NORTH GEORGIA NEPHROLOGY CONSULTANTS
KIDNEY AND HYPERTENSION CLINIC

5105 Jefferson Road, Suite B
Athens, GA 30607
Phone: (706) 227-4075
Fax: (706) 227-4086

Abid Bashir, MD, FACP
Chandrashekar Kashyap, MD
Sarah McMillan, NP-C

2151 W. Spring St., Suite 160
Monroe, GA 30655
Phone: (706) 227-4075
Fax: (706) 227-4086

W W W . N G N C C O R P . C O M

CARE EVERYWHERE® OPT-OUT/OPT-IN REQUEST

Federal and State laws allow health care providers to disclose much of your health information, without your written permission, when other hospitals, physicians, and health care providers need to treat you. The sharing of your health information between the physicians who treat you is helpful in the continuity and coordination of your care and may reduce duplicative testing.

Until now, we did this sharing of medical records using telephone, mail, or facsimile. New technology now allows us to share health information electronically in a secure manner. One method for sharing this information electronically is called *Care Everywhere*, which is available to participating health care providers who use the same electronic medical record system as North Georgia Nephrology Consultants (NGNC).

Most of your NGNC health information is automatically included in *Care Everywhere* unless you request in writing for it to be excluded. To have your health information excluded from *Care Everywhere* you must sign this Opt-Out form. Examples of information that is Not available via Care Everywhere includes substance abuse treatment, sexual assault/forensic records and behavioral health treatment records.

If, in the future, you want to change your Opt-Out decision, you must complete a new form and send it to your local NGNC Health information Management (Medical Records.) Your request will be processed within 5 business days of receipt.

PLEASE PRINT

First Name	MI	Last Name

Date of Birth (mm/dd/yyyy)	Daytime Phone

☐ Opt Out: I request that my North Georgia Nephrology Consultants health information be excluded from *Care Everywhere*. I understand this means that other health care providers will not be able to obtain my health information, and **they may still Obtain it through other methods.**

☐ Reverse my Opt Out: I previously chose to Opt-Out of *Care Everywhere* and not allow my North Georgia Nephrology consultants (NGNC) health information to be electronically available. By checking this box and signing this form. I am reversing my prior request to exclude my health information from *Care Everywhere.*

Patient/Authorized Representative Signature: ________________________Date: _______________

If Authorized Representative, Relationship to Patient: ______________________________________

Print Representative Name: ____

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Care Everywhere: Sharing Information Electronically

State and Federal laws allow health care providers to disclose your health information without your written permission when other hospitals, physicians, and health care providers need to treat you. This exchange is helpful in coordinating your care. Until now, this sharing was performed using the telephone, mail or facsimile. We now have technology that allows us to share health information electronically and securely. It is called *Care Everywhere.*

Frequently Asked Questions

Question: What is Care Everywhere?

Answer: Care Everywhere allows doctors and nurses from different organizations to electronically exchange patient health information. It is a tool within our electronic medical record that is used to securely share patient health information with other healthcare providers. Anyone who receives care at participating *Care Everywhere* organizations may benefit from *Care Everywhere.* Whether you are traveling and need emergency medical attention, or perhaps you visit other healthcare providers in the community, *Care Everywhere* allows these providers to access more information about your health status so that they can better meet your medical needs.

Questions: What type of information is Not shared/available through Care Everywhere?

Answer: Information that will not be shared through Care Everywhere includes:

- Behavioral health treatment
- Substance abuse program services
- Sexual abuse/Forensic records

Additionally, it is unlikely that we can electronically exchange patient records, with other countries in this same way. The process for this exchange would require patient authorization for the release of your information. Records that are not available via *Care Everywhere* would need to be separately requested from the facility.

Question: Who can see my information in Care Everywhere?

Answer: Only health care professionals involved in your care during your health care visit can view your information. Healthcare professionals may only access your information to coordinate your care and treatment.

Question: How do I sign up for Care Everywhere?

Answer: There is no sign-up process for *care Everywhere*. The sharing of patient information for treatment purposes is permitted use of medical information.

