Welcome Letter

Thank you for choosing Kidney Care and Hypertension Center for your medical care. Please read the following information so that we may make your experience with our practice a positive and productive one. Below is a few office policies:

1. **Release of medical information:** You authorize Kidney Care and Hypertension Center, LLC to release your medical records to any physicians, hospitals, or agency involved in your medical care.

2. **Prescription refills:** Before calling our office for a refill, please check with your pharmacy if any refills are present. For proper medical care, patients must be seen within 12 months to obtain a refill. If your insurance company requests a three-month mail-in order, please allow ample time for the order to be received through mail. The office staff will make every effort to refill prescription on the same business day it was requested. Always check with your pharmacy first before picking up your prescription.

3. **Referrals:** Please check with your insurance company and your primary care physician's office whether you need referrals to see a specialist. Failure to provide referral at time of visit may result in charges billed directly to yourself.

4. **No Show and Cancellation Fee:** A 24-hour cancellation notice is required for all appointments cancellation. We reserve the right to charge a fee for repeated no show appointments.

5. **Medical Records:** Written authorization from the patient/parent or guardian must be obtained to release medical records. At least one week's notice is required to complete your request for medical records. The cost is $1 per page when records are released directly to the patient. There is no charge if records are forwarded directly to a new physician.

6. **Payment policy:** Co-payments are to be collected at the time services are received.

   **A fee of $35 will be charged for all returned checks.** All medical services provided are directly charged to the patient or responsible party. The patient will be responsible for any balance that is not covered by his/her insurance policy. Private pay and non-insured patients will be asked for payment at the time of service.

7. **Office policies subject to change without notice.**

I have read and understand the office policy and agree to abide by its guidelines.

Print Patient Name _____________________________________________________

Signature of patient or responsible party __________________________________

Date_________________________________________________________________
PATIENT INTAKE FORM

Last name: _______________________ First Name: ______________________

Date of birth: __________________ SSN#: ___________________________

Age: __________ Gender (circle one):         Male           Female

Home (mailing) address: ____________________________________________

1st call phone number (cell or home): __________________________________

2nd call phone number (cell, home or work):____________________________

Email address (print): _____________________________________________

Name of primary insurance: __________________________________________

Subscriber of primary insurance (circle one):         Self           Spouse           Parents

Subscriber info: Name______________DOB___________________________

SSN: _________________________Name of employer: ________________________

Name of Secondary Insurance if you have one:___________________________

Subscriber of secondary insurance (circle one):         Self           Spouse           Parents

Subscriber info: Name______________DOB___________________________

SSN: _________________________Name of employer: ________________________

Emergency contact: Name_________________Phone: ____________________

Relationship with you

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payments of benefits, and authorize the use of this signature on all insurance submissions.

By signing this form, I acknowledge that I have access to a copy of the Notice of Privacy Practices provided by Kidney Care and Hypertension Center on its website kidneycarenj.com. I have the opportunity to ask any questions about the notice and all my questions have been answered.

Print name:________________________ Signature: ______________________

Date: ___________________________________
Your name: ______________________________________________________________________

Your pharmacy name_____________________________________________________________

Allergy to medications:___________________________________________________________

Please list ALL of your medications, vitamins, & supplements

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<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>When taken</th>
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<tbody>
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<td>(example: Aspirin 81mg Once a day)</td>
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Please use the back of this paper if you need more space.

Please list all your physicians you would like us to keep in contact with:

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<tr>
<th>Physicians name</th>
<th>Specialty</th>
<th>Phone Number</th>
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RECORDS RELEASE AUTHORIZATION

I hereby authorize___________________________________ to release my medical records.

Patient's Name:___________________________________________

Patient's Address: _________________________________________

Patient's Date of Birth:_____________________________________

Social Security Number: ____________________________________

Patient's Signature:________________________________________

Date: _____________________________________________________

Please send records to:

Kidney Care and Hypertension Center, LLC
Xinye (Cindy) Wu, M.D.
49 Veronica Ave Suite 202 Somerset NJ 08873
Tel: (908) 393 2737
Fax: (908) 393 2738

Comments:
Please send the following record:

_____ All record
_____ History and Physical
_____ Progress notes
_____ Consultation letters
_____ Medication list
_____ Lab result
_____ Radiology record
_____ Pathology record
_____ Echo result
_____ Other

Thank you for your prompt response. Reivesed Jan 2019