IDAHO NEPHROLOGY ASSOCIATES

- ❑ Nicholas Hunt, MD
- ❑ Thomas Pintar, MD
- ❑ Elizabeth Kendrick, MD
- ❑ Chris Sjoberg, CNN-NP
- ❑ Harry Ross, NP-C

Dear Patient,

Welcome to Idaho Nephrology Associates! It is our goal to provide you with the highest quality of care. In preparation for your upcoming appointment, please note the following items:

Your Appointment: Please arrive **15 minutes prior** to your scheduled appointment time.

What to Bring: *please note that your visit may be rescheduled if you do not have all of the required information.*

- Completed forms enclosed in this packet
- Photo Identification
- Medications– bring all bottles
- Insurance Card(s)
- Referrals (if necessary)

If a Laboratory Request is enclosed, please complete 24 to 48 hours PRIOR to your visit at the lab of your choice.

For Referrals: If applicable, please contact your insurance carrier to obtain a prior authorization. The authorization/referral can be faxed to:

Attn: Idaho Nephrology Associates
208-367-3332

If you have any questions prior to your appointment, please feel free to call us at 208-501-8955. We look forward to serving your medical needs.

Sincerely,

The Physicians and Staff
Idaho Nephrology Associates

For more helpful information, please visit our website: www.idahonephrology.com

5610 West Gage Street, Suite A, Boise, ID 83706
Phone: 208-501-8955 Fax: 208-367-3332

West Valley Medical Complex
1906 Fairview Ave, Suite 430
Caldwell, ID 83605

Mountain Home
840 North 4th East
Mountain Home, ID 83647

Fruitland
910 NW 16th Street, Ste. 102
Fruitland, ID 83619

Baker City
3820 17th Street
Baker City, OR 97814

Name:		
Home Address:		
City:	**State:**	**Zip:**
Home Phone:	**Cell Phone**:	
Date of Birth:	**SSN:**	
Sex:	**Marital Status:**	
Email:	**Primary Language:**	

Race: ***Please check box:***

☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American
☐ American Indian/Alaska Native ☐ White ☐ More than 1 race ☐ Unreported / Refused to report

Ethnicity: ***Please check box:***

☐ Hispanic / Latino ☐ Not Hispanic / Latino ☐ Unreported / Refused to report

In the event of an emergency please contact:		
Name:		
Home Ph.:	Work Ph.:	Cell Ph.:

Physician Information:	
Primary Care Physician:	Phone:
Address:	
Referring Physician:	Phone:
Address:	

Pharmacy Name:	
Address:	Phone:
Mail Order Pharmacy Name:	
Address:	Phone:

Insurance Information:	
Primary Ins:	Secondary Ins:
Subscriber:	Subscriber:
DOB:	DOB:
Policy ID:	Policy ID:
Group #:	Group #:
Employer:	Employer:

Assignment of Benefits / Authorization for Treatment:
I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that benefits be made payable to the provider on my behalf. I understand that I am financially responsible for the charges not covered by my insurance carrier.

