Nephrology Associates of St. Louis, LLC

Today's Date: _____

PATIENT INFORMATION (Please Print)

Patient: _____ Birth Date:_____ Age:_____
last name first middle

Home Address:_____
street address city/state/zip

Primary Phone:_____ Check One: ☐ Home ☐ Cell ☐ Work ☐ Other:_____

Secondary Phone:_____ Check One: ☐ Home ☐ Cell ☐ Work ☐ Other:_____

Email Address:_____ Preferred Correspondence Address: ☐ Email Address ☐ Mailing Address

Soc. Sec. No:_____ Check One: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Check One: ☐ Male ☐ Female

Employed by:_____ Occupation_____

Employer's Address_____ ( )_____
street address city/state/zip work phone

How did you hear about us: _____

Family Physician: _____ Referring Physician_____

Person/ Persons Responsible for Payment: (If different from patient)

Name: _____ Relationship: _____ Soc. Sec. No. _____

Address: _____
street address city/state/zip

Primary Phone: ( )_____ Secondary Phone: ( )_____

SPOUSE OR GUARDIAN INFORMATION

Check one: ☐ Spouse ☐ Guardian: _____ Soc. Sec. No._____

Address: (street/city/zip) _____Home/Cell #( )_____

Employed By:_____ Work #( )_____

Address: (street/city/zip)_____

If above name is a parent, please complete the following for the other parent: Soc Sec No._____

Name:_____ Home #( )_____

Employed By: _____ Work # ( )_____

Address: (street/city/zip)_____

INSURANCE INFORMATION

1st Insurance:_____ 2nd Insurance:_____

Person Insured:_____ ☐ M ☐ F Person Insured:_____ ☐ M ☐ F
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Policy No._____ Group No._____ Policy No._____ Group No._____

Soc. Sec. No. _____ Birth Date_____ Soc. Sec. No. _____ Birth Date_____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled, to be made on my behalf to Nephrology Associates of St. Louis, LLC for any services furnished me. I authorize release of medical information needed to determine these benefits payable to related services.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that any information obtained from Nephrology Associates of St. Louis, LLC staff is not to be deemed as a guarantee of benefits. I also understand it is MY responsibility to determine my actual insurance benefit levels.

_____Signature of Patient (or Legal Guardian)

Patient Name:_____

AUTHORIZATION FOR TREATMENT
FINANCIAL RESPONSIBILITY
FINANCIAL INTEREST DISCLOSURE

1. CONSENT

I authorize my physician and other physicians that may treat me, their associates and assistants and Nephrology Associates of St. Louis, LLC (hereinafter referred to as "NASTL"), its staff, employees, agents and students to provide the medical care considered advisable by my physician. In consenting to treatment, I have not relied on any statements as to results. My physician will provide a clear description of the treatment ordered or recommended the material risks associated with the proposed treatment, excepted benefits of the treatment, a comparison of the benefits versus no treatment, and reasonable alternatives to the recommended treatment. My participation in treatment will indicate the above referenced benefits and risks have been fully explained. My signature consenting to treatment will also signify my clear understanding that I am always in control of what treatment is performed and that I may, at any time, refuse all or any part of the recommended treatment. I may also withdraw from treatment at any time.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient information, including medical information. I herby authorize NASTL, its affiliates, and my treating physician to release by electronic means or otherwise any medical, prescription and/or billing information concerning my care, including copies of my medical records, to the following:

A. Any health professional, including but not limited to my referring physician, involved in my care for the purpose of facilitating the continuity of my medical care.

B. Any person or entity responsible for, or any person or entity acting as an agent for, the party responsible to pay for the medical services rendered to me at NASTL by employees of NASTL or any person providing services at NASTL or any affiliate. The parties responsible to pay may include third party payors, self-insurers, workers' compensation carriers and governmental agencies.

C. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining eligibility in government sponsored benefit programs.

D. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by NASTL, affiliates, and/or their physicians, provided that those studies are deemed appropriate by NASTL, affiliates, and/or their physicians.

E. Any continuing care, residential, or long-term care facility, or home health agency for the purpose of providing services for my care.

I acknowledge that the above authorization for release of information to the above-mentioned has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

3. HEALTH INSURANCE BENEFITS

I understand that any insurance I may have is a contract between me and my insurance company. NASTL is not a party to this contract, in most cases. In cases where NASTL is a party to my insurance contract, NASTL will handle claims according to its agreement with the insurance company. NASTL will not become involved in disputes between me and my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc, other than to supply factual information as necessary. I understand I am responsible for verifying my level of benefits with my insurance company, obtaining appropriate referrals or preauthorization's from my insurance carrier or my primary care physician, and for coverage of supply & educational items, probes, or other durable medical equipment (DME) should such items be needed. I am also responsible for timely payment on my account.

