

Hello and welcome to LA County Nephrology.

You have been scheduled for an appointment with LA County Nephrology in the coming weeks. Please arrive 30 minutes prior to your scheduled appointment time so we can ensure all needed information is updated in our electronic health records (EHR).

For your convenience, we have provided a questionnaire below. We request that you complete and submit this questionnaire and arrive 30 minutes before your scheduled appointment. Please be certain to bring your insurance card(s) and a picture I.D. to your appointment.

On your behalf, we will request your medical information from the referring physician with your permission. Please follow up with your physician's office to sign a medical release form so we can obtain your medical records.

Our policy is to collect co-payments and co-insurance at the time of service. If you are unable to make payment at the time of service, please contact our office prior to your appointment to make financial arrangements. For your convenience, we accept cash, check, Visa, MasterCard, and American Express.

To summarize the information above:

- Complete the questionnaire below and bring it to your scheduled appointment.
- Arrive 30 minutes before your scheduled appointment.
- Bring your insurance cards and photo I.D. to your appointment.
- Bring a medication list, including prescribed medications, over-the-counter medications, vitamins and supplements.
- Be prepared to give a urine specimen when you arrive for your appointment.
- Be prepared to make any necessary co-payment at the time of your visit.

Thank you for the opportunity to serve you. We look forward to meeting you. If you have any questions, please contact

our office, and the staff will be happy to assist you.

Sincerely,

LA County Nephrology

## Patient Registration Form

Please complete in full and use blue or black ink.

### Patient Information

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

Last Name : \_\_\_\_\_ First Name : \_\_\_\_\_ MI: \_\_\_\_\_

Sex (circle) Female      Male      Date of Birth: \_\_\_\_\_

Social Security Number : \_\_\_\_\_

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

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

Home or Mobile Phone : \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Marital Status (circle)      Married      Widowed      Divorced      Separated      Single

Race (circle)      African American      Caucasian      Hispanic      Asian      Native American      European

Driver's License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

### Patient Employer Information

Status (Circle)      Employed      Retired      Disabled      Student      Other

Employer's Name: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

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

### **Emergency Contacts**

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

Relationship : \_\_\_\_\_

Phone : \_\_\_\_\_

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

Relationship : \_\_\_\_\_

Phone : \_\_\_\_\_

### **Responsible Party Other than Patient**

Last Name : \_\_\_\_\_ First Name : \_\_\_\_\_ MI: \_\_\_\_\_

Sex (circle) Female    Male                      Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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

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

Employer \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### **Primary Care Physician and Referring Physician**

Primary Care Physician \_\_\_\_\_

Phone \_\_\_\_\_

Referring Physician (if different from PCP) \_\_\_\_\_

Phone \_\_\_\_\_

**Insurance Information**

Primary Insurance Name \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Phone# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Phone# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

**Pharmacy Information**

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

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

Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

### Medication List

Name of Medication	Strength	Directions (ie. 1 per day, 2 every 6 hours)

Have you ever taken any anti-inflammatory medications such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.? Yes \_\_\_\_ No \_\_\_\_.

If YES, please list medications:

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Medication allergies:

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## Health History

	No	Yes		No	Yes
Anemia	N	Y	Hyperlipidemia	N	Y
Arthritis	N	Y	Hyperparathyroidism	N	Y
Asthma/COPD	N	Y	Hypertension	N	Y
Atrial Fibrillation(AFIB)	N	Y	Kidney Cyst	N	Y
Congestive Heart Failure(CHF)	N	Y	Kidney Failure	N	Y
Cancer	N	Y	Kidney Stones	N	Y
Cancer within Last 5 Years	N	Y	Lupus	N	Y
Coronary Artery Disease	N	Y	Polycystic Kidney Disease	N	Y
Diabetes Type 2	N	Y	Protein in Urine - Proteinuria	N	Y
Diabetes Type 1	N	Y	Recurrent Urinary Tract Infections	N	Y
Blood in Urine - Hematuria	N	Y	Stroke	N	Y
Hepatitis A	N	Y	Thyroid Disorder	N	Y
Hepatitis B	N	Y	Transplant	N	Y
Hepatitis C	N	Y	Vitamin D Deficiency	N	Y

Other

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Previous Hospitalizations and Surgeries (Please include dates)

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### Family Medical History

Has anyone in your family had any of the following:

Kidney disease: Yes  No  If yes, list family member(s): \_\_\_\_\_

Protein in urine: Yes  No  If yes, list family member(s): \_\_\_\_\_

Blood in urine: Yes  No  If yes, list family member(s): \_\_\_\_\_

Dialysis: Yes  No  If yes, list family member(s): \_\_\_\_\_

Diabetes Type 1: Yes  No  If yes, list family member(s): \_\_\_\_\_

Diabetes Type 2: Yes  No  If yes, list family member(s): \_\_\_\_\_

Hypertension: Yes  No  If yes, list family member(s): \_\_\_\_\_

SLE: Yes  No  If yes, list family member(s): \_\_\_\_\_

Kidney Stones: Yes  No  If yes, list family member(s): \_\_\_\_\_

Polycystic Kidney Disease: Yes  No  If yes, list family member(s): \_\_\_\_\_

Cancer: Yes  No  If yes, list family member(s): \_\_\_\_\_

Deafness: Yes  No  If yes, list family member(s): \_\_\_\_\_

Other: Yes  No  If yes, list family member(s): \_\_\_\_\_

### Current Social History (circle)

Alcohol Intake:	None	Occasionally	Moderate	Heavy
Chewing Tobacco:	None	1 per day	2-4 per day	5+ per day

Tobacco – years of use : \_\_\_\_\_

Smoking Status:	Never Smoked	Former Smoker	Current every day smoker	Current some day smoker	Smoker – current status unknown	Unknown if every smoked
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Smoking – None 1PPW 2 PPW 1/4PPD 1/2PPD 1PPD 2PPD 3+PPD

How much?

Has smoked since age: \_\_\_\_\_

Illicit Drugs : \_\_\_\_\_

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner

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

**REVIEW OF SYSTEMS** - Please check and describe how you are feeling today

<b>Constitutional :</b>	<b>Musculoskeletal:</b>
<input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Gain ( _____ lbs) <input type="checkbox"/> Weight Loss ( _____ lbs)	<input type="checkbox"/> Muscle aches <input type="checkbox"/> Arthralgias/joint pain <input type="checkbox"/> Back pain
<b>Eyes :</b>	<b>Skin:</b>
<input type="checkbox"/> Dry Eyes <input type="checkbox"/> Vision Change	<input type="checkbox"/> Jaundice <input type="checkbox"/> Rash <input type="checkbox"/> Itching
<b>Nose :</b>	<b>Psychiatric:</b>
<input type="checkbox"/> Frequent Nosebleeds	<input type="checkbox"/> Depression <input type="checkbox"/> Restless sleep
<b>Mouth/Throat:</b>	<b>Endocrine:</b>
<input type="checkbox"/> Sore throat <input type="checkbox"/> Snoring <input type="checkbox"/> Dry mouth	<input type="checkbox"/> Increased thirst <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance
<b>Cardiovascular:</b>	<b>Hematologic/Lymphatic:</b>
<input type="checkbox"/> Chest pain on exertion <input type="checkbox"/> Shortness of breath when walking <input type="checkbox"/> Palpitations <input type="checkbox"/> Known heart murmur <input type="checkbox"/> Light-headed on standing <input type="checkbox"/> Swelling in the extremities	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Easy bruising <input type="checkbox"/> Excessive bleeding
<b>Gastrointestinal:</b>	<b>Allergy/Immunologic:</b>
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Change in appetite <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Nausea	<input type="checkbox"/> Runny nose <input type="checkbox"/> Itching <input type="checkbox"/> Hives
<b>Genitourinary:</b>	<b>Other :</b>
<input type="checkbox"/> Urinary loss of control <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Increased urinary frequency <input type="checkbox"/> Blood in urine	<hr/> <hr/> <hr/>

**Consent for Release of Information and Test Results**

I, \_\_\_\_\_, give my consent and authorization to the staff of LA County Nephrology to relay medical information to the following persons. This information may include but is not limited to scheduled appointments and/or surgeries, lab, radiology testing and medications.

Please check and complete the following: Contacts: Phone: Relationship to patient:

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OK to leave messages/fax:

Yes   No

Answering Machine at Home \_\_\_\_\_

Mobile Phone # \_\_\_\_\_

Fax Machine # \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

### Financial Policy

Welcome to LA COUNTY NEPHROLOGY. We are dedicated to quality healthcare. We have experienced staff that understands your need for confidentiality and compassion. We are required to have you provide information to our office in order to file your insurance. Please be sure you have given us the correct insurance card as we will need to copy both front and back of the card. We also will ask that you provide us with a picture ID for your chart (i.e. driver's license, etc.). Co-payments are due at the time of service. We ask that any balance owing be paid promptly.

Please read and sign the following so that we may file your insurance.

