**The Nephrology Group, Inc.**
Comprehensive Kidney Care

568 E. Herndon Ave., Suite 201, Fresno, CA 93720
Phone 559-228-6600
Fax 559-226-3709

# New Patient Packet

Complete this form on screen or print it and fill it out by hand. Bring the finished form to your appointment.

## NEW PATIENT REGISTRATION

Tell us who you are and how to reach you. This is the information that creates your chart.

### Patient information

Last name

First name

Middle initial

Date of birth

Sex

◯ Male ◯ Female

Social Security number

Street address

Apartment number

City

State

ZIP code

Email

Primary phone

Primary phone type

◯ Home ◯ Cell

Second phone

Second phone type

◯ Home ◯ Cell

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## About you

Relationship status

◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Registered domestic partner

Number of children

Race and ethnicity

☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Hispanic ☐ American Indian/Alaska Native
☐ Prefer not to specify

Preferred language

◯ English ◯ Spanish ◯ Hmong ◯ Lao ◯ Punjabi ◯ Vietnamese ◯ Hearing impaired/Sign ◯ Other

If other, please specify

How did you hear about our practice?

◯ Mailer ◯ Friend/Family ◯ Online ◯ Referral ◯ Other

## EMERGENCY CONTACTS AND PHARMACY

Who should we call if we cannot reach you, and where do you fill prescriptions?

### Emergency contact 1

Name

Relationship to patient

Home phone

Cell phone

Work phone

### Emergency contact 2

Name

Relationship to patient

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Home phone

Cell phone

Work phone

### Pharmacy

Preferred pharmacy

Pharmacy phone

## INSURANCE INFORMATION

Please bring your insurance cards to your appointment so the front desk can copy them.

### Guarantor

The person financially responsible for the account. Leave blank if that is you.

Guarantor name

Relationship to patient

### Primary insurance

Insurance

Co-pay amount

Subscriber's name

Subscriber's SSN

Subscriber's date of birth

Group number

Policy number

Patient's relationship to subscriber

- ◯ Self
- ◯ Spouse
- ◯ Child
- ◯ Other

### Secondary insurance

If applicable.

Insurance

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Co-pay amount

Subscriber's name

Subscriber's SSN

Subscriber's date of birth

Group number

Policy number

Patient's relationship to subscriber

◯ Self ◯ Spouse ◯ Child ◯ Other

## MEDICAL HISTORY

Check everything that applies. Leave anything that does not apply unchecked.

### Past medical history

Conditions you have had

- ☐ Stroke(s)
- ☐ High Cholesterol
- ☐ Bleeding/Clotting Problems
- ☐ Jaundice/Hepatitis
- ☐ Blood Transfusions
- ☐ Arthritis
- ☐ Rheumatic Fever
- ☐ Allergies
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Speech/Hearing Problems
- ☐ Cancer
- ☐ Stomach/Ulcer
- ☐ Kidney Disease
- ☐ Pneumonia
- ☐ Heart Attack/Heart Disease
- ☐ Diabetes
- ☐ Back Problems
- ☐ Emphysema

If you have had a blood transfusion, when?

Other conditions

### Past surgical history

Surgeries you have had

- ☐ Ear/Nose/Throat
- ☐ Joints (hip/knee/shoulder)
- ☐ Hemorrhoid
- ☐ Hysterectomy
- ☐ Hernia
- ☐ Pacemaker/ICD (defibrillator)
- ☐ Appendectomy
- ☐ Eye/Cataracts/Laser
- ☐ Breast

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- [ ] Back/Neck
- [ ] Gallbladder
- [ ] Stomach/Bowel
- [ ] Open heart/Vascular

Other surgeries or hospitalizations

### Family history

Conditions that run in your family

- [ ] Stroke
- [ ] Cancer
- [ ] Heart Disease
- [ ] Diabetes
- [ ] Kidney Disease
- [ ] High Blood Pressure

Other family history

## SOCIAL HISTORY AND ADVANCE DIRECTIVES

### Alcohol, tobacco and other substances

Do you drink alcohol?

- ◯ Yes
- ◯ No

If yes, what and how much on an average day?

Do you smoke?

- ◯ Yes
- ◯ No

If yes, packs per day

For how many years?

Do you use other nicotine products?

- ◯ Yes
- ◯ No

If yes, please explain

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Do you use any recreational drugs? Please list them

## Daily life

Do you exercise regularly?

- ◯ Yes
- ◯ No

If yes, times per week

Type of exercise

Diet

- ☐ Regular
- ☐ Diabetic
- ☐ Low fat
- ☐ Low salt
- ☐ Other

Do you use caffeine?

- ◯ Yes
- ◯ No

If yes, cups per day

Hobbies

Do you use a seatbelt?

- ◯ Yes
- ◯ No

Do you wear glasses or contacts?

- ◯ Glasses
- ◯ Contacts
- ◯ Neither

Do you wear hearing aids?

