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 brick building directly across the street from Carrollton Eye Clinic).

Bremen:

108 Redding Drive – Bremen, GA 30110
Located behind the Bremen Village (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 Liberty Road (Exit 26) 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 30 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

Bryan D. Quinn, MD
Atiya Charchar, MD
Emily Massey, NP-C

Kilsy A. Cuello Pichardo, MD
Thuy Le, DO
Bernard Muthoni, NP-C

Patient Demographics

Name: _____
FIRST MI LAST

Date of Birth: _____ SSN: _____

Marital Status: married single divorced widowed Gender: male female

Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Email Address: _____

Primary Care Physician: _____

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:

_____ _____ **Signature of**

Patient or Legally Authorized Individual **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.)

ALLERGIES: Please list all medication allergies.

_____

_____

_____