PATIENTS

We accept Medicare assignment on covered Medicare charges. Payment of the 20% Medicare co-insurance amount or annual deductible or any non-covered charges is expected at the time of service, unless the patient has a supplemental insurance, in such cases, insurance will be filed with the supplemental carrier, however, any unpaid Medicare approved amount is expected to be paid by the patient within thirty (30) days of filing the claim if the supplemental policy does not pay the balance. Medicare may not cover certain services it determines not to be of medical necessity. In cases where a service has the possibility of being in such a category, the patient will be asked to sign a form indicating acknowledgement of the possibility and agreement to take full financial responsibility for all such services Medicare determines not to be medically necessary.

MEDI-CAL PATIENTS

We ask that our Medi-Cal patients have proof of coverage at each visit. If you have a Share of Cost our insurance department will discuss a payment plan with you if needed.

WORKER'S COMPENSATION PATIENTS

We must have prior authorization to treat from either the employer or the insurance carrier adjuster assigned to the case. Should the employer or carrier subsequently deny a validated worker's compensation service, such charges will be the financial responsibility of the patient and payment in full will be expected.

RELEASE

I hereby acknowledge that I have read, understand and agree to comply with all policies outlined herein. I also acknowledge should my account go to collections; I will be charged 10% APR on any and all outstanding balances.

_____Date_____

Signature of Patient/Guarantor

AV NEPHROLOGY MEDICAL GROUP, INC.

Standard Authorization of Use and Disclosure of Protected health Information

Notice of Privacy Practices Updated 03/06/2019

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.**

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals through our Care Everywhere program for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of A V Nephrology Medical Group. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law-Enforcement: Your health information may be disclosed to law-enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Information to be used or disclosed

The information covered by this authorization includes:

Treatment; Payment (Example: insurance and billing purposes) **Healthcare; Law Enforcement (**Example: Death Certificate); and **Public Health Reporting** (Example: CDC)

Purposes of Disclosure:

Information listed above will be disclosed according to the information above authorized.

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by **Antelope Valley Nephrology Medical Group, Inc.**

Other uses and disclosures: require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Information described above may be disclosed to:

Name of person/organization

_____

Name of person/organization

_____

Additional Uses of Information
Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising: Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box.

❑ Please do not use my information for fund-raising purposes.

Marketing: Unless you request us not to, there are some marketing activities for which we may use your name and address, to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please check off the following box:

❑ Please do not use my information for marketing purposes

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

AV NEPHROLOGY MEDICAL GROUP Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Lancaster Office Staff or Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:

AV NEPHROLOGY MEDICAL GROUP, INC.
ATTN: JACKIE CERVANTES
1759 W AVE J #101
LANCASTER, CA 93534-2703
(661) 948-1388
EFFECTIVE DATE: 09/23/2013

Expiration Date of Authorization

This authorization is effective through January 1, 2099 or __/__/__ unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to AV Nephrology Medical Group, Inc. 1759 W Ave J#101 Lancaster, CA 93534. You should contact Jackie Cervantes to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once AV Nephrology Medical Group, Inc discloses it to another party.

Right of the Individual

- You may inspect or copy information used or disclosed under this authorization
- You may refuse to sign this authorization.

Effect of refusing authorization
If you refuse to sign this authorization, AV Nephrology Medical Group Inc. Will not deny you any treatment except **research-related treatment** or treatment that you have requested for the purpose of disclosure to other,

Including:

Treatment conditioned on authorization _____

Signature of refusal _____

AV NEPHROLOGY MEDICAL GROUP, INC. Reserves the right to modify the privacy practices outlined in the notice.

Signature _____

❑ **I have received a copy of the notice of privacy practices for AV NEPHROLOGY MEDICAL GROUP, INC.**

❑ **I opt-out from the Care Everywhere Program, I do not want AV NEPHROLOGY MEDICAL GROUP, INC to allow other physicians or provider offices to access my records through the Epic program.**

Name of Patient (Print or Type) _____

Signature of Patient _____

Date _____

Signature of Patient Representative _____

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient _____