

# Georgia Kidney Associates

Edward D. Himot, M.D.  
 Indira Chervu, M.D., F.A.C.P.  
 Robert D. Jansen, M.D.  
 Akin O. Ogundipe, M.D.  
 Vijay Nath, M.D.  
 Sandeep Jagan, M.D.

## Patient Information Sheet

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Instructions:** Please provide the information requested below as completely as possible. This information will be used to assist us in providing you with the best medical care possible. The form will be reviewed by the doctor, and you will then be asked for additional information during your visit.

What problems brought you to see the doctor today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** Have any of your relatives had any of the following diseases? If so, please indicate which relative(s) was (were) affected:

Disease	Family Member(s)
Diabetes	
High Blood Pressure	
Heart Attack	
Other Heart Disease	
Stroke	
Cancer	
Kidney Failure	
Arthritis	
Lupus or Similar Disease	
Deafness	
Bleeding Problems	
Inherited Disease	

Father: Living Yes  No  Health Status: \_\_\_\_\_  
 Cause of Death: \_\_\_\_\_

Mother: Living Yes  No  Health Status: \_\_\_\_\_  
 Cause of Death: \_\_\_\_\_

Brothers: Number Living ( ) Number Deceased ( )

Sisters: Number Living ( ) Number Deceased ( )



# Georgia Kidney Associates

## REVIEW OF SYSTEMS

Please answer Yes or No to each question and provide an explanation of **each** affirmative answer.

General	Yes	No	Explanation
Change in appetite			
Change in weight			
Anemia			
Bleeding Problem			
History of Cancer			

Endocrine	Yes	No	Explanation
Diabetes			
Thyroid Disease			
Cortisone Use			

ENT	Yes	No	Explanation
Glasses			
Changing Vision			
Deafness			
Sinus problems			
Swallowing problem			
Other			

Pulmonary	Yes	No	Explanation
Cigarette use			
Cough up Blood			
Chronic Cough			
Asthma			
Pneumonia			
Emphysema			
Chronic Bronchitis			
Shortness of Breath			
Other			

Cardiovascular	Yes	No	Explanation
Rheumatic Fever			
Heart Murmur			
Chest Discomfort			
Chest Pain			
Heart Attack			
Irregular Pulse			
Palpitations			
Shortness of Breath			
Swelling			
High Blood Pressure			
Heart Failure			
Fainting			
Blood Clots			
Abnormal EKG			
Cardiac Catheter			
Exercise Test			
Other			

# Georgia Kidney Associates

## REVIEW OF SYSTEMS (CONT'D)

Gastrointestinal	Yes	No	Explanation
Hepatitis			
Jaundice			
Blood in Stools			
Nausea/Vomiting			
Ulcers			
Vomiting Blood			
Chronic Diarrhea			
Constipation			
Cancer			
Other			

Renal and GU	Yes	No	Explanation
Kidney Stones			
Bright's Disease			
Blood in Urine			
Kidney Failure			
Voiding Difficulty			
Bladder Surgery			
Bladder Infections			
Kidney Infections			
Prostate Disease			
Other			

Musculoskeletal	Yes	No	Explanation
Joint Pain			
Joint Swelling/Head			
Deformed Joints			
Broken Bones			
Skin Rash			
Skin Cancer			
Hair Loss/Gain			
Nail Problems			
Other			

Neurologic	Yes	No	Explanation
Seizures			
Stroke			
Headaches			
Change in Vision			
Dizziness			
Fainting			
Tremor/Shakes			
Trouble Walking			
Psychiatric Problem			
Other			



# Georgia Kidney Associates

## Patient Registration Form

Patient Name: \_\_\_\_\_  M/ F Date: \_\_\_/\_\_\_/\_\_\_  
(First) (MI) (Last) (Sex)

Home Address: \_\_\_\_\_  
(Street / Number) (City) (State) (ZIP)

Home Phone: (\_\_\_\_) - \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_ Marital Status: \_\_\_\_