- ◯ Yes
- ◯ No

## Advance directives

If you have any of these documents, please bring our office a copy.

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Do you have a legal guardian or Healthcare Power of Attorney?

◯ Yes ◯ No

If yes, who?

Do you have a Living Will or an Advance Directive?

◯ Yes ◯ No

Do you have a DNR (Do Not Resuscitate) order?

◯ Yes ◯ No

## MENTAL HEALTH

Are you, or have you ever been, under the care of a psychiatrist or psychologist?

◯ Yes ◯ No

If yes, please explain and name the provider

Please check any that apply

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Dysthymia
- ☐ Anxiety/Panic
- ☐ Suicidal

## CURRENT MEDICAL SYMPTOMS

Check everything you are experiencing now.

Current symptoms

- ☐ Stroke(s)
- ☐ Allergies
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Bleeding/Clotting Problems
- ☐ High Blood Pressure
- ☐ Heart Attack/Heart Disease
- ☐ Jaundice/Hepatitis
- ☐ Speech/Hearing Problems
- ☐ Diabetes
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Back Problems
- ☐ Arthritis
- ☐ Stomach/Ulcer
- ☐ Emphysema
- ☐ Rheumatic Fever

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Other symptoms

## MEDICATIONS AND ALLERGIES

Current medications
Include the strength and dosage. If you have a printed list, we may ask for a copy.

| Medication | Dosage (mg, units, drops) | When taken (daily, am, pm) | Reason you take it |
|---|---|---|---|
| | | | |
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Are you allergic to anything? If so, please list it and describe your reaction

## YOUR OTHER PROVIDERS

So we can coordinate your care, please list the other providers you see.

Other providers

| Provider name | Specialty | Contact information |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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## CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

Please read these policies. You will sign the printed copy when you bring it to the office.

### 1. Individual's financial responsibility

Our practice participates in most insurance plans. However, since each plan has different requirements, coverage limitations and exclusions, it is the responsibility of the patient to understand and meet the requirements of their individual plan and will directly bill your insurance under these plans. Please understand that health insurance plans may not cover all of the cost of our services. The charges for which you, the patient, are responsible for are detailed below. The payment for these charges is due at the time services are rendered.

Copay: Co-payments are due at time of service. A portion of the charge that is not covered by insurance and due from the patient. This is collected at each office visit (preventive visit 'annual physical' may be exempt). TNG accepts cash, check, or debit and/or credit card payment.

Deductible: The amount of money that you must pay each year before the health insurance plan starts to pay for any covered services. If you have a high deductible and you have not had any significant medical expenses, it is likely that you will need to pay for the entire office visit out of pocket, since our charges are much lower than most deductibles.

Coinsurance: Your health insurance plan may require that after you meet your deductible you continue to pay a portion of the medical expenses. Coinsurance is the percentage of maximum allowable charges that you will be required to pay, and may vary according to the type of services provided.

Out-of-pocket maximum: The maximum amount that you are responsible for per calendar year. Once you pay this amount, the insurance plan will pay for all covered medical expenses at 100 percent, meaning there are no further copays, deductibles, or coinsurance payments.

Maximum allowable charges, contractual discount: As a condition of participation in your insurance network, we have agreed to accept lower payment for covered services than our cash prices. Even if you are responsible for payment for services because of deductible, we cannot charge you more than the maximum allowable charge specified by your insurance. The difference between our cash prices and the insurance negotiated prices is the contractual discount.

Non-covered services: Your contract with the insurance company will likely specify that some services are not covered. Insurance companies are free to specify which services can be excluded from coverage. Health plans vary significantly in what they cover.

If your account has a balance exceeding $50 we require that you pay the outstanding balance by cash or a credit card before we provide any further services to you.

Notice of your rights to receive a Good Faith Estimate: You have the right to receive a Good Faith Estimate explaining how much your medical care will cost. Under the law, health care providers need to give patients who do not have insurance or who are not using insurance an estimate of the bill for medical items and services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services, including related costs like medical tests, prescription drugs, equipment, and hospital fees. Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

### 2. Insurance authorization for assignment of benefits

I hereby authorize and direct payment of my medical benefits to The Nephrology Group on my behalf for any services furnished to me by their provider, TNG. You are responsible for knowing the nature and scope of your health insurance coverage. It is possible that TNG is not a participating provider with your insurance company and/or plan. Further, it is also possible that some or all the services the Practice provides at a given time may not be covered by your insurance company and/or plan. You will nevertheless be responsible for the payment of such items and services.

### 3. Authorization to release records

I hereby authorize TNG to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

### 4. Medicare request for payment

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by TNG. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

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### 5. No show and cancellation policy

If I am a new patient and do not call to cancel or reschedule my appointment within 48 hours, I will be charged a fee of $35.00. If I am an established patient and do not call to cancel or reschedule my appointment within 24 hours and I no-show, I will be charged a fee of $35.00.

### 6. Medical records request

Upon request, we will provide you with copies of medical records, subject to the following charges as provided under the Health and Safety Code section 123100, which are subject to annual adjustment based on statute. Per page fee, not to exceed 25 cents per page.

### 7. Forms completion policy

Completing paperwork for schools, employers, the Family Medical Leave Act (FMLA) claims, long-term care, life insurance, the Department of Motor Vehicles, and disability claims goes beyond your routine medical care. Therefore, it cannot be billed to your insurance company. Since all forms require your physician's signature, we are personally responsible for the accuracy of the information provided. Incomplete or inaccurate information may have far-reaching consequences for your case. Filling out forms thus requires careful consideration and a considerable amount of our time. Therefore, it is our office policy to charge for the completion of any form as follows: processing fee of $25 per form. We will complete the form and fax it to the designated recipient, or return it to you if you prefer, within 5 business days of receipt of payment.

### 8. Prescription refills

If you are a new patient, please contact your previous physician to obtain adequate supply of medications until you can establish care with us. For established patients, please keep the following in mind when requesting a refill. Our office policy is to process medication refills within two business days. Exceptions to this policy may or may not be granted. To have a safety margin, please request your refill at least one week before you run out of the medications. For mail-order, please let us know at least two weeks before you run out.

### 9. Principal Care Management program (PCM)

Principal Care Management (PCM) is a Medicare-backed program that healthcare providers use to engage patients in proactive chronic disease management. Services rendered are driven by the patient's individual care plan, which is created in collaboration with the patient upon PCM enrollment. Care plans serve as a comprehensive guide to a patient's goals, health history, and behavior. PCM strengthens the relationship between you and your nephrologist. PCM structure, with monthly touch points and care team access, improves patient engagement and overall quality of care.

### 10. Remote Patient Monitoring program (RPM)

Remote Patient Monitoring (RPM) is a Medicare-backed program that enables healthcare providers to remotely collect and monitor your health data using medical devices. This program allows your care team to track your vital signs and health metrics regularly, enabling early detection of potential health issues and proactive intervention. RPM strengthens the relationship between you and your nephrologist by providing continuous monitoring and timely communication, improving patient engagement and overall quality of care.

### 11. Weapon-free environment

Weapons of any kind are not allowed at any of TNG's practice sites, unless you are from law enforcement.

### 12. Pet-free environment

For the health and safety of our patients, TNG has a No-Pets policy. This No-Pet policy applies to pets, emotional support animals, comfort animals and therapy animals. We comply with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service animals are required to be leashed or harnessed except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks.

### 13. Release of information

I hereby authorize The Nephrology Group, Inc. (TNG) to release to my insurance companies, employer insurance groups, health plans, Medicare and Medicaid programs, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by TNG and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to TNG. This authorization shall not conflict with any internal TNG policy regarding release of information, which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal law.

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### Acknowledgement

By signing, the undersigned acknowledges that: (i) I have been provided a copy of The Nephrology Group (TNG) Patient Financial Responsibility Form; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due, or to become due, to TNG for the Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed; and (vii) failure to pay when due may subject me to late payment charges. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original. Once I have signed this agreement I agree to all of the terms and conditions contained herein and the agreement shall be in full force and effect.

☐ I have read and understand the policies above. I understand that I will sign the printed copy before or at my appointment.

## PERIPHERAL ARTERIAL DISEASE RISK ASSESSMENT

These questions help your nephrologist decide whether a painless, non-invasive circulation test would benefit you. Your care team completes the scoring.

### Your care team

Date

Nephrologist

Primary care physician

Cardiologist

Vascular surgeon

Podiatrist

### Risk questions

What is your present age?

◯ 50 or less ◯ 51 to 64 ◯ 65 or older

Are you on dialysis?

◯ Yes ◯ No

Do you have diabetes?

◯ Yes ◯ No

Do you have high cholesterol, or are you taking cholesterol medication?

◯ Yes ◯ No

Do you have high blood pressure?

◯ Yes ◯ No

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Have you ever had a heart attack, stroke, or cardiac procedure such as a stent placement?

◯ Yes ◯ No

Do you experience discomfort in your buttocks, thigh or calf when walking?

◯ Yes ◯ No

If you do experience pain, does it improve when you stop walking?

◯ No ◯ Sometimes ◯ Yes

Have you ever had a wound, sore, ulcer or infection in your foot or ankle?

◯ Yes ◯ No

Have you ever had a toe or part of your foot amputated or removed?

◯ Yes ◯ No

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PAD total score for all columns

Refer for ABI?

◯ Yes ◯ No

Scoring: 0 to 9 unlikely PAD. 10 to 15 questionable. 15 or more likely benefits from a painless, non-invasive test for peripheral arterial disease.

Signature of Patient, or Authorized Representative or Responsible Party

Date

Print Patient Name, or Authorized Representative or Responsible Party

Relationship to Patient