OCEAN RENAL ASSOCIATES, P.A.

Dear: _____

You have an upcoming New Patient appointment on

_____

with Dr. _____

Enclosed is the New Patient paperwork for you to fill out at your leisure and return with you at your appointment time.

Please also bring your

INSURANCE CARDS (Referral if needed)

MEDICATIONS IN THE BOTTLES (or detailed list)

LAB RESULTS AND ANY RAGIOLOGY RESULTS (not films)

And all **RECORDS** from your referring Dr. _____.

It is imperative these items are brought with you for the appointment.

We will also call to confirm your appointment a few days ahead of the scheduled date and time, and will tell you these same instructions as noted above.

We look forward to meeting you!

If you have any questions please feel free to contact our office.

OCEAN RENAL ASSOCIATES, P.A.

Date of Service: _____

☐ New Patient ☐ Established Patient ☐ New Insurance Patient Acct # _____

PATIENT INFORMATION

Last Name of Patient | First | Date of Birth | Age | Sex | Soc.Sec. #

Address | City | State | Zip

Home Phone | Work Phone | Employer | Employer Phone

RESPONSIBLE PARTY INFORMATION

Last Name of Patient | First | Date of Birth | Age | Sex | Soc.Sec. #

Address | City | State | Zip

Home Phone | Work Phone | Employer | Employer Phone

PRIMARY INSURANCE

Insurance Co. Name | Subscriber

Policy No. | Group No.

Address

City | State | Zip

Phone

SECONDARY INSURANCE

Insurance Co. Name | Subscriber

Policy No. | Group No.

Address

City | State | Zip

Phone

Referring Doctor Name: _____ UPIN# _____ Authorization# _____

Type of Exam: _____

Diagnosis: _____

Please attach copy of insurance card (both front and back) and copy of referral form (if applicable)

I hereby authorize my Insurance Company to pay by check made payable and mailed directly to the Physicians named below:

Ocean Renal Associates 210 Jack Martin Blvd Suite D-1 Brick, NJ 08724

For the medical and surgical benefits allowable, and otherwise payable to my current insurance policy, as payment toward the total charges for the services rendered. I understand that as a courtesy to me, the Physician and/or HPSA will file a claim with my insurance company on my behalf. However, I am financially responsible for, and hereby do agree to pay, in a current manner, any charges not covered by the insurance payment. If it necessary to file a formal collection action, I agree to pay all costs, including reasonable attorney's fee incurred by the outpatient medical center in the collection of the outstanding fees.

X_____

Patient Signature or Responsible Person Date

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PATIENT RIGHTS AND RESPONSIBILITIES

AS A PATIENT, YOU HAVE THE RIGHT TO:

- Considerate, respectful care at all times, and under all circumstances with recognition of your personal dignity.
- Personal and informational privacy, within the law.
- Information concerning your diagnosis, treatment and prognosis to the degree known.
- Confidentiality of records and disclosures. Except when required by law, you have the right to approve or refuse the release of records.
- The opportunity to participate in decisions involving your health care, unless contraindicated by concerns for your health. Make decisions about medical care, including the right to accept or refuse medical or surgical treatment and the right to initiate advance directives such as a living will or a durable power of attorney. If you already have a living will or advance directive, please speak to the nurse.
- Information concerning the implementation of any advance care directive.
- Impartial access to treatment regardless of race, color, sex, national origin, religion, handicap or disability.
- Receive an itemized bill for all services.
- Know the identity and profession status of individuals providing services to you.
- Reports any comments concerning the quality of services provided to you at *Ocean Renal Associates* and receive fair follow-up on your comments.

AS A PATIENT, YOU ARE RESPONSIBLE FOR:

- Providing, to the best of your knowledge, accurate and complete information about your present health status and post medical history and reporting any unexpected changes to the appropriate practitioner.
- Following the treatment plan recommended but the primary practitioner involved in your case.
- Providing an adult to transport you home after your procedure and to be responsible for you at home for the first 24 hours after your procedure.
- Indicating whether you clearly understand the contemplated course of action and what is expected of you.
- Your actions, if you refuse treatment, leave the facility against the advice of the practitioner, and/or do not follow the practitioner's instructions relating to your care.
- Assuring that the financial obligations of your health care are fulfilled as expediently as possible.
- Providing information about and/or copies of any living will, power of attorney, or together directive that you desire us to know about.

If you have any questions regarding your rights and responsibilities, please discuss your concerns with us. I have received a copy of the above information.

Patient Signature _____ Date _____

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ASSOCIATES, P.A.

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Our Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____.

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Keep original, and give copies to your health care provider, agent and family members

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Patient Name: _____ DOB: _____

Pneumo Vaccination

Was this administered by this office: (circle one) YES NO

Was this administered by another provider: (circle one) YES NO

Date: _____

Did you refuse the vaccination: (circle one) YES NO

Flu Vaccination

Was this administered by this office: (circle one) YES NO

Was this administered by another provider: (circle one) YES NO

Date: _____

Did you refused the vaccination: (circle one) YES NO

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Name: _____

Please put a check mark next to those that apply.

FAMILY HISTORY

Kidney Disease

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Diabetes

_____ None ___ Father ___ Sibling
___ Mother ___ Child

High Blood Pressure

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Ischemic Heart Disease

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Cancer

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Stroke

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Gout

_____ None ___ Father ___ Sibling
___ Mother ___ Child

ADPKD

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Dementia

_____ None ___ Father ___ Sibling
___ Mother ___ Child

Status

Father ___ Living ___Deceased ___Unknown
___ Age of Death Cause of Death_____

Mother ___ Living ___Deceased ___Unknown
___ Age of Death Cause of Death_____

Social History

Current Marital Status ___Married _____Single ___Divorced
___Separated ___Widowed

Living Arrangement ___Alone ___Spouse
___Significant Other ___Family Member
___In Home Caregiver ___Assisted Living

Occupation ___ Retired ___Employed
___ Unemployed ___ Student

Current/Former Occupation _____

Deficits ___Hearing Loss ___ Poor Vision/Blindness
___Limited Mobility ___Transport Challenges

Habits

Tobacco Use ___Current ___ Former ___Never Used
Type ___Cigarettes ___Pipes ___Cigars
Frequency ___ Everyday ___Some Days ___Unknown
___Packs a day ___ Year Started ___Year Quit

Alcohol Use
Amount ___Current User ___Former User ___Never Used
___ Occasional social drink
___ 1-2 drinks per day
___ 3 or more drinks per day ___ Year Quit

Recreational Drug Use
Type ___Marijuana ___Heroin ___Cocaine
___Ectasy ___Amphetamines ___Barbiturates
___LSD ___Opium ___Other
___Year Quit

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Patient Medication Sheet

Patient Name_____ DOB_____

Allergies _____

Pharmacy_____

Name of Medication	Dosage	Times per Day