Coastal Nephrology & Hypertension Center, P.A.
Coastal Internal Medicine of Jupiter, P.A.

641 University Blvd. Ste. 211 Jupiter, FL 33458
Phone: (561) 253-8121 Fax (561) 253-8021

Please print and complete as accurately as possible.

Today's Date:_____

Patient name: _____
Last First MI

Social Security #:_____ Date of Birth:_____ Sex: □ F / □ M

Cell Phone:_(_____)_____ Home Phone:_(_____)_____

Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Secondary Address:_____

Race: □ American Indian or Alaskan Native / □ Asian / □ Native Hawaiian or Other Pacific Islander

□ Black or African American/ □ White/□ Hispanic/□ Other Race/□ Other Pacific Islander/□ Unreported

Ethnicity: □ Hispanic or Latino/□ Not Hispanic or Latino/□ Refuse to report

Marital Status: □ Single / □ Married / □ Divorced / □ Widowed / □ Legally Separated

Occupation:_____ Employer:_____

Employer Address:_____

Employer Phone:_____

How did you hear from us? □ Friend / □ Relative / □ Physician / □ Hospital / Other:_____

Date of last physical exam:_____

What is your reason for visit?_____

Emergency Contact:
Name:_____ Phone: _(____)_____
Relation to Patient: Spouse / Partner / Child / Friend / Other:_____
Address:_____
City:_____ State:_____ Zip Code:_____
HIPAA Authorized? □ Yes / □ No

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Insurance Information:

Insurance company:_____ Account holder name:_____

Relationship to patient:_____ Birth date:_____ SSN:_____

ID #:_____ Group ID #: _____

Is the patient covered by additional insurance? ☐ Yes / ☐ No

If YES: Insurance company name:_____ Account holder name:_____

Relationship to patient:_____ Birth date:_____ SSN:_____

ID #:_____ Group ID #: _____

Insurance Assignment and Release:

*I certify that I have Insurance coverage with:*_____
Name of Insurance Company(ies)

*And assign directly to Dr.*_____ *all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.*
The above named Doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or one year from the date signed below.

MEDICARE AUTHORIZATION
*I request that payment of authorized Medicare Benefits and, if applicable, Medical benefits, be made either to me or on my behalf to*_____ *(name of doctor or clinic) for any services furnished to me by that provider.*
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medical Insurer, and their agents any information needed to determine these benefits for related services.

Signature:_____ Date:_____
Signature of patient, parent, guardian, or personal representative

Print name:_____ Relationship to patient:_____
Please print name of patient, parent, guardian, or personal representative

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Family History:

Family Members	Alive/Deceased/Unknown	Age	Present Health or Cause of Death
Father			
Mother			
Siblings, how many?			
Children, how many?			
Spouse			

Check illnesses which have occurred in any of your blood relatives:

☐ Diabetes ☐ Cancer ☐ Bleeding Tendency ☐ Kidney Disease ☐ Tuberculosis

☐ Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Nervous Illness ☐ Allergy

☐ Other:_____

Surgical/Hospitalization History:

Please list any surgical procedures or recent hospitalizations.

Date	Surgical Procedure/Reason Hospitalized

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Medical History:

General

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

Cardiovascular

- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Irregular/rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Eye, Ear, Nose, Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache / Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-flashes / halos

Male only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

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Female only

Date of last menstrual period:_____
Date of last pap smear:_____
Have you had a mammogram? Yes / No
Are you pregnant? Yes / No
Number of children:_____

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other: _____

Check conditions you have or have had in the past:

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Health Habits:

Check which you use & how much:

- ☐ Caffeine_____
- ☐ Street drugs_____
- ☐ Tobacco_____
- ☐ Other:_____

Check if your work exposes you to:

- ☐ Stress
- ☐ Heavy lifting
- ☐ Hazardous substances
- ☐ Other:_____

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Medications:

List medications you are currently taking:

1._____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Pharmacy name & phone number:

_____

Allergies:

List allergies to medications and substances:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. We are to inform you about our privacy practices by providing you with this notice. We will not disclose of your information without your written consent unless you have listed the persons below.

