Patient Information

Sierra Nevada Nephrology
775-322-4550

Last Name: _____ First Name: _____ Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Email: _____

Date of Birth: _____ Social Security #: _____ Sex: M F

Race: _____ Ethnicity: Hispanic or Latino Non Hispanic or Non Latino

Language Preference: _____ Preferred Form of Contact: Letter Phone Call Email Fax

Marital Status: single married widowed divorced legally separated

Spouse Name: _____

Student Status (if applicable): full-time part-time

Employment Status: full-time part-time retired not employed disabled

Employer: _____ Employer Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: (____) _____

Insurance Information

Primary Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer Name: _____ Employer Phone: (_____) _____

Secondary Insurance Company: _____

ID #: _____ Group # _____

Name of Insured: _____ Date of Birth: _____ SS#: _____

Employer Name: _____ Employer Phone: (_____) _____

Referring Doctor: _____

I hereby authorize the release of any medical information necessary to process my claim, and authorize payment of medical benefits to the undersigned physician or supplier for the services rendered.

Date: _____ Signature of Patient / Guardian: _____

MEDICAL HISTORY

NAME: _____ BIRTHDATE:_____

DRUG ALLERGIES: _____ PRIMARY CARE PHYSICIAN: _____

PRESCRIPTION MEDICATIONS:

NAME DOSE TIMES PER DAY	NAME DOSE TIMES PER DAY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OVER THE COUNTER MEDICATIONS

NAME DOSE TIMES PER DAY	NAME DOSE TIMES PER DAY
_____	_____
_____	_____
_____	_____

YOUR MEDICAL HISTORY

	CIRCLE ONE	How long?		CIRCLE ONE	How long?
KIDNEY DISEASE	YES NO	_____	CANCER	YES NO	_____
HIGH BLOOD PRESSURE	YES NO	_____	SEIZURES	YES NO	_____
DIABETES	YES NO	_____	STROKE	YES NO	_____
HEART ATTACK	YES NO	_____	LUNG PROBLEMS	YES NO	_____
HEART DISEASE OR HEART FAILURE	YES NO	_____	BLADDER OR PROSTATE PROBLEMS	YES NO	_____
KIDNEY STONES	YES NO	_____	GALLSTONES	YES NO	_____
STOMACH OR BOWEL PROBLEMS	YES NO	_____	ARTHRITIS OR BACK PROBLEMS	YES NO	_____

DO YOU HAVE ANY SPECIAL DIETS? _____

DATE OF LAST VACCINATIONS: TETANUS _____ FLU SHOT_____ PNEUMONIA_____

LIST PREVIOUS SURGURIES

_____	_____
_____	_____
_____	_____

HOSPITALIZATIONS (LAST 3 YEARS)

_____	_____
_____	_____

DO YOU CURRENTLY SMOKE? YES NO HOW LONG? _____ HOW MANY PACKS/DAY _____
DO YOU USE ALCOHOL? YES NO HOW MANY DRINKS / DAY _____

ADDITIONAL COMMENTS _____

Have you had any of the following during the past six (6) months?

GENERAL HEALTH

Good General Health	no	yes
Weight Gain	no	yes
Weight Loss	no	yes
Fever or Chills	no	yes
Fatigue	no	yes

EYES

Blurry Vision	no	yes
Eye Irritation	no	yes
Eye Discharge	no	yes
Vision Loss	no	yes
Eye Pain	no	yes

EARS, NOSE, THROAT

Earache or Drainage	no	yes
Ringing in the ears	no	yes
Decreased Hearing	no	yes
Nasal / Sinus Congestion	no	yes
Sore Throat	no	yes

CARDIOVASCULAR

Chest Pains	no	yes
Palpitations	no	yes
Difficult Breathing	no	yes
Fainting	no	yes
Swelling of Feet	no	yes

RESPRITORY

Frequent Coughing	no	yes
Spitting up Blood	no	yes
Shortness of Breath	no	yes
Asthma or Wheezing	no	yes
Pain with Breathing	no	yes

GASTROINTESTINAL

Nausea	no	yes
Vomiting	no	yes
Frequent Diarrhea	no	yes
Constipation	no	yes
Abdominal Pain	no	yes

GENITOOURINARY

Frequent Urination	no	yes
Burning or Painful Urination	no	yes
Blood in urine	no	yes
Getting Up at Night to Urinate	no	yes
Incontinence or Dribbling	no	yes

MUSCULOSKELETAL

Joint Pain or Stiffness	no	yes
Joint Swelling	no	yes
Muscle Weakness	no	yes
Muscle Pain or Cramps	no	yes
Back Pain	no	yes

SKIN

Rash	no	yes
Itching	no	yes
Unhealing Wounds	no	yes
Changes to Skin Color	no	yes
Skin Dryness	no	yes

NEUROLOGICAL

Headaches	no	yes
Light Headed or Dizzy	no	yes
Paralysis	no	yes
Convulsions or Seizures	no	yes
Sensation Changes	no	yes

PSYCHIATRIC

Memory Loss	no	yes
Anxiety	no	yes
Depression	no	yes
Suicidal Ideations	no	yes
Hallucinations	no	yes

ENDOCRINE

Cold Intolerance	no	yes
Heat Intolerance	no	yes
Excessive Thirst	no	yes
Excessive Urination	no	yes
Excessive Hunger	no	yes

HEMATOLOGICAL/LYMPHATIC

Slow to Heal After Cuts	no	yes
Enlarged Glands	no	yes
Easily to Bruise or Bleed	no	yes
Anemia	no	yes
Blood Transfusions	no	yes

ALLERGIC/IMMUNOLOGIC

Skin Itching	no	yes
Skin Rashes	no	yes
Hay Fever Symptoms	no	yes
Chronic Infections	no	yes
Reaction to Medications	no	yes

Known food allergies _____

_____

_____

Patient Signature _____

Physician's Signature _____

Sierra Nevada Nephrology Consultants
Financial Policy

- We are providers for many local and national health plans. We will work with your insurance carrier to file and collect payment for claims; however, you are responsible for all co-payments and deductibles. These are due at the time services are provided. You need to keep the billing department updated with all your current insurance information.

- Managed health care plans require pre-authorization for many procedures and treatments. We will contact your primary care physician and insurance carrier to obtain authorizations. Ultimately, it is the responsibility of the patient to insure all authorizations are in place before the service is provided.

- Uninsured patients are required to pay at the time services are provided. There are several payment options available. Please contact our billing department to discuss your account.

- If we do not receive payment from you or your insurance carrier within 30 to 90 days your account will be considered delinquent. No patient may carry a balance over 90 days without payment arrangements with the billing department.

- We understand that each patient has unique circumstances that can affect their ability to pay. Each account will be considered individually, and we may request proof of income before your account is given financial hardship status.

- Accounts are turned over to our collection agency only as a matter of last resort. In our experience these accounts are the result of patients not communicating with the billing department. We are willing to assist you to insure your account remains in good standing.

- Any patient whose account has been turned to collections will receive 30 days emergency care only and must transfer their care to another Nephrologist not associated with our group.

I have read and I understand the above policy.

Date:_____

Patient signature:_____

PATIENT RESPONSIBILITIES

We at Sierra Nevada Nephrology Consultants would like to thank you for the opportunity to provide care to you and your family. At SNNC we view healthcare as a collaborative approach between you the patient and our healthcare providers. Please initial each of the following to indicate you have read and fully understand the following responsibilities:

_____ After your first two appointments with a physician, you will be scheduled with one of our nurse practitioners in order to provide you with high-quality care, personalized health counseling, and accessibility. This physician/nurse practitioner collaboration will continue for as long as you are an SNNC patient.

_____ For all appointments, please bring a current insurance card and photo ID and all current medications.

_____ For prescription refills, please call your pharmacy. They will contact us via fax with the necessary information. Allow 24-48 hours for all refills. Refills will not be called in after normal operating hours or on weekends. You will need to allow longer if a prescription requires a prior authorization.

_____ If you should need to cancel your appointment, please provide our office with at least a 24 hour notice. Multiple no-shows can lead to dismissal from this practice.

_____ All copays, deductibles, and payments for non-covered services are **due at check-in**. If the copayment cannot be paid, the office has the right to reschedule your appointment. We accept cash, check, and credit cards. We do not accept debit cards.

_____ If you would like to have your labs reviewed you will need to call and make an appointment with a nurse practitioner or wait until your next scheduled appointment. Labs will not be reviewed over the phone.

_____ If you require a surgical clearance letter, allow at least 72 hours from request to pick up. Depending on the date of your last appointment and lab work, and the nature of the surgery, we might require that you be seen in our office for an evaluation.

SIERRA NEVADA NEPHROLOGY CONSULTANTS
670 Sierra Rose Dr Reno NV 89511
775-322-4550 FAX 775-322-4776

PATIENT PRIVACY AND CONFIDENTIALITY GUIDELINES

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to not disclose to anyone any personal health or identifiable information about our patients without their authorization. We may be required to disclose health and personal information about you in your treatment, to bill for our services and to collect payment from you or your insurance company or to review the quality of services to you. We may disclose information about you for the benefit of governmental benefit programs or in response to a warrant or subpoena. We may be required to provide health information about you to outside business associates such as our transcriptionist. These business associates are required to sign a contract with us stating that any information they come in contact with must be held in the strictest of confidence. We may be required to disclose personal information about you to contact you as a reminder of an appointment, to renew or prescribe medications or for alternative treatment options. We also may need to release medical information about you to your spouse and family members.

Sierra Nevada Nephrology Consultants and its associates will make every effort to protect your health and personal information however many instances in a medical practice require us to divulge this type of information.

Sierra Nevada Nephrology Consultants and its associates have my permission to release information concerning my personal health or identifiable information for but not limited to the information listed above.

PRINTED NAME OF PATIENT	**SIGNATURE**
DATE	**SIGNATURE OF PARENT OF GUARDIAN**

DO NOT RELEASE INFORMATION CONCERNING MY HEALTH TO THE FOLLOWING: _____

We reserve the right to make changes to this notice at any time. In the event that there is a material change to this notice, the revised notice will be posted.

If you have any complaints concerning our privacy practices you may contact our Privacy Officer, by mail at the above address or phone.

Revised 01-01-2014

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CONSENT TO ACCESS MEDICAL RECORDS FOR CLINICAL RESEARCH SCREENING

Sierra Nevada Nephrology Consultants participates in clinical research trials. As part of this effort, we screen patient medical records to identify if they are eligible for participation.

I understand that by checking the "YES" box, I am giving my permission for SNNC to access my medical records for the purpose of identifying whether or not I am eligible to participate in a clinical trial. By checking the "NO" box, I am stating I am not willing to participate in clinical research and do not want my information to be used for identifying whether or not I am eligible to participate in a clinical trial.

☐ **Yes, I do give my permission to SNNC to screen my medical records for the purpose of identifying if I am eligible for participation in clinical research.**

☐ **No, I do not give my permission to SNNC to screen my medical records for the purpose of identifying if I am eligible for participation in clinical research.**

PRINTED NAME OF PATIENT _____ **SIGNATURE** _____

DATE _____ **SIGNATURE OF PARENT OF GUARDIAN** _____

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