Summit Nephrology Medical Group, Inc.

151 N. Sunrise Ave., Ste. 1205
Roseville, CA 95661
916-789-1505

Phone Consult Policy

I understand that the preferred method of communications is through My Health Online and I have been offered enrollment.

Signature _____ Date _____

_____ Decline _____ Accept

Financial Policy

I understand that I am financially responsible for charges incurred for services rendered. I understand that my insurance will be billed as a courtesy and that I am responsible for any remaining balance, copayments or charges that are denied due to non-coverage. I authorize Summit Nephrology Medical Group, Inc. to bill my insurance and accept payment on my behalf for services rendered.

Name _____ D.O.B. _____

Signature _____ Date _____

Summit Nephrology
MEDICAL GROUP, INC.

Adarsh Bhat, M.D. Brian Thornton, M.D.
Lana Gafter, M.D.
Don Chang, M.D. Sourabh Kharait, M.D.
Greg Spin, D.O.
Jackson Wang, M.D. Hiba Hamdan, M.D.

Patient Contact Information Restriction

In general, the HIPPA privacy rule gives the individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

- □ Home Telephone Number: _____
- □ Ok to leave a message with detailed information
- □ Leave message with call back number only
- □ Cell Phone Number: _____
- □ Ok to leave message with detailed information
- □ Leave message with call back number only

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Date**

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Summit Nephrology Medical Group Inc is required by law to maintain the privacy of our patient's health information. With your written approval, we may **verbally** disclose your health information to others, including designated family members, friends, or others who are involved in your health care.

Please Print

Patient's Name: _____ **DOB**: _____

Address: _____ **City**: _____ **Zip**:_____

I authorize the following person(s) to receive **verbal** information from Summit Nephrology Medical Group INC regarding my health care.

Family Member: _____ Phone: _____

Family Member: _____ Phone: _____

Family Member: _____ Phone: _____

Other (Friend, Caregiver): _____ Phone: _____

Other (Friend, Caregiver): _____ Phone: _____

Description of the information that may be used or disclosed:

1. All verbal health information pertaining to me related to the diagnosis, treatment, or prognosis with respect to any physical, accident, illness, medical condition and any other health related information.
2. I understand that if the person(s) that receives the information described herein is not a health care clinician covered by federal privacy regulations, the information described here may be redisclosed by such person and will likely no longer be protected by federal privacy regulations.
3. If the person completing this authorization is the personal representative of the patient, please describe and provide proof of authority to act on this person's behalf.

Patient Signature: _____ Date: _____

(If the patient signature is his/her mark, it must be witnessed by staff)

Patients Representative: _____ Date: _____

(Signature by Patients Representative must include a copy of documentation granting them authority to act on patient's behalf) A copy of this form is as valid as the original. You may revoke this form in writing at any time. (This form is valid for 1 year after date signed or until revoked)

Summit Nephrology Medical Group, Inc.

Welcome to our practice. We are committed to providing the best, most comprehensive care possible. Please assist us by Providing the following information. All information is confidential and is released only with your consent.

Patient Name **Today's Date**	**Date of Birth** **Sex** **Age**
Marital Status (please circle one) **Single Married Divorced Widowed**	**Parent Name (if patient is a minor)**
Patient's Social Security Number (Required)	**California Driver's License No.**
Home Address	**City** **State** **Zip**
Mailing Address (if different)	**City** **State** **Zip**
Home Telephone Number	**Work Telephone Number**
Occupation	**Employer's Name**
Employer's Address	**City** **State** **Zip**
Spouse Name **Spouse D.O.B.**	**Spouse's Employer**
Referring Physician	**Address** **Phone/Fax**
Primary Care Physician (if different from referring physician)	**Address** **Phone/Fax**
PHARMACY NAME	**PHARMACY PHONE NUMBER**
NOTIFY IN CASE OF EMERGENCY	
Name	**Relationship**
Address	**City** **State** **Zip**
Home Telephone	**Work Telephone**
Nearest Relative (not living with you)	**Address**
Home Telephone	**Work Telephone**
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)	
Name	**Telephone**
Address	**City** **State** **Zip**
Primary Insurance Company	**Claim Address**
Subscriber's Name	**Subscriber's Date of Birth**
Subscriber's SSN#	**Insurance ID No.**
Secondary Insurance Company	**Claim Address**
Subscriber's Name	**Subscriber's Date of Birth**
Subscriber's SSN#	**Insurance ID No.**

Please Read Our Financial Policy Statement and Agreement on Next Page.

Summit Nephrology Medical Group, Inc.

Welcome to our practice! Please take a few minutes and fill out the enclosed medical questionnaire prior to your appointment. By taking the time to provide us this information you will help our physicians to be more comprehensive and efficient during your evaluation. Please fill in information, circle appropriate diagnoses and symptoms and use the blank lines under each heading to provide information that you feel is relevant.