____________________________________ ________________________

Patient / Authorized Representative Signature **Date**

Financial Policy

Welcome to St. Clair Specialty Physicians, PC. In order for us to deliver quality care, we have established the following financial policy. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have any change of personal information, please notify the receptionist.
3. Payment of your deductible, co-payment, or any charge for non-covered services is required at the time of your visit. If you have a balance after an insurance payment from a previous service, we will expect payment for that service as well. You will be assessed a $10.00 Late Payment Fee if payment is not rendered at time of service or not received by the office within 7 days after date of service. We accept cash, check, Visa, Master Card, and Discover.
4. Returned checks will incur a $30.00 processing fee.
5. Understand that, to the extent permitted by law, you are responsible for any costs not covered under your insurance plan. Three statements will be sent to you. Accounts not paid at that time will be referred to a collection agency.
6. If you choose to have an out of network physician provide services, you will be responsible for all charges.
7. **MEDICARE PATIENTS**: We are participating providers with Medicare and will bill Medicare for all covered charges. If applicable, your supplemental insurance will also be billed for you. If you do not have supplemental insurance, you will be billed according to Medicare guidelines. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
8. **COMMERCIAL PLANS**: If we participate with your plan we will bill your insurance for you. Your co-payment will be collected at the time of service. If your health plan requires you to have an authorization to see a specialist, you will need to obtain that from your primary care physician's office prior to seeing the specialist. If your referral is not processed 24 hours prior to your appointment, the visit will be cancelled unless the visit is emergent. No retroactive referral can be obtained. If we do not participate with your insurance plan, we will expect payment at the time of service. If we have not received your referral and you choose to be treated, you will be responsible for all charges incurred for all services rendered.
9. **SELF-PAY PATIENTS**: Patients with no insurance will be expected to pay in full at the time of service. A 25% Prompt Payment Discount will be applied to all charges paid in full at time of service. If you will not be able to pay in full at time of service, you must contact our billing department to make payment arrangements or assistance in obtaining financial aid.
10. Due to the financial impact to the office, all patients are expected to arrive at their scheduled appointment time. New patients are to arrive 15 minutes prior to their scheduled appointment time. The office would appreciate a call if an appointment needs to be cancelled. When possible, please give the office a 24 hour cancellation notice.

Please remember whether you do or do not have insurance, you are responsible for payment of your incurred charges. If you have any questions regarding our financial policy, please contact our billing department at (586) 247-4300.

Patient or Authorized Representative Signature ______________________________________ Date _______________

Medical History Form

The information you provide to your doctor is confidential and cannot be released without your permission.

Name:____ DOB:___________ Today's Date:_______________

Reason for visit:____

____

____

____

1. ALLERGIES

Please specifically include any medications that caused high potassium, a cough or face to swell.

____

____

____

____

2. IMMUNIZATIONS

- ☐ Flu Vaccine — Date of Immunization: ____________________ Place received:________________________________
- ☐ Pneumonia — Date of Immunization: ____________________ Place received:________________________________
- ☐ Hepatitis B — Date of Immunization: ____________________ Place received:________________________________

3. FAMILY MEDICAL HISTORY

Relative	Age	Living	Medical Conditions
Father		☐ yes ☐ no	
Mother		☐ yes ☐ no	
Sibling: ☐ M ☐ F		☐ yes ☐ no	
Sibling: ☐ M ☐ F		☐ yes ☐ no	
Sibling: ☐ M ☐ F		☐ yes ☐ no	
Other:		☐ yes ☐ no	
Other:		☐ yes ☐ no	

4. SOCIAL HISTORY

Type	Yes	No	How much?	How long?
Tobacco	☐	☐		
Alcohol	☐	☐		
Illicit Drug Use	☐	☐		

Exercise (what exercise do you do and how often?):____

Occupation (describe your job):____

Physician use only.

Medical History Form

Name:______________________________ DOB: ________________

5. PREGNANCY

Number of Pregnancies:________________ Number of Deliveries:________________

6. SURGERIES

Surgery	Year	Location

7. MEDICAL PROBLEMS

- ☐ Stroke
- ☐ TIAs (mini strokes)
- ☐ Dementia
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Bone Disease
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Emphysema
- ☐ Cancer
- ☐ Sleep Apnea
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Kidney Disease
- ☐ High/Low Potassium
- ☐ Liver Disease
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2
  - Year of onset:__________
  - Complications: ☐ Eye ☐ Kidney ☐ Nerve
- ☐ Gout
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bowel Disease
- ☐ Stomach Ulcers
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Transfusion
- ☐ Anemia
- ☐ Blood Clots
- ☐ Mental Illness
- ☐ Other Disorder

9. HEALTH MAINTENANCE

	Yes	No	N/A	
Colonoscopy Screening (50-75 years of age)	☐	☐	☐	Date of last screening:________________
Mammogram Screening (41-69 years of age)	☐	☐	☐	Date of last screening:________________
Pap Smear (23-64 years of age)	☐	☐	☐	Date of last screening:________________

Physician use only.