Question: What if I don't want to participate in Care Everywhere?

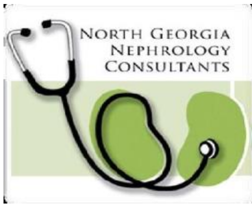
Answer: During the registration process, alert your Patient Access team member you would like to complete a *Care Everywhere* Opt-Out Request. If you choose to change/reverse your *Care Everywhere* election at any time, simply complete the Opt-Out Request and send to your local North Georgia Nephrology Consultants health information Management (Medical Records) department.

Question: How long does it take for my change in preference for Care Everywhere to take effect?

Answer: Updating your *care Everywhere* option may take up to 5 days.

Question: If I opt out of Care Everywhere, does that mean that other health care providers cannot obtain my health information without my written consent?

Answer: No, state and federal laws still allow access to most of your health information, without your written consent, as long as the request is made by other health care providers who are involved in your care. This information would be shared via telephone, mail or facsimile.



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Locations:
5105 Jefferson Rd. Ste. B Athens, GA 30607
3431 Highway 81 South, Loganville, GA 30052
2151 West Spring Street Ste. 160 Monroe, GA 30655
429 Loganville Hwy 105, Winder, GA 30680
1110 Commerce Dr, Greensboro, GA 30642
(P): 706-227-4075 (F): 706-227-4086

Patients Name: Mr. / Mrs. / Ms. ____ Jr /Sr / III

DOB: _________/_________/___________ SS #: ______________-_____________-_____________

Address: ____ City / State / Zip: ________________________

Marital Status: □ Single/Never married □ Married □ Divorced □ Widow/Widower

Currently living with? __________________ Occupation: ___________________________________

Please provide us with a reliable contact number so that we may reach you. If we are able to leave a message for you on any of the numbers listed, please indicate so by circling Yes or No.

Home Phone: _______________________________________ Yes / No

Cell Phone: ____ Yes / No

Work Phone: ____ Yes / No

Email: ____

Emergency contact: ____

Name *Phone* *Relation*

How did you hear about North Georgia Nephrology Consultants? Physician / Friend / Relative / Telephone / Internet

Please List your:

Referring Physician: ____ Phone: ___________________________

Reason for the referral (if known): ____

Primary Care Physician: ______________________________________ Phone: ___________________________

Please list ALL providers that you routinely see that is not listed above: (for example, Cardiologist, Endocrinologist, Urologist etc.)

Physicians Name	**Specialty**	**Last Date Seen**

Please provide us with your pharmacy that fills most of your prescriptions: (If you are currently using more than one pharmacy, please inform the medical staff)

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Pharmacy's Name: ____

Address: ____ City / St / Zip ___________________

Phone #: ____

Please list ALL medications that you are currently taking along with the dosage and directions (including vitamins, OTC medications and/or birth controls):

Drug Name	**Dosage (mg, mL, mcg, units, etc.)**	**Frequency (times per day)**

(If more space is needed please use a blank sheet of paper)

Please list any known drug allergies that you may have: *(including the reaction that it may cause)*

____

____

____

____

____

Medical History / Health Conditions

	Yes	No		Yes	No		Yes	No
Kidney Disease: *(if yes, please specify)*			Cancer: *(if yes, please specify)*			Skin Disease: *(if yes, please specify)*		
Kidney Stones			Chronic Bronchitis/Emphysema			Asthma		

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High Blood Pressure			Blood Clot in the Lungs			COPD		
Diabetes / High Blood Sugar			Blood Clot in the Legs			Depression		
Anemia			Blood Transfusion			Anxiety		
Stroke			Bleeding from Bowels			Thyroid Problems		
High Cholesterol			Ulcer in the Stomach			Epilepsy/Seizures		
Congestive Heart Failure			Gallstones			Prostate Problems		
Irregular Heart Beat			Gout			**Other*****: (if yes, please specify)***		
Heart Attack			Arthritis					
Heart Murmur								

Surgeries

	Yes	Date	No		Yes	Date	No
Nephrectomy				Bladder Surgery			
Cataract Surgery: *(If yes, please specify)*				Joint Scope Surgery			
Tonsillectomy *(Tonsils Removed)*				Knee/Hip Joint Replacement			
Neck Artery Surgery				Back Disk Surgery			
Open Heart Surgery/Catherization				Prostate Surgery			
Appendectomy				Hernia Surgery			
Gallbladder Removal				Vasectomy			
Abdominal Surgery				Hysterectomy			
Broken Bone Repair *(if yes, please specify)*				Other/Additional Surgeries *(if yes, please specify)*			

Family Medical History

(Please specify relation to you i.e. mother, father, sister, brother, child, etc.)