I, \_\_\_\_\_ authorize LA COUNTY NEPHROLOGY to release information regarding my health to my insurance company. I understand that my insurance company may request records from my physician in order to pay the claims submitted. I give permission to LA COUNTY NEPHROLOGY to send any records necessary to obtain payment for the claims submitted. I assign all insurance benefits to LA COUNTY NEPHROLOGY. I understand that I am fully responsible for any/ and all unpaid charges and agree to pay any balance unpaid by my insurance company. This authorization will remain in effect from this date until revoked by me in writing

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Patient Signature

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Date

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Witness

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Date

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice please contact our privacy officer who is: Sandy Marino

LA COUNTY NEPHROLOGY (the "Practice") is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed. Company will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

Company may use your individually identifiable health information for the following purposes without your authorization:

1. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition. In this regard, we disclose patient data to the CommonWell network as part of a query-based data exchange for permissible treatment purposes.
2. Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. Health Care Operations: We may use and disclose health information in order to support the business activities of your physician's practice. For example, your health information may be used to evaluate the quality of care we provide, for state licensing or to identify you by name when you visit the office. You understand and acknowledge that we will disclose information in accordance with HIPAA laws to our affiliates (namely, Renal Care Organization, LLC and RCO Analytics, LLC) for the purposes of creating a population health care delivery model with goals of improving quality of health care and outcome, reducing costs of health care, and increasing savings to patients.
4. Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.
5. Treatment Options: We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as afterhour's telephone

answering, billing or quality assurance. Our Business Associates agree to protect the privacy of your health information.

7. Research: We may use your information in conjunction with agents of the Practice who may be required to review your files, just as our employees are so permitted, in order to determine whether you are qualified for a research project. If you are asked to join a research project, you will be asked first to execute an authorization, granting the Practice or a research organization the right to use your protected health information.

Company may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- Food and Drug Administration.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- If you are an inmate of a correctional facility.
- To health oversight agencies.
- To your employer if we provide health care services to you at the request of the employer, whereupon we shall provide you written notice of release so such information.
- For certain judicial and administrative proceedings pursuant to an administrative order. For law enforcement purposes. To a medical examiner, coroner or funeral director.
- For the facilitation of organ, eye or tissue donation if you are an organ donor. For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- In order to follow various mandates for clinical quality metric reporting, benchmarking, and related matters.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.
- Sign in sheet.

Unless you object, company may also disclose your information to family members and/or other persons involved in your care or payment for your care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death.

Company may leave messages for you at work or home about your visits. If you do not want us to do so, please inform our Privacy Officer in writing. All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Company will provide you with an authorization form to complete and return to the address listed on it.

**YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY**

**OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.**

1. **Restrictions on Use and Disclosure:** You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications:** You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access:** You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **Record Amendment:** You have the right to request amendments to your health records created by and for this Company if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. **Accounting of Disclosures:** You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Company has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice:** You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

**Complaints:**

You may complain to us or to the Secretary of Health and Human Services (Office for Civil Rights/U.S. Department of Health & Human Services) on-line at HHS.gov if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Lauren Ellenburg at (480) 610-6100 for further information about the complaint process.

If you have any questions about this notice, please contact Practice's Privacy Office; (323) 726-3868

**Acknowledgement of Receipt of  
Notice of Privacy Practices**

I acknowledge that I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed and protected.

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Patient Name

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Name/Relationship if signed by individual other than patient

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Patient Signature

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Date

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Witness

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Date

### CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for providers to send electronically, an accurate, error free, and understandable prescription from the provider's office to the pharmacy. This program also includes:

- Medication History Transactions: provides the healthcare provider with information about your current and past prescriptions. This allows your providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy reactions, adverse drug reactions, and duplicative therapy. The medication history information would include medications prescribed by your healthcare provider at Southwest Kidney Institute, P.L.C. as well as other healthcare providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease, and HIV/AIDS. As part of this consent form, you specifically consent to the release of this and other sensitive health information.

#### **Consent**

By signing this consent form, you are agreeing that your provider at LA COUNTY NEPHROLOGY may request and use your prescription medication history from other healthcare providers and/or third party benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to receive medical care, payment for your medical care, or your medical care benefits. You also have the right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke your consent at any time in writing. Please note, this revocation will not have an effect on any actions taken prior to receipt of the revocation. Understanding all of the above, I hereby provide informed consent to Southwest Kidney Institute, P.L.C. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

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Signature of Individual (or Legal Representative):

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Individual's Name (Print):

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Name of Legal Representative, if applicable (Print):

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Relationship

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Date