Medical History Form

The information you provide to your doctor is confidential and cannot be released without your permission.

Name:____ DOB:___________ Today's Date:_______________

Preferred Pharmancy:____

Pharmancy Address:____

____

10. PRESCRIPTIONS, OVER THE COUNTER AND VITAMINS

List all prescriptions, over the counter, and vitamins	Dose (mg)	Times a day	Ordering Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			

Name:_______________________________________ DOB:________________________________

Review of Systems

For each symptom below, please circle the appropriate answer.

Constitutional Symptoms

Chills	Yes / Not Currently
Fever	Yes / Not Currently
Significant Weight Loss	Yes / Not Currently
Significant Weight Gain	Yes / Not Currently
Headache	Yes / Not Currently

Integumentary

Persistent Itch	Yes / Not Currently
Skin Rash	Yes / Not Currently

Other_____________________________________

Eyes/Ear/Nose/Throat

Eye Pain	Yes / Not Currently
Visual Changes	Yes / Not Currently
Difficulty Hearing	Yes / Not Currently
Ear Pain	Yes / Not Currently
Hay Fever	Yes / Not Currently
Sinus Pain	Yes / Not Currently
Throat Pain	Yes / Not Currently

Other_____________________________________

Respiratory

Frequent cough	Yes / Not Currently
Snoring	Yes / Not Currently
Shortness of breath	Yes / Not Currently
Wheezing	Yes / Not Currently

Other_____________________________________

Cardiovascular

Chest pain	Yes / Not Currently
Heart skips a beat	Yes / Not Currently
Swelling	Yes / Not Currently
Varicose Veins	Yes / Not Currently
Palpitations	Yes / Not Currently

Other_____________________________________

Gastrointestinal

Abdominal Pain	Yes / Not Currently
Diarrhea/ Constipation	Yes / Not Currently
Nausea	Yes / Not Currently
Vomiting	Yes / Not Currently

Other_____________________________________

Genitourinary

Difficulty Urinating	Yes / Not Currently
Urinary frequency	Yes / Not Currently
Painful Urination	Yes / Not Currently
Urine Retention	Yes / Not Currently

Other_____________________________________

Musculoskeletal

Joint pain	Yes / Not Currently
Back pain	Yes / Not Currently
Muscle pain	Yes / Not Currently
Neck Pain	Yes / Not Currently

Other_____________________________________

Neurological

Dizzy spells	Yes / Not Currently
Numbness	Yes / Not Currently
Tingling	Yes / Not Currently
Tremors	Yes / Not Currently

Other_____________________________________

Psychological

Do you feel severely depressed? yes / no

Tired/Sluggish, if so, pick a reason below:

☐ Trouble Sleeping

Other_____________________________________

Endocrine

Too hot/ too cold	Yes / Not Currently
Excessive thirst	Yes / Not Currently

Hematologic/Lymphatic

Bruising/Bleeding	Yes / Not Currently

Other_____________________________________

Physician Comments:

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of St. Clair Specialty Physicians, P.C. Notice of Privacy Practices on the date indicated below.

Patient Name:____ **Birth Date:**______________

Signature:____ **Date:**___________________

Information about Agent (attach appropriate documentation):

Agent:____ **Title:**___________________

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby authorize SCSP to discuss My Health Information with:

____

Name(s)

For this Authorization, "My Health Information" means (check one or more):

________All Records (clinic notes, diagnostic testing/results, history and physical, billing, immunization, mental health, etc.)

________Other (Please Specify):____

I understand that:

- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid unless I revoke/withdraw this Authorization or unless an earlier date is specified here: ______________. I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to SCSP.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Signature of Patient Only: ____Date:______________

For Office Use Only:

_____Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

_____Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

_____Other____

Staff Name:______________________________Signature:__________________________Date:___________