Welcome to Our Practice

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____ Home Phone_____ Cell Phone_____

PATIENT INFORMATION

Name_____ SS#_____
Last First MI

Address_____ email_____

City_____ State_____ Zip_____

Sex ____M ____F Age_____ Birthdate_____
Minor _____Single _____Married _____Separated _____Divorced _____Widowed_____

Patient Employer/School_____ Occupation_____

Employer/School Address_____ WorkPhone#_____

Referring Doctor_____ Phone#_____

In case of emergency, who should be notified?_____ Phone#_____

PRIMARY INSURANCE

Subscriber Name_____ Relationship to patient_____
Last Name First Name MI
Birthdate_____ Soc. Sec#_____

Address_____ City_____ State_____ Zip_____
Employed by_____ Occupation_____

Bus. Address_____ Bus. Phone_____

Insurance Company_____ Address_____

ID#_____ Group#_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _____Yes _____No
Subscriber Name _____ Relationship to patient_____
Birthdate_____ Soc Sec.# _____
Address _____ City_____ State_____ Zip_____
If different from patient's
Employed by_____
Insurance Company_____
ID#_____ Group#_____

ASSIGNMENT AND RELEASE

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____
Signature of patient or parent/guardian if minor Date

CENTRAL MARLAND NEPHROLOGY, L.L.C.

Ali Ipakchi, M.D. Arun Jayakumar, M.D. Sanil Nath, M.D.
Jonathan Rudick, M.D. Nirmala Yadla, M.D. Ratna Yadla, M.D.

7331 Hanover Parkway
Suite B
Greenbelt, MD 20770
Office: 301-345-0605
Fax: 301-345-0606

1127 West Street
Suite 105
Annapolis, MD 21401
Office: 410-562-9878
Fax:301-345-0606

Family and Friends Contact Form

Persons who are involved in you care, (family, friends, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note in emergency situations or other situations outlined on our Notice of Privacy Practice we may share information with others who are not specifically listed on this form)

Please list those persons (including Family & Friends) with whom we may share your information:

_____ _____

_____ _____

_____ _____

From time to time we will leave a message for you (as stated in our Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include <u>details</u> (such as diagnosis, Lab results, Radiology results, medication information, appointment changes) at this number?**

Phone number we can leave a message on: (_____) _____Circle:Home Work Cell
or (_____) _____ Circle: Home Work Cell

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Date of Birth

_____ _____
Print Name of Patient or Legal Representative **Relationship to Patient**

Central Maryland Nephrolgy, LLC

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Central Maryland Nephrology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Central Maryland Nephrology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I receive services from Central Maryland Nephrology, unless revoked by me in writing.

By signing this consent I also confirm that I have received and understand the Notice of Privacy Practices and how the practice may use and/or disclose protected health information. I understand that Central Maryland Nephrology cannot be responsible for use or re-disclosure of information by third parties.

I certify that I have read this form and/or it has been read to me.

Date: _____

Print Name (Patient): _____ **DOB:**_____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this consent, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ **Date:** _____

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CENTRAL MARYLAND NEPHROLOGY ASSOCIATES, L.L.C.
Ali Ipakchi, M.D. Arun Jayakumar, M.D. Sanil Nath, M.D.
Jonathan Rudick, M.D. Nirmala Yadla, M.D. Ratna Yadla, M.D.

NOTICE TO PATIENTS

This notice describes how medical information about you may be used and disclosed. We are required by law to protect the privacy of your protected health information. This document also explains how you can gain access to your medical information and who to contact should you have any complaint. Please read this document carefully and sign the bottom of this form to acknowledge that you have received it.

A. The general consent for release of medical records that you sign authorizes Central Maryland Nephrology to disclose the information in your medical record for treatment, payment and health operations.

   1. For the purpose of providing treatment to you. Your information may be shared with e.g. employees and contractors of the provider, or with other health care providers who are treating you or consulting in your care.
   2. For the purpose of arranging payment for your care. Your information may be shared with your insurer or other third-party payor who is responsible for paying all or part of the cost for your care.
   3. For the purpose of health care operations. We may use and disclose Information that is necessary for our operations e.g. internal quality assessments, contacting other health care providers about treatment alternatives. We may also disclose information to other doctors, nurses and technicians. We may use information about you to remind you of an appointment for treatment of medical care.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. For example if we receive a subpoena for the records or if public

responsibility requires disclosures e.g. to protect public health. We will keep all disclosures of your medical records to the minimum necessary.

E. Your rights regarding health information about you.

1. You have the right to inspect and copy your health information.
2. If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with reason that supports your request. If we do not agree with your request you have the right to ask that your statement be placed in the medical record.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us except for disclosures made for treatment, payment and health care operations.
4. You have the right to receive a paper copy of this notice.

F. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated you may complain to the Secretary of the U.S. Department of Health and Human Services or complain to us by talking to us, calling us, or writing to us with details. Please ask to speak to or contact our privacy complaints contact person whom is our Office Manager. We will not retaliate in any way against a patient for making a complaint.

G. We reserve the right to change our privacy practices and to make new policies effective for all protected health information that we maintain. If we should do so we will issue an updated "notice to patients" to all of our patients.

Please acknowledge receipt and review of this notice by signing below. For further information please call the Office Manager, at 301-345-0605.

Name of patient: _____ Date: _____

Signature of Patient or lawfully authorized representative: _____

Date patient was given a copy of this notice: _____

Welcome to Central Maryland Nephrology
Please complete this form for our records

Name:_____

Phone number:_____

Today's date:_____

Address:_____
_____

Your primary doctor:_____

Birthdate:_____

Other doctors you've seen recently:_____

What is the primary purpose of your visit today?

Describe your medical problems (past and present), especially kidney problems:

1)
2)
3)
4)
5)
6)

What medications are you currently taking?

Name of medicine	Dose	Name of medicine	Dose
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

List your drug allergies (describe the allergic reaction): _____
_____

Tell us about yourself:
Describe your tobacco use (past & present):_____

Describe your alcohol use (past & present):_____

Are you currently employed?_____

What is (was) your occupation?_____

Patient name:_____
Date:_____

Tell us about your family's health:
Describe your mother's medical history:_____
_____

Describe your father's medical history:_____
_____

List all your children and their medical histories:_____
_____
_____

List all your siblings and their medical histories:_____
_____

List all relatives with any history of diabetes:_____
_____

List all relatives with any history of high blood pressure:_____
_____

List all relatives with any history of kidney problems:_____
_____

Check the box if you have any of the medical conditions listed below:

___Fatigue
___Headaches
___Earaches
___Neck pain
___Chest pain
___Asthma
___Diarrhea
___Vomiting
___Bloody urine
___Urinate at night
___Leg swelling
___Tremors
___Rashes
___Weight loss
___Vision problems

___Swollen glands
___Palpatations
___Chronic cough
___Constipation
___Hemorrhoids
___frothy urine
___Frequent urination
___Muscle weakness
___Seizures
___Acne
___Fever
___Double vision
___Sore throat
___Thyroid problems
___Sinus problems

___Abdominal pain
___Vomiting blood
___Urinary tract infect
___Incontinent of urine
___Muscle pains
___Dizziness/vertigo
___Dry skin
___Weakness
___Hearing loss
___Mouth sores
___Goiter

___Emphysema
___Incontinence
___Fainting

___Joint pains
___Blackouts
___Itching
___Dentures
___Ear ringing
___Short of breath
___Short of breath at night
___Blood in stool
___Hepatitis B or C
___Difficult/painful urination

___Poor sensation in limbs
___Hair or nail changes
___Blood clots
___Ulcers

Physician signature:_____