SSN: \_\_\_/\_\_\_/\_\_\_ Known Allergies: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
(Street / Number) (City) (State) (ZIP)

Spouse's or Parent's Name: \_\_\_\_\_ SSN: \_\_\_/\_\_\_/\_\_\_

Spouse's or Parent's Employer: \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
(Street / Number) (City) (State) (ZIP)

Next of Kin/Nearest Relative/Friend: \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
(Street / Number) (City) (State) (ZIP)

### \*\*\*\*\*INSURANCE INFORMATION\*\*\*\*\*

Medicare Number \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Insurance Company #1 \_\_\_\_\_ Group Name \_\_\_\_\_

Address: \_\_\_\_\_  
(Street / Number) (City) (State) (ZIP)

Insured: \_\_\_\_\_ I.D. Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Company #2 \_\_\_\_\_ Group Name \_\_\_\_\_

Address: \_\_\_\_\_  
(Street / Number) (City) (State) (ZIP)

Insured: \_\_\_\_\_ I.D. Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Referred by: \_\_\_\_\_

### \*\*\*\*\*

I authorize any physician, hospital, or clinic to provide full details of my medical history and treatment to Dr. Himot, Dr. Chervu, Dr. Jansen, Dr. Ogundipe, Dr. Nath or Dr. Jaglan. I also authorize Dr. Himot, Dr. Chervu, Dr. Jansen, Dr. Ogundipe, Dr. Nath or Dr. Jaglan to furnish my insurance company any information they may request regarding my present illness or injury.

I hereby assign payment directly to **GEORGIA KIDNEY ASSOCIATES, INC.** the amount now due for medical expenses incurred and payable under terms of my basic insurance as well as Major Medical benefits. I understand that I am financially responsible for any charges not covered by this assignment. **PHOTOCOPIES OF THIS FORM WILL BE VALID.**

\_\_\_\_\_  
Signature of Patient/Parent

\_\_\_\_\_  
(Date)

# Georgia Kidney Associates

Edward D. Himot, M.D.  
Indira Chervu, M.D., F.A.C.P.  
Robert D. Jansen, M.D.  
Akin O. Ogundipe, M.D.  
Vijay Nath, M.D.  
Sandeep Jagan, M.D.

## Preventative Health Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate the last time you had the following preventative health exams and/or immunizations:

### All Patients

	Date
Colonoscopy	_____
Sigmoidoscopy	_____
Cholesterol Screening	_____

### If Diabetic:

	Date
Vision Screening	_____
Podiatry (Foot) Exam	_____
Hemoglobin A1C	_____

### If Male:

PSA	_____
Prostate Exam	_____

### If Female:

Mammogram	_____
Breast Exam	_____
PAP Smear	_____

### Adult Immunizations

Tetanus	_____
Influenza	_____
Pneumonia	_____
Hepatitis A	_____
Hepatitis B	_____

### Childhood Immunizations (check Yes or No)

Mumps	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Measles	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Rubella	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Chicken Pox	Y <input type="checkbox"/> N <input type="checkbox"/>	_____

# Georgia Kidney Associates Inc.

## Financial Policy

The physicians and staff of Georgia Kidney Associates are committed to providing you with the best possible care. We feel that it is important to our professional relationship that you understand our financial policies. Your signature at the end of this policy indicates your acceptance of these terms:

### Managed Care Plans:

If you are covered by a managed care plan commonly referred to as an HMO, POP or POS, our contract requires us to collect a co-payment at each visit. It is our policy to collect co-payments at the front desk before you see the doctor. We appreciate your cooperation in this matter.

Our physicians are both specialists and/or primary care providers (PCP) for most of the major HMOs. **If one of our physicians is your specialist, your insurance company may require a referral before you can be seen in our office.** Our contract with the managed care companies prohibits us from seeing a patient without a referral. Therefore, if you do not have a referral in hand when you arrive, you will be asked to contact your PCP to obtain the referral. This may delay and/or cause your appointment to be rescheduled for lack of required documentation. Should you decide not to follow the referral guidelines, a waiver must be signed and payment in full will be requested at the time of service.

