Renal Physician Associates of Winchester

MRN:_____

Date: _____

Dear _____,

You have been referred to our office by _____ for a nephrology

consultation with Dr. _____ on _____ at

_____.

Please complete all attached paperwork prior to your appointment. Completing these forms in advance allows our providers to better prepare for your visit and ensures timely, quality care.

Please bring the following items to your appointment:
• Insurance card(s)
• Photo identification
• A current list of medications (including dosages)

Please arrive **15 minutes prior** to your scheduled appointment time. A urine sample may be required upon arrival, so we recommend coming with a full bladder.

It is our mission to provide high-quality healthcare. Keeping your scheduled appointment(s) is important to ensuring the best possible care. If you have any questions or concerns, please feel free to contact our office at **(540) 450-1600**.

Kind regards,

Renal Physician Associates of Winchester

812 Amherst Street, Suite 201 ~ Winchester, VA 22601 ~ Phone (540) 450- 1600 ~ Fax (540) 450-0166

Patient Information:

Renal Physician Associates of Winchester

MRN:_____

Date: _____ **Name (Last, First, M):**_____

Address: (Street, City, State, Zip Code)

_____

Home#:_____ **Cell#:** _____**Primary Care Physician:**_____

Social Security Number: _____-_____-_____ **Birth Date:** _____/_____/_____

Gender at Birth:_____ **What do you identify as: Male Female Other**

Email: _____ **Marital Status: (Single / Mar / Div / Sep / Wid)**

Employer: _____ **Employer Phone:** _____

Race: (Caucasian / African American / Indian / Hispanic) Preferred Language:_____

Insurance Information:

Primary Insurance: _____

Policy #: _____ **Group #:** _____

Policy Holder Name: _____ **DOB:** _____ **SSN:** _____-_____-_____

Patient Relationship to Policy Holder: _____

Secondary Insurance: _____

Policy #: _____ **Group #:** _____

Policy Holder Name: _____ **DOB:** _____ **SSN:** _____-_____-_____

Patient Relationship to Policy Holder: _____

Emergency Contact:

Name: _____**Relationship to patient:** _____

Phone (Home): _____ **(Cell):** _____

I hereby authorize Renal Physician Associates to examine and prescribe me such treatment(s) as deemed necessary or advisable based on my diagnosis. I hereby authorize Renal Physician Associates to release any information acquired in the course of my examination or treatment to the insurance company. I understand that Renal Physician Associates will file my insurance claim as a courtesy and I authorize my insurance benefits to be paid directly to Renal Physician Associates. This authorization shall remain valid until revoked in writing.

Signature _____ **Date:**_____

Authorization for Release of Information

Renal Physician Associates of Winchester MRN:_____

Name:	Date of Birth:

The office of Renal Physician Associates is authorized to release protected health information as described below for the identified patient.

Check each person or class of persons that you approve to receive information

Description of information to be released.

☐ Voice messages on: _____ number.	☐ Appointment reminders ☐ Lab results ☐ Other:_____
☐ Spouse or Significant Other: _____	☐ Appointment reminders ☐ Lab results ☐ Other:_____
☐ Other person: _____	☐ Appointment reminders ☐ Lab results ☐ Other:_____
☐ Other person: _____	☐ Appointment reminders ☐ Lab results ☐ Other:_____

Patients Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disc closed but will be effective going forward.
- Information used or disclosed as a result of the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until I revoke it in writing.

_____ _____

Signature of patient or personal representative **Date**

- Description of Personal Representatives Authority (attach if necessary documentation)

Renal Physician Associates of Winchester MRN:_____

Financial Policy

1. Insurance Information

- We require patients to provide current and accurate insurance information **before each visit**.
- Patients are **responsible** for **notifying** our office of any insurance changes (new plan, group number, policy termination, etc.).
- We will verify eligibility and benefits prior to your appointment, but this does not guarantee coverage.
- Our office will file insurance claims as a courtesy; however, **the patient remains responsible for all balances not covered by insurance**.

2. Co-Payments, Deductibles, and Co-Insurance

- **Co-payments** are due **at the time of service**. This is required by law.
- Any deductibles and co-insurance amounts determined by your plan will be billed to the patient after insurance processing.
- We accept all major credit cards, cash, and checks. Please make checks out to Renal Physician Associates of Winchester.

3. Self-Pay / Uninsured Patients

- If you do not have insurance, a **full payment** is required at the time of service.
- We offer **discounted self-pay rates** for patients.

    1. New Patients are required to pay $140.00.
    2. Established Patients are required to pay $100.00.

4. Referrals and Authorizations (More on next page)

- Some insurance plans require **referrals or prior authorizations** for visits, lab tests, or procedures.

- It is the patient's responsibility to ensure referrals or authorizations are in place prior to the appointment.
- Visits not authorized by your insurance may result in **out-of-pocket charges**.

5. Billing and Statements

- Statements are mailed or provided electronically each month.
- Payment is due **within 30 days** of the statement date unless other arrangements have been made.
- Accounts over **90 days past due** may be subject to additional fees.

6. Laboratory and Hospital Services

- Laboratory tests, dialysis services, or hospital visits may be billed separately by outside providers.
- ***Please contact those providers directly for any billing questions related to services not performed in our office.***

7. Missed Appointments / Late Cancellations/ No Shows

- We require **at least 24 hours of notice** for appointment cancellations.
- A **no-show fee** of $25.00 may apply for missed appointments without notice. This $25.00 is required to be paid before next appointment.
- Chronic no-shows may result in dismissal from the practice.

8. Payment Plans/ Financial Hardships

- Payment arrangements must be approved by our billing department.
- Patients on payment plans must stay current with their agreed-upon schedule to avoid interruption of care.

