Carolina Kidney Specialists
1655 Bernardin Ave. Ste. 200 Columbia, SC 29204
Phone: 803-256-1137 Fax: 803-256-1138

Medical history to be completed by the patient and to be reviewed by MD.

PATIENTS NAME: _____

Please list all current medical illness with duration (if known):

1. High blood pressure (YES__ NO __) If yes, how many years _____
2. Diabetes (YES__ NO ___) If yes, how many years _____
3. Are you taking Insulin shots? (YES __ NO ___) If yes, how many years ___
4. _____
5. _____
6. _____

Please list past illnesses and surgeries:

1. _____
2. _____
3. _____
4. _____

Please list name of diseases affecting immediate blood relatives:

1. _____
2. _____
3. _____
4. _____

Do any family members have Kidney Disease? (YES __ NO_) Are they on dialysis (YES __ NO__)

Social / Personal Habits:

1. Tobacco use (YES _NO_)
2. Alcohol (YES__ NO___)
3. Recreational / Street drugs (YES __ NO ___) Type: _____

Please list names of your other doctors:

1. _____
2. _____
3. _____

Please list hospitals that you were treated in within the last two years:

1. _____ (Date of hospitalization Approx.) _____
2. _____ (Date of hospitalization Approx.) _____
3. _____ (Date of hospitalization Approx.) _____

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Please list the name of the substances that caused an allergic reaction in the past:

Medications:

_____

Please list the name of your pharmacy, location and phone number (PRIMARY PHARMACY AND MAIL ORDER PHARMACY):

PRIMARY:

Name: _____

Location: _____

Phone number: _____

MAIL ORDER:

Name: _____

Location: _____

Phone number: _____

PLEASE LIST NAME OF MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING NONPRESCRIPTION SUBSTANCES:

MEDICATION	DOSAGE(MG)	FREQUENCY (ONCE OR TWICE)

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PATIENT INFORMATION

Name: _____

Address: _____

Home phone: _____ Cell phone: _____

Social Security Number: _____ Date of Birth: _____

Marital Status (PLEASE CIRCLE ONE):

- Married
- Single
- Divorced
- Widowed
- Separated

MALE _____ FEMALE _____

Emergency contact Name and Phone number (LIVING OR NOT LIVING WITH YOU):

_____

Patient Employer: _____

Employer Address: _____

(1) Name of insurance company: _____

Address: _____

Policy #: _____ Group #: _____

Name of insured: _____ Relationship to patient: _____

Insured DOB: _____ Insured Social Security: _____

(2) Name of insurance company: _____

Address: _____

Policy #: _____ Group #: _____

Name of insured: _____ Relationship to patient: _____

Insured DOB: _____ Insured Social Security: _____

I CERITIFY THAT I HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DR. ISLAM
NAME OF INSURANCE
ALL INSURANCE BENEFITS IF ANY, OTHERWISE PAY ABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCILLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAME INSURED COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENFITS OR THE BENEFITS PAY ABLE FOR RELATED SERVICES.

SIGNATURE OF PATIENT: _____ DATE: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This authorization is voluntary and made to confirm your direction in the use and disclosure of protected health information based on HIPAA. Please read carefully and make changes as desired.

THE INFORMATION TO BE RELEASED: ALL PROTECTED HEALTH INFORMATION INCLUDING BUT NOT LIMITED TO ALCOHOL/DRUG ABUSE, COMMUNICABLE DISEASE OR PSYCHIATRIC CONDITIONS.

EXCEPTION: _____

Entities authorized to receive, use, and disclose: Carolina Kidney Specialists, LLC., my insurance, referring physician, any physician or healthcare facility to which this office refers me to, and the following family members / friends.

(To stay in HIPAA compliance list parties that we may release information to. (i.e. Parents, Children, Spouse, Caregiver, Friends, Doctors, etc.)

1. _____
2. _____
3. _____
4. _____

Duration of this authorization: Never to expire, unless specified otherwise _____

1. I understand that, if the persons or organizations receiving the information are not subject to federal health information privacy regulations, this information will no longer be protected.
2. I understand that there may be a charge for obtaining or releasing the requested information.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
4. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. I also understand that revocation must be in writing and be received by Carolina Kidney Specialists, LLC at the above address.

The patient (or individual representing the patient) confirming the authorization

I have had the opportunity to read the contents of this authorization and I confirm that the contents are consistent with my direction to you. I understand that by signing this form I am authorizing the use and/or disclosure of protected health information to persons or organizations named above.

Signature: _____ Date: _____

Name: _____

Date of birth: _____ SSN#: _____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Name of representative:_____ Relationship to patient: _____ Signature: _____

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Dear patients,

Thank you for providing us the opportunity to deliver you the state-of-the-art comprehensive kidney disease care. Our physicians are Board Certified Nephrologists and members of distinguished medical societies. All the relevant affairs are HIPAA compliant.

We are faced with highly regulatory and rapidly changing nature of payers, popularity of very high deductible insurances and steadily rising cost of delivery of medical care to our patients. In order to provide excellent medical care, it is extremely important that customary fees for services be paid within a reasonable time period. Therefore, we have hired the following professional medical billing service, and we encourage you to contact the about your account balance questions.

MEDICO OF SOUTH CAROLINA, INC.

PHONE NUMBER: 803-932-9624

If you are unable to resolve your matters with MEDICO personnel, please contact our office manager for further assistance. Thank you again for your understanding.

ASSIGNMENT OF BENEFITS AND PAYMENTS

I authorize payment of medical expenses incurred by me to Carolina Kidney Specialists, LLC for any services furnished by the practice. A photocopy of my insurance card is to be considered as valid proof of medical coverage. I understand that I am financially responsible for charges incurred, whether or not paid by insurance. Further, I understand that payment for the services provided by Carolina Kidney Specialists, LLC is due at the time of service for all patients. In the event of pending insurance payments, the co-payments and/or deductible amounts are to be paid on the of service.

I understand that as a paying patient, total payment of claims must be received with 90 days of service, unless other arrangements have been made with the collections department. I understand that payment not received within 90 days may result in my account being turned over to Carolina Kidney Specialisits, LLC's collection agency. I further understand that after a reasonable amount of time, if my account is still in arrears and payment agreements are not being met. I may receive a letter from Carolina Kidney Specialists, LLC discharging me from the practice. However, I will still be responsible for the bill.

SIGNATURE: _____ Date: _____

WITNESS OF SIGNATURE: _____

POSITION: _____