It is the responsibility of the patient to become familiar with his/her insurance plan and the referral pre-certification process and facilities approved by the plan.

**If one of our physicians is your primary care provider, or, PCP, we must have 72 hours' notice in order to issue or renew a referral to your specialist. Please contact our referral coordinator at Ext. 224 at least 72 hours prior to the day of your appointment to obtain or renew your referral.**

### Commercial insurance:

We will file primary insurance claims to all commercial carriers.

### Secondary Insurance:

It is our policy to file office charges to secondary insurances only for those patients on Medicare. We do, however, file secondary insurance for all hospital stays. We will keep your secondary insurance on file so that, in the event of hospitalization, we can file your secondary claim. You will be provided with the necessary documentation to file your secondary claims at the time of your visit.

### Medicare:

Because our physicians participate with Medicare, we are required to accept Medicare's allowable fee as our total charge. We will collect 20% of the allowable amount at the time of your visit. If you have a secondary insurance carrier, we will wait until it has been filed before collecting the 20% fee.

### Medicaid:

Medicaid patients are required to show proof of coverage at every appointment. Patients will be expected to pay for co-pays and noncovered services at the time of service. Patients covered under Georgia Better Healthcare are required to have a referral from their primary care physician prior to being seen,

### Automobile Insurance:

Patients are required to pay for office visits at the time of (remove .)service. You will be given the necessary paperwork to obtain reimbursement from the automobile insurance carrier.

### Uninsured Patients:

Payment is expected at the time of service. If you are unable to pay the full amount, please ask to speak to our billing office to arrange a payment plan. **Whenever possible, payment arrangements should be discussed prior to the initial appointment.**

### Other Policies.

**There will be a \$20.00 returned check charge added to your account balance if a check is denied or returned for insufficient funds.**Our charges are filed to insurance on a daily basis. If your insurance company has not paid your charges within 90 days of filing, you will be expected to pay the balance in full. Should this occur, our billing office, upon your request, will furnish the necessary paperwork to assist you in obtaining direct reimbursement from your insurance company.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF GEORGIA KIDNEY ASSOCIATES INC.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Responsible Party Signature: \_\_\_\_\_

**GEORGIA KIDNEY ASSOCIATES, INC.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\_\_\_\_\_ acknowledge that I have received a copy of Georgia Kidney Associates, Inc.'s Notice of Privacy Practices. This Notice describes how Georgia Kidney Associates, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_

(Signature of Patient, or Personal Representative) (Date)

\_\_\_\_\_

(Relationship to Patient)

## GEORGIA KIDNEY ASSOCIATES MANAGED CARE POLICY

In order to better serve the needs of our patients, we have enrolled in numerous managed care, HMO's and PPO's.

Each of these managed care plans has different requirements. While we make every effort to keep our records updated on each plan's individual requirements, we must ultimately depend on you, the insured, to advise us of the requirements **for your individual plan** so that we may refer you to facilities and providers that are within your plan's guidelines.

Providing quality medical care for our patients is our primary concern and we are very willing to refer to physicians and/or facilities within your plan's guidelines. Please familiarize yourself with the following information provided in your insurance booklet.

