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WELCOME TO CARROLL COUNTY NEPHROLOGY

****Please bring the completed paperwork with you to your appointment along with your medications and insurance card(s). Please arrive 15 minutes before your appointment time.****

We have four locations for your convenience:

Carrollton:

157 Clinic Avenue, Suite 203 – Carrollton, GA 30117
Located between Tanner Hospital and Walgreens in West Georgia Specialty Center (Three-story building directly across the street from Georgia Vision Institute); we are on the second floor.



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. We share a parking lot with Lifegate church.

Wedowee:

1032 South Main Street Suite 201 – Wedowee, AL 36278
From U.S. Hwy 431, 1.3 miles south of downtown Wedowee; Located on the second floor of the Tanner Medical Center East Alabama Medical Office Building.

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

- **Enclosed Paperwork**
- **All current medications**
- **Insurance Cards**
- **Photo ID**



PATIENT DEMOGRAPHICS

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female ☐ Other/Prefer not to say

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

E-Mail: _____

Ethnicity/Race: _____ Occupation: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Spouse Name: _____ Spouse Phone: _____

Primary Care Physician: _____

RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Phone: _____

****Note: You do not have to complete if you provide a copy your insurance card(s)****

PRIMARY INSURANCE POLICY

Primary Insurance Company: _____

Group #: _____ ID #: _____

Complete the following if you are **not** the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth:** _____

****Note: You do not have to complete if you provide a copy your insurance card(s)****

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: _____

Group #: _____ **ID #:** _____

Complete the following if you are **not** the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____

Policyholder Name: _____ **Date of Birth:** _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

PHARMACY INFORMATION

Pharmacy Name: _____

Location (City): _____ **Phone:** _____

PATIENT CONSENT

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 protecting your medical information. We are required by law to ensure 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:** _____

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 terms 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.

Patient/Legally Authorized Individual: _____ **Date:** _____

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 secondary insurance. If you have deductibles under your plan that apply to our visits, you are responsible for paying them 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 a \$30.00 charge for returned checks. Carroll County Nephrology accepts cash, check, money order, Visa, MasterCard, Discover, and American Express.

Carroll County Nephrology charges a \$45.00 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:

Patient/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 the time of service. You can contact our billing department by dialing (770) 832-0429, extension 5.

Patient/Legally Authorized Individual: _____

Date: _____

Printed Name (if signed for patient): _____

Relationship (Parent/Guardian): _____

MEDICAL HISTORY	
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Have you ever had any of the following?

Atrial Fibrillation	☐ Y ☐ N	Heart Disease	☐ Y ☐ N
Acute Kidney Injury	☐ Y ☐ N	Hepatitis B	☐ Y ☐ N
Anemia	☐ Y ☐ N	Hepatitis C	☐ Y ☐ N
Blood in Urine	☐ Y ☐ N	High Cholesterol	☐ Y ☐ N
Cancer	☐ Y ☐ N	High Potassium	☐ Y ☐ N
Congestive Heart Failure	☐ Y ☐ N	HIV/AIDS	☐ Y ☐ N
Chronic Kidney Disease	☐ Y ☐ N	Hyperparathyroidism	☐ Y ☐ N
COPD	☐ Y ☐ N	Hypertension	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Kidney Stones	☐ Y ☐ N
Diabetic Nephropathy	☐ Y ☐ N	Low Sodium	☐ Y ☐ N
GERD	☐ Y ☐ N	Lupus	☐ Y ☐ N
GOUT	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N
Heart Attack	☐ Y ☐ N	Polycystic Kidney Disease	☐ Y ☐ N
Renal Cyst	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
Stroke	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
UTI	☐ Y ☐ N	Other: _____	

MEDICATION

Please include all prescriptions and over-the-counter medications, as well as any vitamins and/or herbs.

[illegible]

ALLERGIES: Please list all medication allergies.

FAMILY HEALTH HISTORY

Has anyone in your immediate family had the following? **(M) for Mother (F) for Father**

Autoimmune disease	☐ M ☐ F	Heart Disease	☐ M ☐ F
Cancer	☐ M ☐ F	High Blood Pressure	☐ M ☐ F
Dementia	☐ M ☐ F	Kidney Disease	☐ M ☐ F
Diabetes	☐ M ☐ F	Polycystic Kidney Disease	☐ M ☐ F
GOUT	☐ M ☐ F	Stroke	☐ M ☐ F

SOCIAL HISTORY

Do you currently consume alcohol? ☐ Yes ☐ No ☐ Former

- If yes, how many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No ☐ Former

- What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____
- If yes, how often do you smoke per day? _____

Do you currently use any other recreational drugs? ☐ Yes ☐ No ☐ Former

- How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Do you drink caffeine? ☐ Yes ☐ No

How many cups per day? _____

SURGICAL HISTORY

Have you ever had any of the following?

Appendectomy	☐ Y ☐ N	Hysterectomy	☐ Y ☐ N
Bladder Surgery	☐ Y ☐ N	Kidney Biopsy	☐ Y ☐ N
CABG (Bypass)	☐ Y ☐ N	Kidney Removal	☐ Y ☐ N
Cardiac Stent	☐ Y ☐ N	Kidney Stone Surgery	☐ Y ☐ N
Cystectomy	☐ Y ☐ N	Kidney Transplant	☐ Y ☐ N
Dialysis Access Surgery	☐ Y ☐ N	Parathyroid Surgery	☐ Y ☐ N
Gallbladder Surgery	☐ Y ☐ N	Thyroid Surgery	☐ Y ☐ N