FLORIDA KIDNEY AND HYPERTENSION SPECIALISTS, P.A.

Harjas Moorjani, M.D.
Alfredo Pegoraro, M.D.
Rohan Desai, M.D.
Volodymyr Chornyy, M.D.

Tel: 386-668-4650
Fax: 386-668-4649

Aya Pauley, P.A.
Erin Betzner-Potkul, A.P.R.N.

NEW PATIENT REGISTRATION FORM
(PLEASE PRINT)

Please fill this form out completely. All information is for the purpose of treating you and/or filing your insurance claim. It will be kept in the strictest confidence.

Primary Care Physician: _____

Patient: _____
Last Name First Name Middle Initial

Local Address: _____
Street Address City State Zip Code

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Sex: M F ; Marital Status: S M W D

Race: _____ Ethnicity: _____ Language Preference: _____

Driver's License Number: _____ Social Security # : _____

Spouse's Name: _____ Birth Date: _____

If the responsible party is different from the information above please provide:

Name: _____

Local Address: _____
Street Address City State Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Ins.Co.Name: _____	Ins.Co.Name: _____
Policy Number: _____	Policy Number: _____

❖ In case of an emergency, who should be notified? : Name: _____

Phone: _____ Relationship to patient: _____

I authorize the release of information to any physician directly involved in my treatment. I authorize the payment of medical benefits to the physician for services described on the claim form and authorize the release of any information necessary to process the claim. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. If self pay, I realize I am responsible for all office charges and that they are payable at the time of each visit. I certify that the information I have provided is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or my personal information. Co-pays and deductibles are expected to be paid at the time of the service. Thank you.

Patient's Signature: _____ **Date:** _____

FLORIDA KIDNEY AND HYPERTENSION SPECIALISTS, P.A.

Harjas Moorjani, M.D.
Alfredo Pegoraro, M.D.
Rohan Desai, M.D.
Volodymyr Chornyy, M.D.

Tel: 386-668-4650
Fax: 386-668-4649

Aya Pauley, P.A.
Erin Betzner-Potkul, A.P.R.N.

Patient Consent Form

Please read and sign:

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Performance of such procedures as may be deemed advisable or necessary in the treatment of this patient
- The use of prescribed medication
- Performance of laboratory tests that may be considered medically necessary or advisable by the judgment of the physician or their assigned designees
- Performance of diagnostic procedures or tests

I understand that this notice is given in advance of any specific diagnosis or treatment.

I authorize this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I understand that Florida Kidney and Hypertension Specialists, P.A. my include consent at satellite offices under common ownership.

I, the undersigned, authorize Florida Kidney and Hypertension Specialists, P.A. to use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

A photo copy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize the release of medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Florida Kidney and Hypertension Specialists, P.A.

I, the undersigned, give consent to Florida Kidney and Hypertension Specialists, P.A. to use and disclose my information for the purposes of studies with research companies contracted with Florida Kidney and Hypertension Specialists, P.A.

I acknowledge that I have been given the Florida Kidney and Hypertension Specialists, P.A. Notice of Privacy Practices. I understand that if I have any questions or complaints that I should contact the Privacy Officer. Patient or responsible party initials: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content.

_____ _____

Patient or Responsible Party Signature Date

Financial Policy

Thank you for coming to Florida Kidney and Hypertension Specialists. We believe that good care for you and your family states with good communication, and we have created this policy to help our patients understand the responsibilities that they have for payment of our fees. If at any time you have questions or problems with our fees or payment process, please don't hesitate to speak our billing department at 386-668-4650, prompt 5.

Please read, sign, and return to our receptionist.

1. We will collect your co-pay, or percentage of responsibility at the time of service. Please be prepared to pay by cash, check or charge. Returned checks are subject to a service fee of $40.00
2. Please be thorough with your insurance information. Give your insurance card, driver's license, and any authorization you may have to our receptionist. If your PCP/insurance changes for any reason, please notify our billing department as soon as possible to update your records.
3. As a courtesy, we will file your claim to your insurance. Prompt payment is expected from your insurance company. It is useful for you to maintain frequent contact with your insurance company to make sure they are paying as they should.
4. Your insurance will send you and Explanation of Benefits that explains what they have paid to our office. You must keep it on file. If you do not agree with their payment, please contact them. We require our patients promptly pay all charges that we present to them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payments, allowances, or limitations. But, if we present a charge to you, it means that we have taken any such adjustment into account and that you must still pay the amount remaining.
5. If the insurance denies payment due to non-covered service, no authorization etc , you will be responsible for the balance and will be asked to pay our office in a timely fashion. Nonpayment could result in your account being sent to an outside collection service, possibly subject to additional collection fees and the balance reported to the credit bureau.
6. TO ALL MEDICARE PATIENTS: We participate as Medicare providers. We will file Medicare and your secondary insurance, but if payment is not received from your secondary insurance within 45 days of filing, you will be required to pay the balance due. We will then provide you with paperwork to file your secondary insurance. Medicare will only pay for a service that is determined to be reasonable and necessary under section 1862 (A)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under Medicare, you will be responsible for the service charge.
7. HMO or PPO PATIENTS REQUIRING REFERRALS: You are responsible for making sure your first visit and all follow-up visits with our office are authorized by your Primary Care Physician (PCP). This is not our policy, it is the policy of the insurance companies. If the insurance denies payment due to lack of authorization, you are responsible for the bill. It is your responsibility to bring copies of any laboratory tests done by your primary care physician.
8. SELF-PAY PATIENTS: Payment for medical services is expected on the day the service is rendered. You must make payment arrangements prior to being seen by the doctor. First visits can range from $35.00 - $250.00, so please be prepared to make payment.
9. We do offer and accept payment plans. Please contact our billing department prior to being seen to arrange, if needed.
10. There are many times when the doctor requests laboratory/diagnostic tests. In this case, you are reminded to go to the facility that your insurance participates with. Should you get a bill from the outside facility, please contact them at the number listed on their bill. You understand that if your insurance company does not cover or partially covers the charge for tests, or if you fail to go to the appropriate facility then you will be fully responsible for the bill. You release Florida Kidney and Hypertension Specialists from any responsibility of payment.
11. You also agree that if you receive payments directly from your insurance on behalf of the doctor for services rendered, you are requested to forward the payments to the doctor in a timely manner to be applied to your account.
12. **NO SHOW APPOINTMENTS (Effective January 1, 2020) : Patients who do not provide a 24 hr. notice and do not appear for their appointment will be charged a no show fee of $40.00.**

I understand the above information, and I will be financially responsible for the following patient:

Print Name of Patient Signature of Patient/Guardian Date

HIPAA Notice of Privacy Practices

Effective as of March/1/2010

Florida Kidney and Hypertension Specialists, P.A.

2877 Wellness Ave.
Orange City, FL 32763

Deland, FL 32720

386-668-4650

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Florida Kidney and Hypertension Specialist

Medical History

Please take a moment to complete this questionnaire.The information contained herein is absolutely confidential Thank you.

PERSONAL INFORMATION

NAME	DOB	Age	Date
With whom may we discuss test results?			
Referring physician:	Reason for Referral:		
Physician's Address:	City:	State:	Zip:
Phone:			

Medical Problems

Please check all that apply. Use the right side to add more if needed.

Problem	Year Diagnosed	Problem	Year Diagnosed
Diabetes:type I - Type II			
COPD/Emphysema			
Coronary Artery Disease			
High Cholesterol			
Hypertension(high blood pressure)			
Heart Failure			

Surgeries, Accidents, Hospitalizations

Surgical History		Hospital Admissions	
Operation	Date	Reason	Date

Family History

List the members of your immediate family, age, and health status

Name	Age	Health status

Does any member of your family have or had any of the following medical problems (excluding yourself):

Problem	Family Member	Problem	Family Member
Diabetes		Cancer	
High Blood Pressure		Stomach Ulcers	
COPD/ Emphysema		Lupus	
Heart Problems			
Stroke		Other	
High Cholesterol			
Kidney Disease			
Kidney Stones			
Arthritis			

Social History

Occupation:	Marital Status Married Single Widowed Divorced	Recreational Drugs: YES NO Type: Amount: How Often:
Have you ever smoked cigarettes: YES NO Packs/Day: For How Long: Year Started: Year Stopped:		Travel Information: Have been in the military? YES NO Have you lived outside the US? YES NO
Alcohol: YES NO Type: Amount: How Often:		Advanced Directive: YES NO If yes, please bring copy for your chart.

Review of Systems (please circle)

GENERAL			(con't)		
Recent Weight Loss:	YES	NO	GASTROINTESTINAL		
Recent Weight Gain:	YES	NO	Trouble Swallowing:	YES	NO
Fatigue/Tiredness:	YES	NO	Indigestion or Heartburn:	YES	NO
Sensitivity to Cold:	YES	NO	Nausea or Vomiting:	YES	NO
Sensitivity to Heat:	YES	NO	Diarrhea:	YES	NO
Anxiety/Nervousness:	YES	NO	Constipation:	YES	NO
Increased Thirst:	YES	NO	Black Stools:	YES	NO
Fever or Chills:	YES	NO	Jaundice:	YES	NO
Decreased Appetite:	YES	NO	GENITOURINARY		
Increased Appetite:	YES	NO	Burning Urination:	YES	NO
Headaches:	YES	NO	Urgency:	YES	NO
Pallor (pale skin):	YES	NO	Frequent Urination:	YES	NO
SKIN			Cloudy Urine:	YES	NO
Skin Rashes:	YES	NO	Bloody Urine:	YES	NO
Skin Infections:	YES	NO	Foamy Urine:	YES	NO
Abnormal Skin Lesions:	YES	NO	Difficulty Starting Urination:	YES	NO
Changes in Warts or Nevus:	YES	NO	Dribbling:	YES	NO
Sensitivity of the Skin to Sun:	YES	NO	Lack Of Urine Strength:	YES	NO

			Incontinence with Cough of Efforts:	YES	NO
ENT					
Current/Recent Throat/ Ear Infection	YES	NO	MUSCULOSKELATAL		
Trouble Hearing:	YES	NO	Back Pain:	YES	NO
Ringing in Ears:	YES	NO	Small Joints(finger/toe) Pain:	YES	NO
Ear Aches:	YES	NO	Stiffness:	YES	NO
Hoarseness:	YES	NO	Joint Swelling:	YES	NO
Bleeding Gums:	YES	NO	Bone Pain:	YES	NO
Nasal Stuffiness:	YES	NO	CENTRAL NERVOUS SYSTEM		
RESPIRATORY			Dizziness:	YES	NO
Cough:	YES	NO	Weakness of Your Arms or Legs:	YES	NO
Sputum or Phlegm:	YES	NO	Muscle Weakness:	YES	NO
Coughing Blood:	YES	NO	Speech Trouble:	YES	NO
Chest Pain:	YES	NO	Numbness:	YES	NO
CARDIOVASCULAR			WOMEN ONLY		
Chest Pain with Exercise:	YES	NO	Irregular Menstruation:	YES	NO
Swelling of the Ankles/legs:	YES	NO	Heavy Bleeding:	YES	NO
Shortness of Breath with Exercise:	YES	NO	Menopause:	YES	NO
Use More Than One Pillow to Sleep:	YES	NO	Hot Flashes:	YES	NO
Get Up at Night with Shortness of Br	YES	NO	Breast Lumps:	YES	NO
Get Up at Night to Urinate	YES	NO	Nipple Discharge:	YES	NO
How Many Times?					