	Relation		Relation		Relation
Heart Attack		Kidney Disease		Diabetes/High Blood Sugar	
High Blood Pressure		Gout Arthritis		Liver Disease	
High Cholesterol		Osteoporosis		Alcohol Abuse	
Asthma		Stroke		Anxiety / Depression	
Tuberculosis		Epilepsy/Seizures		Glaucoma	

Cancer: *(if yes, please specify)*		Bleeding Problems		Other: (if yes, please specify)	

Additional Information:
____
____
____
____
____

Mother: Living _____ Deceased _____ (if deceased, cause of death if known) ____________________________________

Father: Living _____ Deceased _____ (if deceased, cause of death if known) ______________________________________

How many siblings do you have? Brothers: ____________ Sisters: ____

How many children do you have? Sons: ___________ Daughters: ____

Social History

How often do you exercise (please check frequency): ___ Often ___ Rarely ___Never

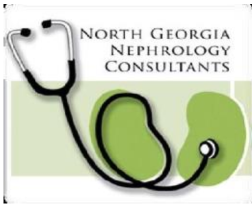
Have you ever smoked? (please check) ___ Often ___ Rarely ___ Never

If yes:

- How many years? __________
- If you have stopped smoking, when did you quit? ____________
- If you currently smoke, how many packs per day? ____________
- Do you use smokeless tobacco? (i.e. chewing tobacco) ____________Alcohol/Drugs
- Do you drink alcohol? ___________
  - If yes, how often? Daily 2-3 times per week Once per month Occasional
- Do you use recreational drugs? _________
  - If yes, which drug and how often? ____
  - If no, have you used recreational drugs in the past? _____________

Female Patients Only

Pregnancy	Have you had any pregnancies? *If yes, how many?*	
	● Did you have preeclampsia or proteinuria during your pregnancies?	
	Have you had any elective abortions?	
	Have you had any miscarriages?	
Reproductive Health	What was the date of your last menstruation? (if known)	
	When was your last Pap Smear?	



	Have you ever had an abnormal Pap Smear? ● If yes, When? ● What was the abnormality? ● What treatment was used?	
	When was your last Mammogram?	
	Have you ever had an abnormal mammogram? □ If yes, When? • What was the abnormality? • What treatment was used	

Current Physical Condition (check yes or no)

General/Constitutional		Yes	No
	Chills		
	Fatigue		
	Fever		
	Night sweats		
	Unexplained weight loss		
	Unexplained weight gain		
Head/Eyes/Nose/Throat Frequent headaches	Frequent headaches		
	Severe headaches		

	Wear glasses/contacts		
	Chronic nasal discharge		
	Impaired hearing		
	Diabetic eye disease		
Endocrine	Thyroid problems		
	Excessive hunger		
	Cold tolerance		
	Excessive thirst		
	Heat tolerance		
Respiratory	Asthma		
	Cough		

	Shortness of breath		
	Wheezing		
	Swelling in the ankles		
	Rheumatic Fever		
	Chest pains		
	Irregular heartbeat		
	Palpitations		
Gastrointestinal	Hemorrhoids		
	Rectal Disease		
	Abdominal pain		
	Blood in stool		
	Change in bowel habits		
	Constipation		
	Decreased appetite		
	Diarrhea		
Hematology	Anemia		
	Excessive bleeding		
	Abdominal bleeding		
	Swollen glands/lymph nodes		
Women Only	Birth Control Use (if yes, please specify)		
	Problems with sexual function		
Men Only	Lump in the groin		
	Scrotal Problems		
	Erectile Dysfunction		
Genitourinary	Blood in the urine		
	Difficulty urinating		
	Frequent urination		

	Painful urination		
	Urinary tract infection		
Musculoskeletal	Chronic back pains		
	On medication for pain		
	Painful joints		
Skin	Oral Ulcer		
	Itching		
	Rash		
	Skin Cancer		
Neurological	Trouble Sleeping		
	Frequent depression		
	Anxiety		
	Nervousness		
	Convulsions		
	History of a stroke		
	Numbness in fingers and toes		
	Dizziness		
	Fainting		
	Memory Loss		
	Seizure		

The information that has been provided regarding my health is true and accurate to the best of my knowledge.

____

Patient's Name (Printed):

______________________________________ ____________________

Patient's Signature **Date**

______________________________________ ____________________

Patient's Representative Signature **Date**

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North Georgia Nephrology Consultants Payment Policy

(Patient Copy)

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

Insurance Coverage:

We will bill your health carriers for service rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to your next appointment. Any balances that are not covered by your insurance carrier(s) will be your responsible, in which the payment is due on your next office visit or upon receiving your "Statement" in the mail, whichever occurs first.

Co-payments:

We have a contractual obligation (with your insurance company) to collect your co-payment at the time services are rendered to you in the office. As so, you have a contractual obligation (with your insurance company) to pay your co-payment at the time of service. Co-payments are the patient's responsibility and are due at the time of service. We are considered specialty care by insurance carriers. If your insurance carriers have a specific co-pay amount for specialty care you will be expected to pay the appropriate amount.

Accepted Forms of Payment:

We accept payments by cash, check, credit / debit (Visa, MasterCard and Discover). We are now participating with Care Credit as a form of payment. Please express your interest to the office staff for more details.

Patient Outstanding Balances:

If you have an outstanding balance with our company, we will send out a monthly "Statement" to the address on file. We expect that you will pay your balance in full upon receiving your monthly billing statement. If you are unable to pay your balance in full as a single payment, please contact our "Billing Department" in advance to set up an arrangement or discuss additional payment options. Our direct office number is (706)227-4075.

Unpaid Accounts:

In the event that you do not satisfy your account balance in a timely manner (defined as making a regular payment each month), we may elect to send your account to an outside agency.

Other Possible Fees:

No-Show Appointment Fee – A no show appointment is a scheduled appointment, in which the patient does not show up for and failed to notify the office. Per company policy, once a patient has a no show his/her first appointment notification will be mail to the home address on file. In the event that a patient has a 2nd no show appointment, there will be a $35.00 fee that will be applied to your account. This is a charge that insurance companies DO NOT cover. It is the patient's responsibility to pay this fee. We are aware that situations occur, so please notify the office as soon as possible if you cannot make your schedule appointment.

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I have read, agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

Patient Printed Name: ____

Patient / Representative's Signature: ____

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Patient Consent Form for Use and Disclosure of Protected Health Information

By signing this consent form, you give North Georgia Nephrology Consultants the permission to use and disclose your protected health information for treatment, payment and healthcare operations except for any restrictions specified below to which we have agreed. Protected health information is individually identifiable information that is created or received, relating to your physical or mental health, including demographic information, collection of payments (from services rendered) and provision of healthcare services to you.

Our Notice of Privacy Practices, states that we may use and disclose protected health information about you. You have the right to receive a copy of the Notice of Privacy Practices before signing this Consent Form by contacting our office. We will also answer any questions or complaints that you may have concerning our protected health information.

You have the right to request information on how your protected health information is being used or disclosed for treatment, payment, or healthcare operation. We are not required to agree to any restrictions, but if we do, we are bound by our agreement. If you wish to make a restriction, please request a copy of our form to request restrictions.

Refusing to sign this consent form, may forfeit your right to receive treatment unless, a licensed healthcare professional has determined that you are in need of emergency treatment or if we are required by law to provide medical treatment. We are required to document any circumstances in which we do not obtain your consent, yet carry out treatment. We will offer you a copy of this documentation should you decide to sign this consent form.

