RATNAJA KATNENI MD INC
ABIM Board Certified Nephrology/Internal Medicine

Welcome to our practice!

Office Hours
Monday through Friday: 9:00 am - 5:00 pm

After Office Hours
For urgent medical issues after regular office hours, please call our office number to be connected to the on-call doctor's paging service. For all other issues, please call us during our regular office hours 9 AM to 5 PM.

Same Day / Urgent Appointments
We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know and we will try to accommodate you as best we can.

Emergencies
Call 911 for medical emergencies.

Medication Refills
We do not want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" when you are picking up your last refill. Please allow 3-4 working days for us to refill your medications.

Forms
Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an evaluation and possible laboratory testing to complete. Most forms require a fee.

Medical Care
We are concerned about your health. In order for us to provide the best possible quality of care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments, scheduling annual physical exams, and completing tests ordered for you.

Canceling Appointments
If for any reason you will not be able to keep your appointment, we ask that you notify us to reschedule at least 24 hours prior to your appointment.

Other Physicians or Heath Care Specialists
If you are seeking healthcare from other physicians in the community, we would like you to ask their office to send us a copy of their notes and studies.

Communication
We believe in having good communication between our office staff and our patients. We encourage you express any questions or concerns to us, so we may better serve you.

**All New Patient Forms must be completed and signed at or prior to your first appointment.*

PATIENT SIGNATURE:
Date: _______

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	NAME YOU PREFER TO BE CALLED	SEX

ADDRESS	APT #	CITY	STATE	ZIP

SOCIAL SECURITY #	BIRTHDATE	PREFERRED CONTACT # (home or cell)	ALTERNATE PHONE #

WORK TELEPHONE #	E-MAIL ADDRESS

EMPLOYER	EMPLOYER ADDRESS	POSITION/ TITLE

EMERGENCY CONTACT NAME & TELEPHONE NUMBER
WHO REFERRED YOU TO OUR OFFICE?
WHO IS YOUR PRIMARY PHYSICIAN? TELEPHONE #
PHYSICIAN ADDRESS

GUARANTOR/ POLICY HOLDER INFORMATION

LAST	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT SPOUSE PARENT OTHER:

ADDRESSS IF DIFFERENT FROM PATIENT

BIRTH DATE	SOCIAL SECURITY #

GUARANTOR/ POLICY HOLDER'S EMPLOYER	EMPLOYERS ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

1. PRIMARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	IPA	PRIMARY CARE PROVIDER

2. SECONDARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	IPA	PRIMARY CARE PROVIDER

All professional services rendered are charged to the patient. Billing services are provided by third party and are HIPPA compliant. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to RATNAJA KATNENI M.D., Inc. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Ratnaja Katneni M.D., Inc. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a $30.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum $6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

PATIENTS SIGNATURE________________________________

PATIENT RESPONSIBILITIES

As a partner in your healthcare, you have the following responsibilities:

1. I will provide accurate health information to your doctor and update us with any health changes.
2. I will schedule routine physical exams and other health maintenance exams recommended to me by my doctor (Pap smear, mammogram, bone density, colonoscopy, routine blood tests, immunizations, etc.). I put myself at risk for not detecting other medical diseases if I only see my doctor for immediate problems. I will make appointments with my doctor to discuss routine health screenings.
3. I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
4. I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. During these appointments my physician may order tests, refer me to a specialist, change my medications, and diagnose a medical problem. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
5. I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal.
6. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.
7. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.
8. I will treat all providers and office staff respectfully and courteously.
9. I will fulfill my financial obligations for care provided to me in a timely manner.
10. I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.
11. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
12. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

I have been informed of my responsibilities and I understand them fully.

Print Name: ____ Date: ____________

Signature: ______________________________________

MISSED APPOINTMENT POLICY

We would like to make you aware of our policy regarding missed appointments and or cancellations without sufficient time notice at least 24 hours before your appointment.

We try to keep our patients scheduled in a timely manner. We know that your time is valuable; therefore, we don't double book appointments. When an appointment is given to you, the time is blocked off specifically for you. If you don't appear or cancel without sufficient time notice, it prevents us from trying to accommodate another patient, resulting in wasted time for the Doctor.

Therefore, if we are not given a sufficient time notice of an appointment cancelation or you simply do not show up for your appointment, we will have to charge you a fee of **$50.00.**

We understand that emergencies do happen, and adequate notice is not always possible. We do ask that you contact our office as soon as you realize that you will not be able to make your appointment or procedure, in order to avoid these charges.

As a courtesy, our EHR system tries to confirm appointments 1-2 days prior. If you have any questions about your appointment day or time, we encourage you to call our office. **Please do not rely on the confirmation call to remind you of your appointment.**

Thank you for your cooperation and understanding. If you have any questions, we will be happy to assist you.

I have read the above policy and agree to comply with the terms and conditions stated.

Signature: ____ Date: _______________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Ratnaja Katneni MD Inc** to use and disclose
protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **Ratnaja Katneni MD Inc** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Ratnaja Katneni MD INC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **RATNAJA KATNENI MD INC, 20072 SW Birch St, Suite 210, Newport Beach, CA 92660**

With this consent Ratnaja Katneni MD Inc may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Ratnaja Katneni MD Inc** may mail or email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Ratnaja Katneni MD Inc** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that **Ratnaja Katneni MD Inc** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Ratnaja Katneni MD Inc** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Ratnaja Katneni MD Inc** may decline to provide treatment to me.

________________________________	____________	__________________________
Signature of Patient or Legal Guardian	Date	Relationship to Patient

________________________________	____
Print Patient's Name	Print Name of Legal Guardian, if applicable

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize **RATNAJA KATNENI MD INC** to use and/or disclose certain protected health information (PHI) about me to the following **FAMILY MEMBER/CAREGIVER**:

Name(s)/Relation: ____

Phone #: ____

This authorization permits **RATNAJA KATNENI MD INC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

____

____

The information will be used or disclosed for the following purpose:

____

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **RATNAJA KATNENI MD INC.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

RATNAJA KATNENI MD INC
20072 SW Birch St, Suite 210, Newport Beach, CA 92660

Signed by: ______________________________ ______________________________
Signature of Patient or Legal Guardian Relationship to Patient

______________________________ ______________________________
Print Patient's Name Date

____
Print Name of Legal Guardian, if applicable