Gulf Coast Kidney Associates
1921 Waldemere St Suite 306
Sarasota, Florida 34239
Phone: (941)917-8722
Fax: (941)917-8727

Patient Registration Packet

(For New Patients Or Hospital Follow-Up Patients)

Thank you for choosing Gulf Coast Kidney Associates!

- --This patient registration packet needs to be **filled out and returned to our office PRIOR to your scheduled appointed.** We have provided you with a self-addressed, stamped envelope for this.
- Enclosed you will find a lab slip. We do require that these labs are done 2 weeks to 10 days before your appointment, unless otherwise specified when scheduling your appointment. **Your appointment is subject to cancellation if you do not get your lab work done in a timely manner.**

On the day of your appointment, please **arrive 15 minutes early.** Please bring all of the items below:

Insurance Cards
Pharmacy Plan ID and mail order address
ALL current medications, including Vitamins & Supplements (We need the actual bottles)

Please do not hesitate to call us with any questions or concerns.

941-917-8722

Gulf Coast Kidney Associates Date: _____

Patient Registration Information GCK Provider: _____

Social Security #: _____

_____

(First Name) (M.I.) (Last Name) (Suffix)

Sex: M_____ F_____ Date of birth:_____

Legal Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

Have you seen a Nephrologist before? _____ If yes, Dr's Name:_____

Dr's Number: (____)_____ City of practice: _____

Our medical providers are participating in a government program that encourages the adoption of electronic health records. This technology is supposed to lead to reduced health care costs but it will also improve the quality of your care and our ability to communicate with you, our patient. As part of this program, the government requires us to record the following demographic information about you:

RACE:

____ Asian
____American Indian or Alaskan Native
____Black/African American
____Hispanic or Latino
____Hawaiian Native/ Pac Island
____White
____More than one race
____Refuse to report

Ethnicity:

____Latino/Hispanic
____Other
____ Refuse to report

Preferred Language: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Cell Phone: (____)_____

Local Home Phone: (____)_____ Work Phone: (____)_____

Do you have an address out of state as well ? _____ If yes, dates out of state: _____

Out of State Address: _____

City:_____ State: _____ Zip: _____ Phone: (____)_____

Referring Provider:_____ Phone: (____)_____

Primary Care Provider: _____ Phone: (____)_____

Pharmacy Name: _____ Phone Number: (____)_____

Cross Streets: _____

Preferred Lab: _____

MEDICARE PATIENTS: Please note that medicare does not always pay your bill first. Please indicate which insurance pays your bills first by providing the insurance information in the Primary Insurance section of this form.
HMO PATIENTS: You are responsible for contacting your primary care doctor and obtaining an an insurance authorization before your appointment.
ALL PATIENTS: Copays are collected at time of service and may be collected before you see the Doctor.

By signing below, I am acknowledging that I have read the above and understand my responsibilities as the patient.

Signature: _____ **Date:** _____

Primary Insurance Company: _____ **HMO**_____ **PPO**_____

Insurance ID # _____ Group # _____

Address on back of Card: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Primary Insurance Subscriber/ Policy Holder:

_____
(Last Name) (First Name) (M.I.)

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Relationship of Policy Holder to Patient: _____ Sex: M _____ F_____

Date of birth: _____ Social Sec. #: _____

Policy Holder's employer: _____ Employer Insurance Plan: Yes_____ No _____

Secondary Insurance Company: _____ **HMO**_____ **PPO**_____

Insurance ID # _____ Group # _____

Address on back of Card: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Secondary Insurance Subscriber/ Policy Holder:

_____
(Last Name) (First Name) (M.I.)

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Relationship of Policy Holder to Patient: _____ Sex: M _____ F_____

Date of birth: _____ Social Sec. #: _____

Policy Holder's employer: _____ Employer Insurance Plan: Yes_____ No _____

Patient Employment Information:

Employed _____ Part-time Student _____ Full-time Student _____ Retired _____ On Disability _____

Employer/ School: _____

Employer phone: (____)_____

Emergency Contact Information:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

I Give my permission to share the following information with the person named above:

Appointment information and reminders: Yes _____ No _____

Billing information: Yes_____ No _____

Medical information: Yes_____ No_____

Second Emergency Contact Information:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

I Give my permission to share the following information with the person named above:

Appointment information and reminders: Yes _____ No _____

Billing information: Yes_____ No _____

Medical information: Yes_____ No_____

Third Emergency Contact Information:

Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

I Give my permission to share the following information with the person named above:

Appointment information and reminders: Yes _____ No _____

Billing information: Yes_____ No _____

Medical information: Yes_____ No_____

Patient Message Consent

(Please check all that apply)

We May Call which of the following regarding your appointments:

____House Phone

_____Work Phone

_____Cell Phone

_____ We May Not Call You Regarding Appointments

We May Call which of the following regarding your blood work or radiology:

____House Phone

_____Work Phone

_____Cell Phone

_____ We May Not Call You Regarding Blood Work or Radiology

May we mail Lab/Radiology requisition slips to your home address?

_____Yes _____No

May we mail Lab/Radiology results to your home address?

_____Yes _____No

By signing below, I am acknowledging that I have given permission for the above forms of communication

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES OF GULF COAST KIDNEY ASSOCIATES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE READ IT CAREFULLY.

This office is required by law to protect the privacy of your health information, give you a Notice of our office legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of this office, which include, but are not limited to, our administrative and operations administrative staff.

1. Uses and Disclosures of Your Health Information: The following categories describe some of the ways that this office may use and disclose your health information.

Treatment: This office will use your health information to provide you with medical treatment/services and for treatment activities of other health care providers. *Example:* Your health information may be used by others involved in your care.

Payment: This office may use your health information for payment activities, such as to determine plan coverage, to bill/collect, or to help another health care provider with payment activities. *Example:* Your health information may be released to an insurance company to get pre-approval of or payment for services.

Operations: This office may use your health information for uses necessary to run its healthcare businesses, such as to conduct quality assessment activities, train, or arrange for legal services. *Example:* this office may use your health information to conduct internal audits to verify proper billing procedures.

Business Associates: This office may disclose your health information to other entities that provide a service to this office or on this office's behalf that requires the release of your health information, such as billing or insurance service, but only if this office has received satisfactory assurance that the other entity will protect your health information.

Individuals Involved in Your Care or Payment for Your Care: This office may release your health information to a friend, family member, or legal guardian who is involved in your care or who helps pay for your care, as prescribed on your signed permission document.

De-Identification: We may also create and distribute health information by removing all reference to individually identifiable health information.

Contact: We may contact you by phone or in writing, to provide appointment reminders.

2. Uses and Disclosures of Health Information Required/Permitted By Law: The following categories describe some of the ways that this office may be allowed or required to use or disclose your health information.

Required by Law/Law Enforcement: This office may use and disclose your health information if required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for purposes such as responding to a court order.

Public Health and Safety: This office may use and disclose your health information to prevent a serious threat to the health and safety of you, others, or the public and for public health activities, such as to prevent injury. *Example:* Florida law requires this office to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: This office may disclose health information about incidents related to food, supplements, product defects, or post-marketing surveillance to the FDA and manufacturers to enable product recalls, repairs, or replacements; and to health oversight agencies for activities authorized by law, such as audits.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-patient privilege, this office may disclose your health information under a court/administrative order, subpoena, or discovery request after attempting to inform you of the request.

Coroners, Medical Examiners, and Funeral Directors: This office may release your health information to coroners, medical examiners, or funeral directors to enable them to carry out their duties.

National Security/Intelligence Activities and Protective Services: This office may release your health information to authorized national security agencies for the protection of certain persons or to conduct special investigations.

Military/Veterans: This office may disclose your health information to military authorities if you are an armed forces or reserve member.

Inmates: If you are an inmate of a correctional facility or are in the custody of law enforcement, this office may release your health information to a correctional facility or law enforcement official so they may provide your health care or protect the health and safety of you or others.

Florida law requires that this office inform you that health information used or disclosed may indicate the presence of a communicable or non-communicable disease. It may also include information related to mental health.

3. Your Rights Regarding Your Health Information: You have the rights described below in regard to the health information that this office maintains about you. You must submit a written request to exercise any of these rights. Forms for this purpose are available at any of the locations where this office provides medical services.

Right to Inspect/Copy: You have the right to inspect and get a copy of health information maintained by this office and used in decisions about your care. This right does not apply to psychotherapy notes and certain other information. By law, this office may charge in advance $1.00 for the first page, $.50 for additional pages, up to $5.00 per x-ray, image, or slide, and $.12 cents per digital page, plus postage, payable prior to the release of the requested records (or those amounts permitted by current law). This office may deny your request in certain circumstances. You may request a licensed health care professional chosen by this office to review a denial based on medical reasons; this office will comply with this decision.

Right to Amend: If you believe health information this office created is inaccurate or incomplete, you may ask this office to amend it. This office cannot delete or destroy any information already

included in your media record. You must provide a reason for your request. this office may deny your request if you ask to amend information that this office did not create (unless the person or entity that created the information is not available to make the amendment); that is not part of the health information this office maintains; that is not part of the information you are permitted by law to inspect and copy; or that is accurate and complete.

Right to Accounting of Disclosures: You have the right to ask for a (free) list of disclosures this office has made of your health information. This office is not required to list all disclosures, such as those you authorized. *You must state a time period, which may not be longer than 6 years or include dates before April 14, 2003.* If you request more than one accounting in a 12-month period, this office may charge you for the cost of the list. This office will tell you the cost; you may withdraw or change your request before the copy is made.

Right to Request Restrictions: You have the right to request a restriction or limit on how this office uses or discloses your health information. You must be specific in your request for restriction. You may restrict disclosure of your health information to a health plan if you choose to pay out-of-pocket in full for the services at the time they are provided. This office is not required to agree to every request. If this office agrees or is required to comply, this office will comply with the request unless the information is required to be disclosed by law or is needed in case of emergency. *Example*: You may want to pay cash in advance for services rather than have your insurance billed.

Right to Request Confidential Contacts: You have the right to request that this office contact you about medical issues in a certain way, such as by mail. You must specify how or where you wish to be contacted; this office will try to accommodate reasonable requests.

Right to a Copy of This Notice: You have the right to a paper or electronic copy of this Notice, which is posted and available at each location where medical services are provided and is on this office's website or both.

Right to be Notified: This office will notify you if your unsecured health information is breached.

4. Changes to this Notice: This office reserves the right to change this Notice and to make the revised Notice effective for health information this office created or received about you prior to the revision, as well as to information it receives in the future. Revised Notices will be posted and available at each location where medical services are provided and on this office's website.

6. Complaints. If you believe your privacy rights have been violated, you may file a complaint with this office's Privacy Official or with the Secretary of the Department of Health and Human Services, Office of Civil Rights.

_____ _____

Signature Date

_____

Printed Name

FINANCIAL ASSIGNMENT AND AGREEMENT

1. PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES, AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCES NOT PAID FOR BY YOUR INSURANCE COMPANY.

2. PRIVATE PAY PAYMENTS (NO INSURANCE COVERAGE) MUST PAY IN FULL AT THE TIME OF SERVICE.

3. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/ OR INSURANCE BENEFITS BE MADE ON MY BEHALF FOR ANY SERVICES FURNISHED ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION, ITS AGENTS, OR ANY INSURANCE CARRIER I MAY HAVE, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

4. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

5. AUTHORIZATIONS FOR VISITS MUST BE OBTAINED BY THE PATIENT OTHERWISE YOU MAY HAVE TO RESCHEDULE UNTIL ONE IS OBTAINED.

6. IF YOUR ACCOUNT IS TURNED OVER TO OUR COLLECTIONS AGENCY FOR NON-PAYMENT, YOU WILL BE RESPONSIBLE FOR THEIR FEES.

SIGN (PATIENT OR PARENT IF MINOR) _____ **DATE** _____

HEALTH QUESTIONNAIRE

NAME: _____ DOB: _____

Reason for your visit: _____ DATE _____

How long have you had this problem? _____ Week(s) _____ Month(s) _____ Year(s)

Pharmacy name and address _____

PLEASE ANSWER *ALL* QUESTIONS ON EVERY PAGE – THANK YOU!

