

# WELCOME TO CARROLL COUNTY NEPHROLOGY

\*\*Please bring the completed paper work with you to your appointment along with your medications and insurance card(s). Please arrive 15 minutes prior to your appointment time.\*\*

**We have three locations for your convenience:**

## **Carrollton:**

157 Clinic Avenue, Suite 203 – Carrollton, GA 30117

Located between Tanner Hospital and Walgreen's in West Georgia Specialty Center (3-story building directly across the street from Carrollton Eye Clinic).

## **Bremen:**

108 Redding Drive – Bremen, GA 30110

Located behind the old Piggly Wiggly shopping center on Highway 78. Take the first right off of Mangham Drive onto Redding Drive (Millennium Business Park). We are in the building next to Millennium Academy Daycare.

## **Villa Rica:**

403 Permian Way, Suite B – Villa Rica, GA 30180

Exit I-20 onto Mirror Lake Boulevard and travel north to the first light at Conners Road. Turn right onto Conners Road and travel past the Publix shopping center. Take the first right (at the Dollar General) onto Permian Way. Then, continue straight through the stop sign and all the way to the curb, the office will be on your right.

**IMPORTANT- Please arrive 15 minutes prior to you scheduled appointment time and be sure to bring the following items with you to your appointment:**

- Enclosed Paperwork
- Photo Identification
- Insurance Card(s)
- All Current Medications

**We look forward to seeing you at your scheduled appointment.**

**Phone: 770.832.0429**

**Fax: 770.838.9108**

**Maria J. Orig, MD., FASN**

**Bryan D. Quinn, MD**

**Myriam C. Vela-Ortiz, MD**

**Kilsy A. Cuello Pichardo, MD**

**Emily T. Massey NP-C**

**Patient Demographics**

Name: \_\_\_\_\_  
FIRST MI LAST

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: married single divorced widowed Gender: male female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Responsible Party**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

## **Pharmacy Information**

Pharmacy Name: \_\_\_\_\_

Location (City): \_\_\_\_\_ Phone: \_\_\_\_\_

## **Emergency Contact**

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

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Our Pledge Regarding Medical Information**

We understand that medical information about you and your health is very personal. As such, our staff is committed to protect your medical information. We are required by law to provide insure that all medical information that identifies you is kept private. To comply with the proper use and disclosure of your medical information, please provide us with the names of the individuals involved in your care and/or with the payment of your care.

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

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

## Authorization for Disclosure of Protected Health Information

To the following person or class of persons: To any and all physicians, healthcare providers, healthcare facilities, or healthcare entities that provide or have provided health care services to the patient named below:

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Note – “You” refers to the person(s) to whom this authorization is directed. “I”/”Me” refers to the patient.

### Authorization

You are hereby authorized to disclose my protected health information, whether oral, written or electronic, pertaining to my complete medical record, including, but not limited to:

- HIV and AIDS confidential information.
- Psychiatric and psychological information, drug, and alcohol abuse treatment information.

You are hereby authorized to disclose my protected health information, whether oral, written or electronic, pertaining to my complete medical record, including, but not limited to, to the following:

- Any physician, healthcare provider, or health care facility that has provided healthcare services to me.
- Any attorney at law representing such physician, healthcare provider, or healthcare facility.

You are hereby authorized to discuss my care and treatment with any attorney or representative of an insurance provider if I assert a claim against another physician, healthcare provider, healthcare facility, or healthcare entity.

I hereby authorize direct payment to Carroll County Nephrology, PC for medical benefits under the term of my insurance and the release of medical records to the indicated insurance company/companies for the purpose of proof of treatment, verification of coverage, and pre-certification.

This authorization expires in three (3) years after the date of execution shown below.

### Patient’s Rights

I understand that I do not have to sign this authorization to receive healthcare benefits (treatment, payment, or enrollment) from the person(s) to whom this authorization is directed. I may revoke this authorization in writing at any time. If I do so, it would not affect any actions already taken by someone in reliance on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance coverage. If I wish to revoke this authorization, I shall do so by sending a letter to the person(s) to whom this authorization is directed. Once the healthcare provider discloses information, any person or organization that receives it may re-disclose it. Patient privacy laws may no longer protect that information. I must 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.

\_\_\_\_\_  
**Signature of Patient or Legally Authorized Individual**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name (if signed on behalf of patient)**

\_\_\_\_\_  
**Relationship (Parent, Guardian)**

## **Financial Policy**

**All co-pays are due at the time of service.** This includes the 20% coinsurance allowed by Medicare if you do not have a secondary insurance. If you have deductibles under your plan that applies to our visits, you are responsible for paying this in a timely manner. Please contact our billing department if payment arrangements are required.

**Carroll County Nephrology requires a 24-hour cancellation notice for all cancellations.** If no one is available when you call, please leave a detailed message with your name, date of birth, and appointment date/time. If appropriate notice is not given, there will be a \$25.00 charge.

**Please be aware that there is \$30.00 charge for returned checks (this is an automatic debit done by our bank).** Carroll County Nephrology accepts cash, check, money order, Visa, MasterCard, and American Express. We do not accept Discover.

**Carroll County Nephrology charges a \$15.00 administrative fee to patients requesting forms to be completed by the staff.** Examples: forms for disability, family medical leave, medical equipment, etc.) The patient is responsible for this fee.

**Please sign below to indicate that you have read and understand all of the above statements:**

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Signature of Patient or Legally Authorized Individual

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Date

## **Self-Pay Policy**

**Our office bills at Medicare rates to patients without insurance coverage.** If you do not have any form of insurance, we ask that you call our billing department when you receive this package. This will give our office time to inform you of the cost of the visit. If you **DO** have insurance coverage, it is **NOT** necessary for you to call our billing department ahead of time regarding this Self-Pay Policy. Payment in full is expected at time of service. You can contact our billing department by dialing (770) 832-0429, extension 5.

# MEDICATION LIST

Please list all medications currently being taken. Please include all prescription and over-the-counter medications as well as any vitamins and/or herbs.

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**MEDICATION NAME:**                      **DOSE:**                      **FREQUENCY:** (daily, twice daily, etc)

MEDICATION NAME:	DOSE:	FREQUENCY:

**ALLERGIES:** Please list all medication allergies.

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