9. Lab Billing Responsibility Notice

Laboratory services are billed separately and are the financial responsibility of the patient. If you have any questions regarding laboratory charges, please contact the laboratory that performed the testing or your insurance provider directly for clarification.

10. Questions or Assistance

If you have any questions about your bill, insurance coverage, or financial options, please contact our billing office 540-450-1600. ext}701

Acknowledgment of Financial Responsibility

I have read and understand the financial policy of Renal Physician. I agree to be financially responsible for all services rendered to me or my dependents.

Patient Name: _____
Signature: _____
Date: _____

Authorized Representative

Name:_____

Relationship to patient:_____

Print name:_____

Signature:_____

Date:_____

Renal Physician Associates of Winchester **MRN:**_____

Patient name: _____Date of birth: _____

Medication Information

Medications: (prescription and over-the-counter medications, vitamins, birth control pills, herbs and supplements.) Please list your medication Name, Dosage, and frequency of each medication.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies: (please list any allergies you may have)

_____
_____

Pharmacy:

Pharmacy name _____
City:_____ State: _____Fax:_____

Renal Physician Associates of Winchester MRN:_____

Current Providers: Please list the names of your providers you see routinely.
(example : Cardiologist, Ect.)

_____
_____
_____
_____

Prior Surgeries and Hospitalizations: (please list all prior operations)

Surgery	Date	Surgery	Date
Appendectomy		Hemorrhoidectomy	
CABG/Heart Bypass		Hernia Repair	
Cataract L/R/B		Hip Replacement L/R/B	
D&C		Knee Replacement L/R/B	
Gall Bladder Removal		Hysterectomy	
Gastric Bypass		Prostatectomy	
Back		Nephrectomy	
Renal Transplant		Thyroidectomy	
Tonsillectomy		Valve Replacement	
AV Fistula		PD Cath	
Other:		Other:	

Renal Physician Associates of Winchester MRN:_____

Medical History

Use the space below to provide details and/or the year of onset

Kidney Disease

Stage (If known) : _____ Transplant
year:_____ Location:_____

Type:

- ☐ Living Relative
- ☐ Living Unrelative

Dialysis Year: _____

Type:

- ☐ Peritoneal Dialysis
- ☐ Hemodialysis

Comprehensive Patient Medical History

Cancer	Year	Cancer	Year
Kidney		Lymphoma	
Breast		Melanoma	
Prostate		Thyroid	
Colon		Leukemia	
Lung		Uterine	
Bladder		Pancreatic	
Testicular		Other	

Heart Disease	Date
Heart Attack Angina	
Atrial Fibrillatory Pacemaker	
Congestive Heart Failure	
Angioplasty/Stent	
Other	

RPAW

Renal Physician Associates of Winchester MRN:_____

ENT	Year	Sickle Cell Trait	Year
Blindness		**Gastrointestinal**	
Cataracts		Acid Reflux	
Glaucoma		Hepatitis Type	
Hearing Problems		Irritable Bowel Syndrome (IBS)	
Genitourinary		Stomach Bowel Ulcers	
Kidney Stones		Inflammatory Bowel Disease	
Enlarged Prostate		Ulcerative Colitis/ Crohn's Disease	
Frequent UTI's		**Respiratory**	
Neurological		COPD	
Neuropathy		Emphysema	
Seizures		Chronic Bronchitis	
Multiple Sclerosis		Asthma	
Stroke		Pneumonia	
Parkinson Disease		Sleep Apnea	
Dementa		TB	
Migraines / Headache		**Endocrine**	
Psychiatric		Hypothyroidism	
Depression		Hyperthyroidism	
Anxiety Disorder		Adrenal	
Musculoskeletal		**Immune / Rheumatology**	
Osteoarthritis		Lupus	
Osteoporosis		Rheumatoid Arthritis	
Other:		HIV	
Anemia		**OB History**	

Renal Physician Associates of Winchester MRN:_____

Blood Infusion		Preclampsia	
Sickle Cell Anemia		Pregnancy induced hypertension	
Any Other:		Gestational Diabetes	
		HX of Difficulty Pregnancies	

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diabetes Unknown
- ☐ Gout
- ☐ Hypertension

Family History:

Please indicate with a check any family members who have had any of the following conditions:

☐ Check here if you don't know your family history.

Medical Condition	MOM	DAD	SIS	BRO	DAUG	SON	Other close relatives
Anemia							
Stroke							
Dementia							
Cancer							
Adult Polycystic Kidney Disease							
Hypertension							
Diabetes Type 1							
Diabetes Type 2							

If cancer was selected please specify the type:

_____

_____

Renal Physician Associates of Winchester MRN:_____

Family Status:

Parent	Status (check one)	Age at Death	Cause of Death
Father	☐ Living ☐ Deceased ☐ Unknown	_____	_____
Mother	☐ Living ☐ Deceased ☐ Unknown	_____	_____

Social History:

Married **Separated** **Single** **Widowed** **Divorced**

Living arrangements:

Lives alone Lives with spouse In home caregiver Lives with Family

Lives with significant Other Lives in Assisted living / Nursing home

Functional / Cognitive

No Impairment Hearing loss Memory Deficit Poor vision / Blindness Limited Mobility

Transportation Challenges

Social history - Habits

Tobacco use: Current Former Never If the former, what year did you quit?_____

Cigarettes Cigars Vapes pipes Chewing tobacco Snuff

If a former or current, how often did you smoke? Everyday Some days Unknown

If current, how many packs a day?_____ And how many total years have you used tobacco?_____

Alcohol use: Current Former Never used Other:_____

Recreational Drug Use: Current Former Never Used

Renal Physician Associates of Winchester **MRN:**_____

Marijuana Heroin Cocain LSD Amphetamines Ecstasy
Barbiturates Opium OTHER:_____