Patient Name:_____ Date of Birth:_____

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME TO BE GIVEN TO:

1. Name:_____ Phone:_____Fax:_____
   Address:_____
   Relationship to patient:_____

2. Name:_____ Phone:_____Fax:_____
   Address:_____
   Relationship to patient:_____

3. Name:_____ Phone:_____Fax:_____
   Address:_____
   Relationship to patient:_____

PLEASE INITIAL BELOW GIVING CONSENT FOR THE FOLLOWING:

- We may disclose and/or share your healthcare information with other health professionals who provide treatment and/or service you. (_____)
- We may use and disclose your health information to seek payment for services we provide to you. (_____)
- We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsibly for your care, in case of any emergency involving your care, your location, your general condition or death. (_____)
- We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards or letters. (_____)

Patient Signature:_____ Date:_____

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Appointment Policy

- Our clinic makes every effort to help you keep your appointment with phone call reminders and appointment cards. However, we recognize that there are times when you are going to be late or miss an appointment altogether.
- Failure to give a 24hr notice of cancellation of an appointment will result in a $50.00 charge for a missed appointment fee.
- Please remember to arrive 15 minutes prior to your appointment time. If you need to re-schedule or cancel your appointment, please call us 24 hours ahead of time. There is a $50.00 charge for no-show and cancellation in less than 24 hours.
- Lab slips: A lab slip is provided to you at the time of scheduling your next appointment. Please save your lab slip. If you are in need of an additional copy for yourself or a copy to be faxed to your laboratory, there is a $5.00 charge.
- Insurance will not pay for these fees; patients will be solely responsible for this charge on their bill.

Signature:_____ Date:_____
Signature of patient, parent, guardian, or personal representative

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Patient Financial Responsibility Form

1. Purpose: Coastal Nephrology & Hypertension Center, P.A. is a Nephrology practice which sees patients for Kidney and Hypertensive Diseases. Patients are referred by their primary care physicians and via self-referral. Patient's demographic and insurance information is collected upon their presentation to the office or via the hospital data obtained by the hospital. Patient information shall be updated annually by the staff and the patient or whenever notified by the patient
2. Upon the initial office visit the patient's insurance shall be reviewed and an assessment of the patient's financial responsibility will be determined. The patient's co-pay, deductible or co-insurance shall be collected at that time.
3. Coastal Nephrology & Hypertension Center/Coastal Internal Medicine of Jupiter accepts cash, credit cards (Visa, MasterCard and American Express) and personal checks from patients. Insurance company payments are made via Electronic Funds Transfer or Check.
4. The patient is responsible for the total charge. As a courtesy we do file the patient's insurance and wait a reasonable amount of time for payment. We do accept assignment and recognize appropriate fee schedules as negotiated within our contacts and as stated by the Medicare/CMS program.
5. Coastal Nephrology & Hypertension Center /Coastal Internal Medicine of Jupiter does accept self-pay patients and payment arrangement should be made at the initial visit. A payment of at least 20% is due at initial visit.
6. Coastal Nephrology & Hypertension Center/Coastal Internal Medicine of Jupiter will attempt to work with the patient to resolve what every balance is owed by the patient. The patient may make payments to reduce the balance over a period of time. That arrangement shall be based on the patient's ability to pay as also agreed upon by the Office Manager. The patient will be billed for the balance fur on a monthly basis. Should the patient not respond to those billings, the patient may be forwarded to a collections agency of the practice's choice. Every effort is made to resolve the balance before the patient is forwarded to a collections agency. This may results in a recording of delinquency on the patient's credit report.
7. We welcome the opportunity to discuss any aspect of our financial policy with the patient. The Office Manager and the physician shall have the ultimate decision as to the resolution of any disputes.
8. Non-Sufficient Funds: There is a $30.00 charge for insufficient funds. This fee shall be in addition to funds already owed by the patient.
9. Broken appointment: Missed or appointments cancelled 2 hours or less prior to appointment, may results in a $50.00 service fee at the discretion of the practice.

Signature:_____ Date:_____
Signature of patient, parent, guardian, or personal representative

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Authorization for Release of Medical Records

Patient Name (Print): Social Security #: Patient DOB:

_____ I authorize Coastal Nephrology & Hypertension Center, P.A.to use or release/disclose my health information as described below.

Please identify the information to be released:

- ☐ Please release my entire record
  -OR-
- ☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):
  - ☐ Problem list
  - ☐ Medication list
  - ☐ List of allergies
  - ☐ Immunization records
  - ☐ Most recent history
  - ☐ Most recent discharge summary
  - ☐ Lab results (dates):_____
  - ☐ X-ray and imaging reports (dates):_____
  - ☐ Other (please describe): _____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name:_____ Phone: _____

Address:_____ Fax: _____

_____

Signature of patient, parent, guardian, or personal representative Date

_____

Witness Signature Date

*This authorization will expire twelve (12) months from the date on which it was signed.