Have you been experiencing any of the following over the past 2 weeks?
(Check all that apply)

___Fever/chills or sweats
___Weight loss or gain
___Fatigue/tiredness
___Headaches
___Allergies/hay fever
___Eye/vision problems
___Ear/hearing problems
___Nose/nasal problems
___Postnasal drip
___Swollen glands
___Coughing spells
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Wheezing
___Chest tightness
___Pain with breathing
___Snoring
___Calf or leg pain
___Chest pain/angina
___Dizzy spells
___Stomach trouble
___Indigestion
___Constipation/diarrhea
___Heartburn
___Ulcers
___Vomiting or nausea
___Dark or bloody stools
___Frequent urination
___Burning urination
___Easy bruising
___Aching muscles
___Anxious feelings
___Frequent thirst/hunger
___Blood in urine
___Other _____

Do you have a problem now or in the past with any of the following?
(Check all that apply)

___ Anemia
___ Arthritis
___ Asthma
___ Bone fractures
___ Bronchitis
___ Cancer
___ Depression
___ Diabetes
___ Emphysema
___ Gastric reflux
___ Gout
___ Hay fever
___ Heart attack/Angina
___ Heart disease
___ Heart murmur
___ Heart valve disease
___ High blood pressure
___ Irregular heart beat
___ Kidney stones
___ Nervousness
___ Osteoporosis
___ Pneumonia
___ Phlebitis, blood clots
___ Prostate problems
___ Rashes
___ Rheumatic fever
___ Seizures
___ Sinusitis
___ Sleep problems
___ Stroke or TIA's
___ Thyroid problems
___ Ulcers
___ Urine infections

ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list below:

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Are you allergic to any foods, dyes, or other?

Please explain:

_____

_____

_____

IMMUNIZATIONS

Do you get the Influenza vaccine every year? ☐ YES ☐ NO Date last received: _____

Have you ever had the Pneumonia vaccine? ☐ YES ☐ NO Date last received: _____

Have you ever had the TB skin test? ☐ YES ☐ NO Date last received: _____

FAMILY HISTORY

	Age	Alive (yes or no)	Medical Problems	Cause of Death
Father:				
Mother:				
Sibling:				
Sibling:				
Sibling:				
Child:				
Child:				
Child:				

NAME: _____ DOB: _____

SOCIAL HISTORY

Birthplace: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Pets at home: ☐ NO ☐ YES _____

Alcohol use: Now? ☐ YES ☐ NO In the past? ☐ YES ☐ NO

How many drinks? ___ Day ___ Week ___ Month

Smoking: Now? ☐ YES ☐ NO In the past? ☐ YES ☐ NO

Age started _____ Age Quit _____ Packs per day _____

Any use of weight loss medications? _____

Occupation: _____

Have you ever been exposed to the following? Please check all that apply.

☐ Asbestos ☐ Dust ☐ Metal ☐ Mining ☐ Wheat dust ☐ Chemicals

Have you ever had a positive TB skin test? ☐ YES ☐ NO

Have you ever been exposed to TB (tuberculosis)? ☐ YES ☐ NO

Where have you lived? _____

Have you traveled abroad? If so, where? _____

_____

MEDICATIONS

Please list ALL medications: Dose How often?

_____

_____

_____

_____

_____

_____

(Additional lines next page)

NAME: _____ DOB: _____

SURGERIES

Year Where

HOSPITALIZATIONS

Year Where

MEDICAL PROBLEMS

NAME: _____ DOB: _____