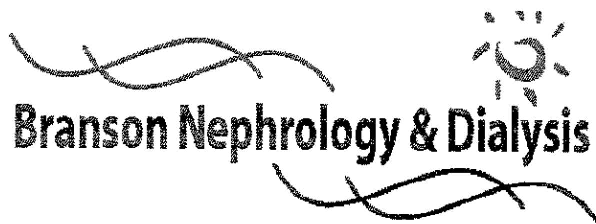


Welcome to Branson Nephrology and Dialysis, LLC.

As your new health care providers, we look forward to serving you and hope that together we can build a relationship that will ensure you receive the highest quality care and service.

Following your will find some information that may be helpful to you as you become part of our practice. If you should have any further questions please feel free to contact us. Our office number is 417-334-8288 and our fax number 417-334-6966.

HOURS OF OPERATION

- Office hours: Monday through Thursday, 8:00 AM to 5:00 PM. Fridays from 8:00 AM to 2:00 PM
- Please call as soon as possible to cancel if you are unable to make an appointment so that the appointment time can be offered to other patients.

PAYMENTS AND INSURANCE

We will submit the charges for our services to your insurance for you. If you have no insurance, payment is required at the time of service. Payment is always expected at the time of service unless you have made prior arrangements with our Billing Department. Co-payments are to be paid on the day of service.

INVOLVEMENT IN YOUR HEALTHCARE

Everyone has a role in making healthcare safe. Our staff is working to make your health care safety a priority. You, as a patient, can play a vital role in making your care safe by becoming an active, involved and informed member of your healthcare team. So **SPEAK UP:**

S – Speak up if you have any questions or concerns and if you don't understand, ask again

P – Pay attention to the care you are receiving and make sure you are getting the right treatment and medication

E – Educate yourself about your diagnosis and your treatment plan

A – Ask a trusted family member or companion to be your advocate

K – Know what medications you take and why you take them

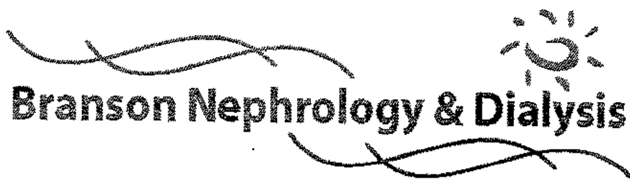
U – Use a healthcare facility that provides quality care

P – Participate in all decisions about your treatment

HELP US TO HELP YOU MORE EFFICIENTLY:

- Let us know if you move, change your insurance, job, or telephone number.
- We have a $25.00 no-show fee and a $15.00 less than 24 hr notice cancellation/reschedule fee.
- If a problem arises, tell us. We will do the best we can to help you with it.
- Have your pharmacy fax us your medication refill request.
- Labs are needed for each office appointment and need to be done at least 1 week prior to the appointment.
- The nurse will ask for a urine sample and will have you fill out a review of systems form at each visit.
- Please remember to bring your insurance cards and all medications, even over the counter, to your visit.

LET'S WORK TOGETHER TO MAINTAIN GOOD HEALTH!



Patient Demographic

PERSONAL DATA (*please print*):

Social Security #: ________-________-________ Sex ***(circle one)***: M F Date of Birth: _____/_____/______

Marital Status ***(please check one)***: ____Married ____Widowed ____Single ____Divorced

Race/Ethnicity: ______ Language: ________ E-mail address: ______________________

First Name: ______________ Middle Name: ________________ Last Name: ______________

Street Address: ____________________ City/ State: ________________ Zip: __________

Home Phone#: ______________Mobile Phone#: ______________ Alt Phone#: __________

Employment Status ***(please check one)***: ____ Employed ____Retired _____ Disabled _____ Unemployed

Employed by:________________________ Address: ______________________________

City/State: ________________ Zip: ____________Work Phone (_____) ______-________ EXT ________

Referring Physician:__________________________ Referring MD Phone#: (________) _______-________

EMERGENCY CONTACT INFORMATION:

In the event of an emergency, please contact:

Full Name: ____________________________________ Daytime Phone (________) _______-________

Relationship to Patient ____________________________ Other Phone (________) _______-________

INSURANCE INFORMATION (*please bring cards for us to copy*):

Primary Insurance: ____________________________

ID#: ____________________________

Group#: ____________________________

Group Name:____________________________

Effective Date ________/________/________

Primary Cardholder:____________________________

Patient's relationship to cardholder:________________

Social Security # ________-________-________

Sex ***(please circle one)***: M F

Date of Birth ________/________/________

Primary Insurance: ____________________________

ID#: ____________________________

Group#: ____________________________

Group Name:____________________________

Effective Date ________/________/________

Primary Cardholder:____________________________

Patient's relationship to cardholder:________________

Social Security # ________-________-________

Sex ***(please circle one)***: M F

Date of Birth ________/________/________

Branson Nephrology & Dialysis

HEALTH QUESTIONNAIRE

PATIENT NAME: ______________________________ Date ____/____/____

Why were you referred here by your primary care physician? What symptoms are you having?

____

____

____

DRUG ALLERGIES/REACTIONS:

____

____

VACCINATIONS: (YEAR LAST VACCINATED)

INFLUENZA _______ HEPATITIS B______

PNEUMONIA ________

Patient Medical History

SURGERIES: DATE/OPERATION

____

____

____

OTHER HOSPITAL STAYS, INJURIES, ILLNESSES AND DATES

____

____

____

- ☐ CANCER
- ☐ DIABETES
- ☐ DIALYSIS
- ☐ URINARY INFECTIONS
- ☐ STROKE
- ☐ TAKING NSAID's FOR LONG PERIOD OF TIME
- ☐ KIDNEY DISEASE
- ☐ LUNG DISEASE
- ☐ HEART DISEASE
- ☐ HEAD INJURY
- ☐ HIGH CHOLESTEROL
- ☐ RENAL TRANSPLANT
- ☐ HIGH BLOOD PRESSURE
- ☐ ABNORMAL BLEEDING
- ☐ PACEMAKER
- ☐ CONGESTIVE HEART FAILURE
- ☐ THYROID DISEASE

FAMILY HISTORY

CHECK ILLNESSES OF BLOOD RELATIVES AND SPECIFY WHO:

- ☐ CANCER ____________________
- ☐ RENAL TRANSPLANT ____________________
- ☐ ARTHRITIS ____________________
- ☐ DIALYSIS ____________________
- ☐ LUNG DISEASE ____________________
- ☐ KIDNEY DISEASE ____________________
- ☐ DIABETES ____________________
- ☐ HIGH BLOOD PRESSURE ____________________
- ☐ HEART DISEASE ____________________

SOCIAL HISTORY

- ☐ LIVING ALONE
- ☐ WITH SPOUSE
- ☐ WITH PARENTS
- ☐ NURSING HOME
- ☐ OTHER (_______)
- ☐ MARRIED
- ☐ SINGLE
- ☐ WIDOWED (YEAR _____)
- ☐ CHILDREN # ______
- ☐ CAFFEINE
- ☐ ALCOHOL USE
- ☐ TOBACCO PKS ___ YEARS ____
- ☐ ILLICIT DRUG USE
- ☐ EXERCISE REGULARLY

☐ EMPLOYED ☐ RETIRED ☐ ON DISABILITY

REVIEW OF SYSTEMS

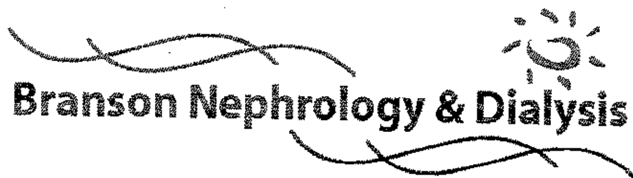
PLEASE CHECK ANY CURRENT PROBLEMS.

YES	**BODY**
[ ]	Fever
[ ]	Chills
[ ]	Night Sweats
[ ]	Decrease in Appetite
[ ]	Feeling tired or poorly
	HEAD
[ ]	Headache
[ ]	Facial pain
[ ]	Sinus pain
[ ]	Change in Vision
[ ]	Frequent Nosebleeds
[ ]	Nasal/Sinus Congestion
[ ]	Tremors/Shakes
[ ]	Loss of Consciousness
[ ]	Seizures/Convulsions
[ ]	Difficulty Walking
	EYE
[ ]	Eyesight problems
[ ]	Eye's light sensitive
[ ]	Itching of the eyes
[ ]	Eye Pain
	EAR/NOSE/THROAT
[ ]	Earache/Ringing in the ears
[ ]	Hearing loss
[ ]	Nasal discharge
[ ]	Mouth sores
[ ]	Bleeding gums
[ ]	Hoarseness
[ ]	Throat pain
	NECK
[ ]	Neck pain
[ ]	Neck stiffness
[ ]	Lump or swelling in neck
	CARDIOVASCULAR
[ ]	Chest pain or discomfort
[ ]	Fast heart rate
[ ]	Palpitations
[ ]	Swelling – Both legs and feet
[ ]	Swelling - One leg or foot
	PULMONARY
[ ]	Difficulty breathing during exertion
[ ]	Cough
[ ]	Wheezing
[ ]	Chest congestion
[ ]	Snoring loudly
[ ]	Currently Smoking, if yes how much________

YOUR NAME:________________________

YES	**GENITOURINARY**
[ ]	Pain during urination
[ ]	Increased urinary frequency
[ ]	Blood in urine
[ ]	Change in urine appearance
[ ]	Feeling of urinary urgency
[ ]	Frequent Daytime urination
[ ]	Frequent Nighttime urination
[ ]	Unable to restrain urination
[ ]	Kidney Stones
	MUSCULOSKELETAL
[ ]	Joint pain, or stiffness localized
[ ]	Muscle aches
[ ]	Gout
[ ]	Joint swelling, localized
	NEUROLOGICAL
[ ]	Dizziness
[ ]	Vertigo
[ ]	Fainting
[ ]	Motor disturbances
[ ]	Sensory disturbances
	PSYCHOLOGICAL
[ ]	Sleep disturbances
[ ]	Anxiety
[ ]	Depression
	SKIN
[ ]	Pruritus
[ ]	Skin lesions
[ ]	Rashes
	ENDOCRINE
[ ]	Excessive sweating
[ ]	Excessive thirst
	GASTROINTESTINAL
[ ]	Difficulty swallowing
[ ]	Heartburn
[ ]	Nausea
[ ]	Vomiting
[ ]	Stomach pain
[ ]	Diarrhea
[ ]	Black or bloody stools
[ ]	Constipation
	BLOOD
[ ]	Easy Bruising
[ ]	Bleed easily
[ ]	**Have you been in the hospital since your last visit here?**

TODAY'S DATE:________________



AUTHORIZATION FOR RELEASE OF INFORMATION
AND
ASSIGNMENT OF BENEFITS

Patient Name: ____

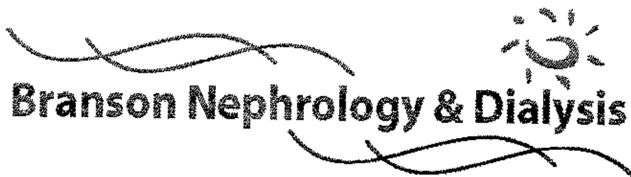
1. I hereby authorize you to release any information acquired in my examination and treatment to the appropriate insurance company for any associated charges.

2. I request that Payment be made directly to Branson Nephrology, L.L.C. on any bills for services furnished by providers or licensed personnel employed by them.

3. In cases where Medicare is the primary insurance, I understand that I am only responsible for the deductible and coinsurance at the Medicare allowable charge amount. For any services that are non-covered under the Medicare program, I agree to pay the usual and customary charge for that procedure.

________________________________ ________________
Patient Signature **Date**

By: ______________________________ ________________________
Signature **Relationship to Patient**



Authorization to Release Medical Information

I, ________________________, hereby authorize John R. Martinez, MD or any associate of Branson Nephrology, L.L.C. who is licensed by the state of Missouri as an MD, PA-C, RN or LPN to release all medical information relating to my medical condition, plan of treatment, medications or other pertinent medical information to the following individuals or Physicians:

Primary Physician(s) ***(list all physicians you are currently seeing)***
Primary Care / Family Practice ____

Other : ____

Other : ____

Family members or guardians:

______________________________ Relationship to Patient________________

______________________________ Relationship to Patient________________

______________________________ Relationship to Patient________________

I understand that by signing this authorization, the above named individuals may discuss my medical history and any current medical conditions, plan of treatment, medications or other pertinent medical information with any licensed member of Branson Nephrology, L.L.C.

Medical Records Policy

It is the standard operating procedure of Branson Nephrology to release a copy of my medical record to any physician who is known to be involved in my medical treatment. A signed medical records release form will be obtained prior to the records being released.

As a patient of Branson Nephrology, it is my right to obtain a copy of my medical chart after submitting a written request and allowing a one week period for the records to be processed. I understand that my medical record will only be released to me and only to other members of my family or authorized agent, including those authorized above.

Patient Signature ____________________________ Date _____/_____/______

Witness __________________________________ Date _____/_____/______

Branson Nephrology / Branson Dialysis
101 Skaggs Road, Ste 301
Branson MO 65616
417-334-8288

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I may refuse to sign this acknowledgement.

I have received a copy of Branson Nephrology, LLC and Branson Dialysis, LLC, Notice of Privacy Practices.

____
Print Name of Patient

____
Patient Signature

____
Date

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because of the following:

Patient Refused to Sign
Communication barriers prohibited obtaining acknowledgement
Emergency situation prevented us from obtaining acknowledgement
Other:______________________________
____

Staff Instructions:

1. All new patients receive the Notice of Privacy Practices on their first visit.
2. Verify the presence of the Acknowledgement Statement is in all office patient charts and if not present, reissue the Notice of Privacy Practices at the first available opportunity.
3. File the Acknowledgment Statement in the medical record with the patient demographic paperwork.