1. Our normal reference lab is **Labcorp**. If your insurance company requires that lab services be provided by a lab other than Labcorp, please advise us of this **before** your lab work is drawn.
2. Some plans required that outpatient x-rays, especially MRI's, ultrasounds and CAT scans are pre-certified **before** the procedure is performed. If this pre-certification number is not obtained **before** the procedure, you may be required to pay for the entire cost of the exam.
3. We normally send our patients to **WELLSTAR RADIOLOGY** for x-rays, scans, and ultrasounds. Some insurance plans specify a different facility be used for these tests. Please let us know **before** your test is scheduled as you will be responsible for the entire charge if you do not go to a facility within your plan.
4. If your insurance company requires a **specialist referral** from your primary care physician (PCP) before you can be seen by our physicians, it is your responsibility to obtain that referral **prior to your appointment**. You should bring the referral with you to your appointment. Our contract with the insurance company prohibits us from seeing you without the referral. If you are seen without a referral and our payment is denied, you will be responsible for the entire balance. If a referral is required and you are unsure of the correct procedure, please let us know when you make your appointment so we can provide assistance.
5. Most insurance companies require pre-certification of hospital admissions. Please let us know if your plan requires this so that our nurses can notify the insurance company as soon as possible of your admission.

Unfortunately, if you do not inform us of any special requirements in your contract and we order or schedule procedures or hospitalization at a non-approved facility, the facility will bill you direct and the charges are your responsibility.

In the event that your coverage has lapsed or expired on the date that the services are rendered, all charges will be denied and ultimately become your responsibility. In order to avoid this, please keep us advised of any insurance or policy changes as they occur.

If you have any questions or need assistance, please know that our staff is available to help in any way that we can. By working together, you should be able to receive all the benefits offered to you and we will be able to concentrate on providing the quality medical care that you deserve.

I have read and understand the office policy as stated above and agree to accept responsibility as described.

---

Patient and/or Insured

---

Date



*Edward D. Himot, M.D.*

*Indira Chervu, M.D., F.A.C.P.*

*Robert D. Jansen, M.D.*

*Akin O. Ogundipe, M.D.*

*Vijay Nath, M.D.*

*Sandeep Jaglan, M.D.*

*Marietta Miller, Administrator*

**OFFICE LOCATIONS**

**Marietta**

55 Whitcher Street  
Suite 460  
Marietta, Georgia 30060  
Tel: (770) 427-7389  
Tel: (770) 928-5315  
Fax: (770) 427-1492

**Woodstock**

120 Stonebridge Parkway  
Suite 330  
Woodstock, Georgia 30189  
Tel: (770) 427-7389  
Tel: (770) 928-5315  
Fax: (770) 427-1492

**MEDICAL CHAPERONE POLICY**

The physicians of Georgia Kidney Associates, Inc. do not perform pelvic exams on their patients. Therefore, we do not routinely require the presence of an additional member of our medical staff during examinations. **HOWEVER, IF YOU FEEL MORE COMFORTABLE WITH A MEMBER OF OUR MEDICAL STAFF PRESENT DURING YOUR EXAM, PLEASE INDICATE BELOW.**

I, \_\_\_\_\_, HAVE BEEN  
(PATIENT'S NAME)  
**ADVISED THAT I MAY HAVE AN ADDITIONAL MEDICAL STAFF MEMBER PRESENT TO CHAPERONE DURING MY EXAM.**

\_\_\_\_\_ I WOULD **LIKE** A CHAPERONE PRESENT.

\_\_\_\_\_ I **DECLINE** TO HAVE A CHAPERONE PRESENT.

\_\_\_\_\_  
(PATIENT SIGNATURE)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(WITNESS)

# GEORGIA KIDNEY ASSOCIATES, INC.

## PATIENT CONFIDENTIALITY FORM

**TO ENSURE THAT THERE IS NO VIOLATION OF YOUR PRIVACY, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:**

In the event that I, \_\_\_\_\_, cannot be reached, Georgia Kidney Associates, Inc. may leave any test result, lab result, appointment information or other confidential medical information with the following:

*Please circle all that apply:*

**Spouse** Name: \_\_\_\_\_ Number: \_\_\_\_\_

**Children** Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

**Home Voice Mail:** Number: \_\_\_\_\_

**Work Voice Mail:** Number: \_\_\_\_\_

**Cell Voice Mail:** Number: \_\_\_\_\_

**Other** Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

If there is anyone you **DO NOT** wish us to discuss this information with, please specify below.

---

---

---

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE