NEW ORLEANS NEPHROLOGY ASSOCIATES, LLC

Metabolic Bone and Stone Center • Nephrology • Hypertension

Friedrichs H. Harris, M.D., F.A.C.P.
Gabriel Rivera, M.D.
Miguel F. Molina, M.D.
Jill Lindberg, M.D., F.A.C.P.
Steven Morris, M.D.
Trac T. Le, M.D.
Hui J. Kim, M.D., F.A.C.P.
Ashwin P. Jaikishen, M.D.

Diplomates of the
American Board of Nephrology

4409 Utica Street, Suite 100
Metairie, Louisiana 70006
(504) 457-3687
Fax: (504) 620-0250

1111 Medical Center Blvd.
Suite N 511
Marrero, Louisiana 70072
(504) 349-6301

Patient's Name	Date of Birth	State DL #	Social Security #
Home Address	City and State	Zip Code	Home Phone
Race _____ Caucasian _____ Black or African American _____ Asian _____Chinese _____ Other Specify:_____________	Ethnicity _____ Not Hispanic or Latino _____ Hispanic or Latino	Language _____ English _____ Spanish _____ Sign Language _____ Other Specify:_____________	Cell Phone Email Address
Patient's Employer	Occupation	Business Phone	Marital Status
In case of emergency, contact:	*Relationship:*	*Phone Number:*	Referring Physician
Spouse's Name	Spouse's Occupation	Spouse's Employer	Spouse's Business Phone

INSURANCE INFORMATION (Please give insurance card to Receptionist):

Primary Insurance Company	Name of Policyholder	Relationship to Policyholder
Identification Number	Group Number	
Secondary Insurance Company	Name of Policyholder	Relationship to Policyholder
Identification Number	Group Number	

I hereby authorize the listed above insurance company(ies) to directly pay New Orleans Nephrology Associates, LLC, for any benefits due me as a result of services rendered. I attest that the insurance listed above is not expired. I hereby agree to pay any and all charges in excess of sums paid by the insurance company(ies). I hereby authorize New Orleans Nephrology Associates, LLC, to release information to the insurance company(ies) for claims submitted on my behalf.

_______________________________________   __________________________

Patient or Authorized Signature/Responsible Signer   Date

OFFICE POLICY – Please read carefully and sign:

- Payment in the form of co-pays and deductibles is expected at the time of the visit and prior to seeing the physician.
- Patients are responsible for obtaining all **Referrals** from their **Primary Care Physicians.** If you do not have a referral at the time of your visit, you will be asked to either pay for the visit or reschedule your appointment.
- Patients are responsible for canceling appointments 24 hours prior to the scheduled appointment. Failure to do so may result in a $35.00 "no-show" fee being assessed.
- As a courtesy to our patients, we file insurance claims for services rendered. However, patients have full responsibility to pay for all services rendered on their behalf. NONA is not responsible for collecting on your insurance claim or for settling a disputed claim. Misunderstandings regarding insurance coverage and policy benefits are matters to be resolved between patients and their insurance company(ies).
- New Orleans Nephrology Associates, LLC, may turn over delinquent accounts to an independent Collection Agency. Patients will be given ample notice and opportunity to pay balances prior to be assigned to a Collection Agency.

I acknowledge and agree that I have read this policy, understand this policy, and agree to abide by this policy.

____ ___________________________

Patient or Authorized Signature/Responsible Signer   Date

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Dear New Patient:

You have an appointment on ____________________ at ____________________________ with

☐ Dr. Harris ☐ Dr. Lindberg ☐ Dr. Morris ☐ Dr. Rivera ☐ Dr. Molina ☐ Dr. Le ☐ Dr. Kim

Your appointment will be at: ☐ 4409 Utica Street, Suite 100, Metairie, LA 70006
☐ 1111 Medical Center Boulevard, Suite N-511, Marrero, LA 70072

In order to efficiently manage your visit with us, we are enclosing some forms for you to complete and return to us in the enclosed stamped envelope before your appointment.

In addition, we ask that you please be sure to:

- <u>PLEASE ARRIVE 15 MINUTES EARLY FOR YOUR APPOINTMENT</u>
- Obtain a referral, if necessary, prior to the visit
- Have your lab and/or test results sent to us by your referring physician prior to the visit. The results should be faxed to 504-620-0250.
- Bring a driver's license or picture ID and your current insurance card(s) with you.
- Bring all current medication bottles to your visit

New Orleans Nephrology is located off the I-10 Service Road on Utica Street behind Clearview Shopping Center. Utica Street is behind Sherwin-Williams.

Please know that we expend a great deal of effort to arrange your appointment so that it will be worthwhile. Therefore, we request that you notify the office at your earliest convenience if you need to cancel or reschedule an appointment. Any no-show appointment will result in a $35.00 fee.

Thank you.

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RE: OFFICE CO-PAYS

Dear Valued Patient:

Managed Care contracts require that all co-pays be remitted upfront prior to seeing the doctor. Otherwise, contract terms with insurers may be violated. Our physicians have a LEGAL OBLIGATION to collect co-payments.

Waiving co-payments for Medicare patients violates Federal Law; it may be construed as an inducement to see a specific doctor. It is considered FRAUD by the Center for Medicare and Medicaid Services.

Thank you for your understanding of these guidelines when we ask for your co-payment.

Many thanks,

New Orleans Nephrology Associates, LLC

We accept cash / checks / money orders / Visa / Mastercard / Discover for co-payments and balances

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MEDICATION RECORD

PATIENT:______________________________ DATE OF BIRTH.:______________

MEDICATION	Dose (Strength)	Frequency	Start Date	Stop Date	Reason

ALLERGIES

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MEDICAL / SOCIAL / FAMILY HISTORY

Patient Name:________________________________ DOB:________________

Check items that apply to you:

Immunization Schedule

- ☐ MMR
- ☐ Varicella
- ☐ Hepatitis A, adult
- ☐ Hepatitis B, adult
- ☐ Pneumonia
- ☐ Td, adult
- ☐ Meningococcal
- ☐ Influenza

Past Medical History

- ☐ Kidney disease
- ☐ Chronic kidney disease
- ☐ Stage of kidney disease
- ☐ Transplantation
- ☐ Dialysis
- ☐ Polycystic kidney disease
- ☐ Acute kidney failure
- ☐ Glomerulonephritis
- ☐ Diabetes
- ☐ Type I
- ☐ Type II
- ☐ Type unknown
- ☐ High blood pressure
- ☐ Essential
- ☐ Renovascular
- ☐ White coat syndrome

Past Medical History – Heart

- ☐ Heart attack
- ☐ Angina (chest pain)
- ☐ Angioplasty
- ☐ Coronary stent
- ☐ Coronary bypass
- ☐ Other______________

____
____
____

Past Medical History - Cancer

- ☐ Lung
- ☐ Breast
- ☐ Prostate
- ☐ Colon
- ☐ Melanoma (skin)
- ☐ Bladder
- ☐ Lymphoma
- ☐ Kidney
- ☐ Thyroid
- ☐ Leukemia
- ☐ Pancreatic
- ☐ Jaundice
- ☐ Other____________________

____

Other

- ☐ Stroke
- ☐ Gout

Ears/Eyes/Nose/Throat

- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing problems

Cardiovascular

- ☐ Atrial Fibrillation
- ☐ Pacemaker
- ☐ AICD/Defibrillator
- ☐ Valve heart disease
- ☐ Congestive heart disease
- ☐ Mitral valve prolapse
- ☐ Other______________

Respiratory

- ☐ COPD
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep apnea

Gastroenterology
- ☐ GERD (reflux)
- ☐ Stomach/bowel disorder
- ☐ Gallbladder
- ☐ Hepatitis
- ☐ Inflammatory bowel disease
- ☐ Gluten intolerance
- ☐ Lactose intolerance

Genitourinary
- ☐ Enlarged prostate
- ☐ Kidney stones
- ☐ Frequent urinary infections

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Osteoporosis

Neurological
- ☐ Multiple sclerosis
- ☐ Seizure disorder
- ☐ Parkinson's disease
- ☐ Dementia

Psychiatric
- ☐ Depression
- ☐ Anxiety

Endocrine
- ☐ Hypothyroidism (low)
- ☐ Hyperthyroidism (high)

Hematology
- ☐ Anemia
- ☐ Sickle cell anemia
- ☐ Sickle cell trait
- ☐ Blood transfusion
- ☐ Thalassemia

Immuno/Allergy
- ☐ HIV
- ☐ AIDS
- ☐ Rheumatoid arthritis
- ☐ Lupus

Surgical History ☐ N/A

____
____
____
____
____
____

Family History

Kidney Disease
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Diabetes
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

High Blood Pressure
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Heart Disease
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Cancer
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Stroke
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Gout
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Polycystic kidney dx
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Dementia
- ☐ None
- ☐ Father
- ☐ Mother
- ☐ Sibling
- ☐ Children

Father
- ☐ Living
- ☐ Decreased ______/Age
- ☐ Cause of death______________________
- ☐ Unknown

Mother
- ☐ Living
- ☐ Decreased ______/Age
- ☐ Cause of death______________________
- ☐ Unknown

Social History

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

Living Arrangements
- ☐ Alone
- ☐ Spouse
- ☐ Significant Other
- ☐ Family member
- ☐ In home care
- ☐ Assisted living facility

Occupation
- ☐ Retired
- ☐ Unemployed
- ☐ Employed
- ☐ Occupation

  ____

Deficiencies
- ☐ Hearing loss
- ☐ Poor vision/blindness
- ☐ Limited mobility
- ☐ Transportation challenges

Habits
- ☐ Current user
- ☐ Former user
- ☐ Never used
- ☐ Unknown

- ☐ Tobacco
- ☐ Cigars
- ☐ Chewing tobacco
- ☐ Snuff

________ Packs/day
________ Years
________ Year quit

- ☐ Every day
- ☐ Some per day
- ☐ Unknown

Alcohol
- ☐ Current user
- ☐ Former user
- ☐ Never used
- ☐ Occasional social drink
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Recreational drugs
- ☐ Current user
- ☐ Former user
- ☐ Never used

- ☐ Marijuana
- ☐ Amphetamines
- ☐ LSD
- ☐ Heroin
- ☐ Ecstasy
- ☐ Opium
- ☐ Cocaine
- ☐ Barbiturates
- ☐ Other

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BONE FLOW SHEET

Patient:______________________________ ***D.O.B.:***____________________

Approximate Dates Only

1st Fracture ______________

2nd Fracture ______________

*3rd Fracture*______________

*4th Fracture*______________

*# Fractures during past 3 years:*____________________________

*Total number of fractures:*____________________________

**# Spontaneous fractures (vertebral, back, ribs):*____________

**# Traumatic fractures:*____________________________

*(see explanation)

	Dates	**Place**
Previous bone density measurement		
Previous bone x-rays		
Previous joint replacements		
Previous medical evaluation of bone loss		

PAST THERAPY (Give Dates)

Prolia____________________
Fluoride____________________
Citracal____________________
Thiazides____________________
Estrogen____________________
Calcitonin____________________
Birth Control Pills____________
Forteo____________________
(subcutaneous PTH)__________
Bisphonates (Fosamax, Reclast, Actonel, Boniva)
____
Testosterone (patches or shots)
____

MEDICAL HISTORY (Give Dates)

Long period of bed rest (*>6 mos*)
____
Gastric surgery______________
Intestinal bypass______________
Anorexia____________________
Bulimia____________________
Hyperparathyroidism__________
Diabetes____________________
Hypertension________________
Bone Disease________________
Thyroid Disease______________
Arthritis____________________
Asthma____________________
Kidney Disease______________
Excessive weight loss (*>10 lbs in 1 month at any time*)__________

FAMILY HISTORY

Fracture____________________
Fair hair/skin________________
Hyperparathyroidism__________
Ulcers____________________
Diabetes____________________
Endocrine____________________
Bone disease________________
Loss of height________________
Stones____________________

CURRENT MEDICATIONS (Dates)

____
____
____
____
____

ALLERGIES

____
____
____
____

Do you take ...? *(type and dose)*

Antacids__________
Multivitamins__________
Vitamin D__________
Vitamin C__________
Calcium__________
Thyroid hormone__________
Anticonvulsant__________
Protein supplement__________
Herbal preparation__________
Blood thinners__________
Inhaled steroids (ex., nasal spray for allergies):__________
Frequency (ex.10 days, once a year, twice a year, or continually for 8 years:
____
Oral steroids (ex. Prednisone pills)
____

FEMALE HORMONE HISTORY

Last period__________
Menopause__________
(surgical or natural)
First period__________
Pregnancy/delivered__________
Children__________
Infertility__________
Decreased libido__________
Hot flashes/mood swings associated with menopause:
____

DIETARY HABITS

Water__________
Tea__________
Coffee__________
Juice__________
Soda__________
Milk__________
Alcohol__________

Fruit__________
Salt (L)_____ (M)_____ (L)_____
Meat intake__________
Cheese__________
Ice Cream__________
Yogurt__________
Tobacco__________

MALE HORMONE THERAPY

Infertility__________
Impotence__________
Decreased libido__________
Prostate cancer ☐ yes ☐ no
If yes, type of treatment (such as hormone injections:__________
____

EXERCISE (Type & Frequency)__________

JOB: Past:__________ Present:__________

Explanation:

* *Spontaneous = a fracture that occurred without falling or with minimal activity. Example: rib fracture with coughing, fracture in backbone (vertebra) without any trauma to back, foot fracture while walking.*
* *Traumatic = car accident, falling, etc.*

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HIPAA MEDICAL AUTHORIZATION

Patient Name:______________________________ Date of Birth:________________

Previous Name:______________________________

I. I hereby authorize Dr. ____________________ to disclose my health care information.

II. You may use or disclose my medical information to:

1. Name of person(s) or organization:______________________________

   Address:____________________ City ____________ State____________

   Relationship:______________________________

2. Name of person(s) or organization:______________________________

   Address:____________________ City ____________ State____________

   Relationship:______________________________

III. I prefer to be contacted by:

Home Phone Number:________________________

Cell Phone Number:________________________

Other:________________________

IV. You may leave medical information regarding the call on my:

Home Voice Recorder:________________________

Cell Phone Voice Message:________________________

No messages allowed:________________________

Other:________________________

V. You may leave the following medical information:

Appointment Information:______________________________

Lab result/information/instructions:______________________________

Medication information:______________________________

VI. Purpose of this authorization

☐ At my request

☐ Other:______________________________

☐ Check here when New Orleans Nephrology Associates, LLC, requests the authorization for marketing purposes.

☐ Check here when New Orleans Nephrology Associates, LLC, will get something of value for providing health information for marketing purposes.

VII. This Authorization ends:

☐ On (date):______________________________

☐ When the following event occurs:______________________________

VIII. My Rights:

- I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment or eligibility). However, I do have to sign an authorization form to take part in a research study or to receive healthcare when the purpose is to create health information for a third party.
- I may revoke this authorization in writing by sending a letter to the healthcare provider to which the authorization is directed. If I do this, it will not affect any actions already taken by the healthcare provider based upon this authorization.
- I may not be able to revoke this authorization if its purpose is to obtain insurance.
- I understand that once the healthcare provider discloses my health information, the person or entity that receives it may re-disclose it. The HIPAA Privacy laws may no longer protect it.

______________________________ ______________________________
Patient Name (Print) Date

____
Patient Signature

____
Guardian/Individual legally authorized to sign on behalf of Patient

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NOTICE OF PRIVACY PRACTICES

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

New Orleans Nephrology Associates, LLC, is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with the Notice of our legal duties and privacy practices with respect to protected health information. New Orleans Nephrology Associates, LLC, is required by law to abide by the terms of this notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for services rendered, and by the administrative personnel reviewing the quality of care you receive.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders
- We may contact you to provide appointment reminders.

Treatment Information
- We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services
- We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our **compliance with relevant laws.**

Family and Friends
- Unless you object, we may disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification
- Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care, location, general condition, or death.

Health Oversight Activities
- We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities ***authorized by law***, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect
- We may disclose your medical information when it concerns abuse, neglect or violence to you **in accordance with federal and state law**.

Legal Proceedings
- We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement
- We may disclose your medical information for law enforcement purposes or other specialized government functions.

Coroners, Medical Examiners, and Funeral Directors
- We may disclose your medical information to a coroner, medical examiner, or a funeral director.

Organ Donation

- If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Public Safety

- We may use or disclose your medical information to prevent or lessen a serious threat to a health or safety of another person or to the public.

Workers' Compensation

- We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

Business Associates

- We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

HIPAA regulations do not require the Notice of Privacy Practices to include a list of all situations requiring authorization, or a description of recordkeeping for psychotherapy notes.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. You may request a Revocation of Authorization form by contacting:

New Orleans Nephrology Associates, LLC
4409 Utica Street, Suite 100
Metairie, LA 70006
(504) 457-3687
Terry A. Caluda, Practice Manager

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

- You may ask to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You may request a paper copy of this Notice of Privacy for Protected Health Information.
- You have the right to be notified if your confidential personal or healthcare information has been breached.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

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REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of the Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at New Orleans Nephrology Associates, LLC, and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGMENT

I hereby acknowledge that I have received and have had an opportunity to ask questions concerning the Notice of Privacy Practices of New Orleans Nephrology Associates, LLC.

______________________________ ______________________
Patient or Patient Representative Date

____
Representative's Relationship to Patient

NEW ORLEANS NEPHROLOGY ASSOCIATES, LLC

Metabolic Bone and Stone Center • Nephrology • Hypertension

Friedrichs H. Harris, M.D., F.A.C.P.
Gabriel Rivera, M.D.
Miguel F. Molina, M.D.
Jill Lindberg, M.D., F.A.C.P.
Steven Morris, M.D.
Trac T. Le, M.D.
Hui J. Kim, M.D., F.A.C.P.
Ashwin P. Jaikishen, M.D.

4409 Utica Street, Suite 100
Metairie, Louisiana 70006
(504) 457-3687
Fax: (504) 620-0250

1111 Medical Center Blvd.
Suite N 511
Marrero, Louisiana 70072
(504) 349-6301

Diplomates of the
American Board of Nephrology

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a healthcare provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient Name:______________________________ Date of Birth:________________

Persons/Organizations authorized to release the information:______________________________

Persons/Organizations authorized to receive the information:______________________________

Specific description of information (including dates[s]):______________________________

____

I hereby authorize New Orleans Nephrology Associates, LLC, (NONA) personnel to leave a detailed message, i.e., lab/ testing results/ appointment information, on my answering machine:

Patient Signature:______________________________

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on:____________________ Initials:____________

2. I understand that I may revoke this authorization at any time by notifying NONA, in writing, but if I do revoke this authorization, my revocation will not have an effect on any actions taken by NONA in reliance upon my authorization before it received my revocation. Initials:____________

You may revoke this authorization by signing a Revocation of Authorization form and returning it. To request a Revocation of Authorization form, you may contact New Orleans Nephrology Associates, LLC, 4409 Utica Street, Suite 100, Metairie, LA 70006, (504) 457-3687, Terry A. Caluda, Practice Manager.

3. I understand that my revoking this authorization form will not condition my treatment or payment for my healthcare services on your completing and signing this authorization.

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<u>Section B: Must be completed when New Orleans Nephrology Associates, LLC requests the authorization for its own use or for another covered entity to disclose information to New Orleans Nephrology Associates, LLC, for treatment, payment, or healthcare operations purposes.</u>

To be completed by New Orleans Nephrology Associates, LLC.

1. The purpose of this disclosure is:______________________________

2. NONA ☐ will ☐ will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy the health information in accordance with the policies.

<u>Section C: Must be completed for all authorizations</u>:

I have received a copy of New Orleans Nephrology Associates, LLC's Notice of Privacy Practices.

Patient Name:____________________________________ Patient Social Security Number:____________________
(Please Print)

____ Date:_______________________________________
(Signature of Patient or Patient's Representative)

____ ____
(Printed Name of Patient or Patient's Representative) (Relationship to Patient)