Past Medical History (Please circle):

Diabetes	**Hypertension**	**Coronary Artery Disease**
Stroke	**High Cholesterol**	**Blood Clots**
Peripheral Vascular Disease	**Lupus**	**Arthritis**

Other: _____

_____

Please Explain: _____

_____

_____

Surgical History (Include name and date of surgery):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Social History:

Marital Status: **Married** **Single** **Divorced** **Widowed** **Other**_____

Employment Status: _____

Alcohol (Drinks per day and years used):_____

Tobacco (Packs per day, number of years used and quit date):_____

Patient Name: _____

Family History (Please include significant medical history for family members including age of their passing if relevant)

Mother: _____

Father: _____

Siblings: _____

_____

Children: _____

_____

Medication List (Please include dose per pill, number of pills taken and times per day. For example "Metoprolol 50 mg tabs, one tablet two times a day":

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

Patient Name: _____ **Date:** _____

Allergies (Medications or meaningful environmental allergies): Please list reaction also

1. _____

2. _____

3. _____

4. _____

Review of Systems List

In the last 30 days have you had any history of the following: (Please check yes or no)

General

Y	N	
☐	☐	Activity Change
☐	☐	Appetite Change
☐	☐	Chills
☐	☐	Sweats
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Unexpected weight change

Eyes

Y	N	
☐	☐	Eye discharge
☐	☐	Eye itching
☐	☐	Eye pain
☐	☐	Eye redness
☐	☐	Irritation
☐	☐	Photophobia (fear of lights or eye discomfort in light)
☐	☐	Vision loss/disturbance

Endo

Y	N	
☐	☐	Cold intolerance
☐	☐	Heat intolerance
☐	☐	Polydipsia (excessive drinking of water)
☐	☐	Polyphagia (excessive hunger)
☐	☐	Polyuria (excessive urinating)

HEENT/Allergy

Y	N	
☐	☐	Congestion
☐	☐	Dental problem
☐	☐	Drooling
☐	☐	Ear discharge
☐	☐	Ear pain
☐	☐	Facial swelling
☐	☐	Hearing loss
☐	☐	Mouth sores
☐	☐	Nosebleeds
☐	☐	Postnasal drip
☐	☐	Runny nose
☐	☐	Sinus pressure
☐	☐	Sneezing
☐	☐	Sore throat
☐	☐	Tinnitus(ringing in the Ears)
☐	☐	Trouble swallowing
☐	☐	Voice change

Resp

Y	N	
☐	☐	Apnea (temporary cessation of breathing)
☐	☐	Chest tightness
☐	☐	Choking
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Stridor (harsh, vibrating noise when breathing)
☐	☐	Wheezing

CV

Y	N	
☐	☐	Chest pain
☐	☐	Leg swelling
☐	☐	Palpitations

GU

Y	N	
☐	☐	Difficulty urinating
☐	☐	Dysuria (painful urination)
☐	☐	Enuresis(involuntary urination)
☐	☐	Flank pain
☐	☐	Urinary frequency
☐	☐	Genital sore
☐	☐	Hematuria (blood in urine)
☐	☐	Urinary urgency
☐	☐	Decreased urine
☐	☐	Penile discharge
☐	☐	Penile swelling
☐	☐	Scrotal swelling
☐	☐	Testicular pain
☐	☐	Menstrual problem
☐	☐	Pelvic pain
☐	☐	Vaginal bleeding
☐	☐	Vaginal discharge
☐	☐	Vaginal pain

Patient Name: _____ **Date:** _____

GI

Y	N	
☐	☐	Abdominal distention
☐	☐	Abdominal pain
☐	☐	Anal bleeding
☐	☐	Blood in stool
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Nausea
☐	☐	Rectal pain
☐	☐	Vomiting

Musculoskeletal

Y	N	
☐	☐	Arthralgias (pain in joint)
☐	☐	Back pain
☐	☐	Gait problem
☐	☐	Joint swelling
☐	☐	Myalgias (pain in muscle)
☐	☐	Neck pain
☐	☐	Neck stiffness

Heme

Y	N	
☐	☐	Enlarged lymph nodes
☐	☐	Bleeding

Neuro

Y	N	
☐	☐	Dizziness
☐	☐	Facial asymmetry
☐	☐	Headaches
☐	☐	Light-headedness
☐	☐	Numbness
☐	☐	Seizures
☐	☐	Speech difficulty
☐	☐	Syncope (fainting)
☐	☐	Tremors
☐	☐	Weakness

Psych

Y	N	
☐	☐	Agitation
☐	☐	Behavior Problem
☐	☐	Confusion
☐	☐	Decrease in concentration
☐	☐	Sadness
☐	☐	Hallucinations
☐	☐	hyperactive
☐	☐	Nervous/anxious
☐	☐	Self injury
☐	☐	Sleep disturbance
☐	☐	Suicidal ideas

OTHER: _____

_____

Thank you again for taking the time to do this. We at Summit Nephrology Medical Group look forward to providing you excellent care!

Patient Signature: _____ **Date of Birth:** _____

Print Name: _____ **Date:** _____

Sutter Health

Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Sutter Health and its affiliates to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by Sutter Health or its affiliates under my cell phone plan.

My text/mobile phone number is: (___) _____. □ Patient initials

I know that I am under no obligation to authorize Sutter Health or its affiliates to send me text messages. I may opt-out of receiving these communications at any time by calling the Service Desk @ (877) 607-6484, or by responding STOP to 622622. Please allow 2-3 business days for processing.

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Sutter Health and its affiliates to the phone number that I have provided.

Patient Name: _____ DOB: _____

Signature: _____, _____

(Patient/legal representative) (Relationship if other than patient)

Printed Name: _____, Date: _____

(Legal representative)

Fax: Patient Services Contact Center
Attn: My Health Online (877) 607-6484

Mail: Patient Services Contact Center
Attn: My Health Online
PO Box 255386
Sacramento, CA 95865-5386