You have the right revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent. You may request to use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply inform us in writing.

Patient Printed Name: ____

Patient / Representative's Signature: ____

Date: ________________________

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Consent for Medical Care and Treatment

I understand, that I may have a medical condition that could require possible diagnosing and treatment. I do voluntarily consent to such treatment, services and procedures that may be recommended under the general specific instructions of the North Georgia Nephrology Consultant physicians.

I acknowledge, that the practice of medicine is not an exact science and the physicians of North Georgia Nephrology Consultants has made no guarantees as to the results of treatment or examination.

North Georgia Nephrology Consultants recognizes the importance maintaining confidential information regarding a patient's medical condition. We also want to provided our patients with timely communication regarding laboratory or diagnostic test results. We understand that because of the patient's schedule and our office schedule this may sometimes be difficult. North Georgia Nephrology Consultants will not under any circumstances leave messages regarding your medical information.

Acknowledge that it may be difficult for the physician or his staff to personally communicate with the patients regarding laboratory or diagnostic tests results. It is the policy of this office not to leave information on the patient's answering machine.

If the physician or the physician staff cannot reach the patient at the home or business phone number. It is policy of this office that a message will be left with the person that answers the telephone to advise the patient to return the phone call.

It is the policy of this office not to release any medical information to a patient's family members. We cannot discuss your medical condition, or release diagnostic test results to your spouse without your consent. **Information regarding my medical condition, including, laboratory and diagnostic test results, can be given to my spouse**.

I AGREE _______ I DO NOT AGREE _______

It is the policy of this office to participate in clinical research designed to improve the quality of patient care; this may necessitate the review of the patient's medical records be research staff.

It is the policy of this office that all prescriptions needed to be refilled that you give us a 48-hour time-frame to get it filled.

Patient Printed Name: ____

Patient / Representative's Signature: _________________________Date: ___________________________

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Full Name (Print) ___________________________________ SS # _______________________ DOB ________________

The patient listed above is authorizing North Georgia Nephrology Consultants to obtain health records from the person(s)/company/agency/facilities listed below:

Name, Position or Department: ____

Organization: ____

Address: ____

Phone: ____ **The information to be disclosed related to the services date beginning ____________________ and ending ___________________________**

Entire Medical Record	Medication List	Consultation Note
Demographic Information	Physician Office Visits	Immunization
History and Physical	Test Results (Labs, X-ray, Imaging)	Physical Therapy Notes
Medical/Surgical History	Discharge Summary	Other:

The purpose of this disclosure:

Referral to Specialist	Insurance	Other:
Continuing Care	Change of Doctor	Other:

CONDITIONS AND NOTIFICATIONS:

This authorization for the release of information expires twelve (12) months from the date of the patient's signature. You may inspect or request a copy of the health information to be used or disclosed. This authorization may be revoked at any time in writing addressed to the Office Manger ath the office address provided to you.

SIGNATURES:

I hereby authorize the use or disclosure of the personal health information as described above. I understand that this authorization is voluntary and I have the right to refuse the signing of this authorization. I understand that refusing to sign this authorization will NOT effect my health care management.

Signature of Patient/Personal Representative: ____ Date: _________________________

Personal Representative (PRINT): ____

Relationship to the Patient: ____

Release by: ____Date: _____________________________________

(Department Representative Name)

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CONSENT FOR APPOINTMENT REMIDER IN TEXT MESSAGE AND PORTAL ACCESS VIA EMAIL

Thank you for choosing North Georgia Nephrology Consultants as your health care provider for medical needs. We really value you as a patient. To help us continue our high quality of services, we would like to hear from you.

If you are agreeable, we can send you a text message or email to remind you of your next appointment and to ask for a feedback of our services.

We will really appreciate if you can take some time to provide us your valuable feedback.

Thanks, and Regards

North Georgia Nephrology Consultant

Referring or Primary Physician Name ____________________ Physician Contact____________________

________________________________ ____________________________________
Good Number to Contact Email Address

________________________________ ____________________________________
Patient Signature Date