4. MEDICARE/TRICARE/VA INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim filled by NASTL. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year.

5. GUARANTEE FOR PAYMENT

I accordance with the above terms and in consideration of the services provided to the above named patient by NASTL the undersigned agrees, whether he/she signs as patient or guarantor, to pay NASTL for all services rendered. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payor, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred. Further, the undersigned acknowledges and agrees that Late Payment/Rebilling charges of the greater 1.5% of the balance or $10.00 are added to unpaid accounts on a monthly basis after 30 days from date of initial billing, and that Patient and Guarantor shall be responsible for all collection fees, attorney fees, court costs, and other fees incurred by NASTL as a result of collection action for amounts due on this account.

6. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services furnished by NASTL, and its physicians, I authorize direct payment to NASTL of all insurance benefits applicable to my care, which are now or which shall become due payable by me.

7. DISCLOSURE STATEMENT – DAVITA TOWN AND COUNTRY WEST

Pursuant to Missouri state law this disclosure is to advise you the physicians of NASTL, specifically Qing Chen, MD, Graeme Mindel, MD, Tricia Pavlopoulos, MD, and Jay Seltzer, MD have an investment interest in Davita Town and Country West and Davita Town and Country West at Home. We wish to inform you that should you be referred to the above named facility you are free to seek services elsewhere. Your ongoing care will not be conditioned on, or affected by accepting the referral to Davita Town and Country West or Davita Town and Country West at Home.

8. NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received and been given the opportunity to review NASTL's Notice of Privacy Practice and am aware of my rights and the uses of my protected health information as indicated in this notice.

_____ _____

Signature of Patient or Person Authorized to Consent/ Relationship to Patient — Date

_____ _____

Signature of Guarantor (if other than custodial Parent or legal guardian) — Date

_____ _____

Witness — Date

NEPHROLOGY ASSOCIATES OF ST. LOUIS, LLC
Walker Medical Building
12855 N. Forty Drive, Suite 205
St. Louis, MO 63141
Phone: (314) 720-0900

MEDICATION LOG

Patient Name: ____ DOB: ________________________

Home Phone: _____________________________ Alternate Phone: _____________________________

Pharmacy: __________________________________ Pharmacy Phone: _________________________

List All Allergies: ____

MEDICATION	DOSE	FREQUENCY

MEDICAL HISTORY

NAME:_____ DATE:_____

DATE OF BIRTH:_____ MARITAL STATUS:_____

OCCUPATION:_____

PREVIOUS OCCUPATION:_____

DATE OF LAST PHYSICAL EXAMINATION:_____

PLEASE LIST ALL SYMPTOMS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PERSONAL HISTORY (please circle all answers that apply)

Have you ever had:

Anemia	yes	no	Gallbladder Disease	yes	no	High Blood Pressure	yes	no
Jaundice	yes	no	Rheumatic Fever	yes	no	Colitis or Bowel Disease	yes	no
Arthritis	yes	no	Kidney Disease	yes	no	Thyroid Disease	yes	no
Tuberculosis	yes	no	Bladder Disease	yes	no	Bleeding Disorder	yes	no
Measles	yes	no	Chicken Pox	yes	no	Small Pox	yes	no
Mumps	yes	no	Plerisy	yes	no	Cancer	yes	no
Stroke	yes	no	Diabetes	yes	no	Epilepsy	yes	no
Hayfever	yes	no	Asthma	yes	no	Pneumonia	yes	no
						Any Bone or Joint Disease	yes	no

Do you smoke?_____ Do you drink alcohol?_____

Do you have any allergies? yes no

Please list your allergies: _____

_____

Surgery

Have you had any operations? Please list below.

Type:_____ Year:_____
Type:_____ Year:_____
Type:_____ Year:_____
Type:_____ Year:_____

Nephrology Associates of St. Louis, LLC
(NASTL)

HIPAA Acknowledgement
(Health Insurance Portability & Accountability Act)

I acknowledge that I have received and been given the opportunity to review NASTL's Notice of Privacy Practices and am aware of my rights and the uses of my protected health information as indicated in this notice.

_____ _____
Signature Date of Birth

_____ _____
Printed Name Today's Date

BELOW IS A LIST OF PERSONS I AUTHORIZE TO RECEIVE MY MEDICAL INFORMATION FROM NASTL, AND WHO MAY DISCUSS MY CARE WITH NASTL.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

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Next Year:_____/_____ Next Year:_____/_____ Next Year:_____/_____
date/initials date/initials date/initials