Allergies

Do you have any drug allergies? YES NO

Drug Name	Reaction

Do you have any food allergies? YES NO

Food Name	Reaction

Please note any additional information below

NAME: _____

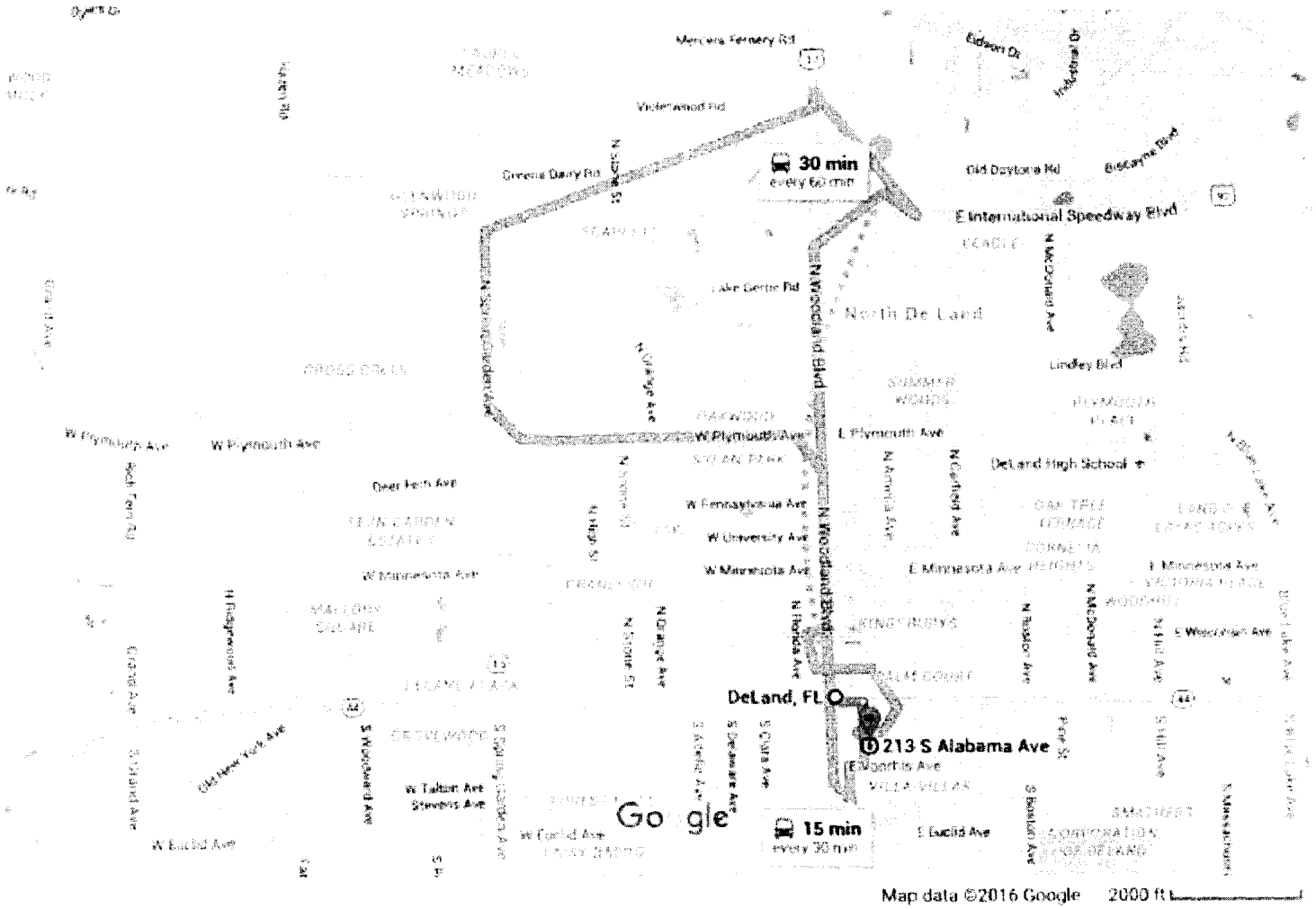
DOB: _____

MEDICATION	STRENGTH	# OF PILLS	# TIMES A DAY	COMMENTS	MORN	NOON	EVENING	BEDTIME

ALLERGIES

DRUG NAME	REACTION

Google Maps DeLand, FL to 213 S Alabama Ave, DeLand, FL Drive 0.3 mile, 1 min



DeLand, FL

1. Head east on E New York Ave toward Alabama Ave Greenway Trail/DeLand Greenway

0.1 mi

2. Turn right onto S Alabama Ave
   Destination will be on the left

0.2 mi

213 S Alabama Ave

DeLand, FL 32724

These directions are for planning purposes only. You may find that construction projects, traffic, weather, or other events may cause conditions to differ from the map results, and you should plan your route accordingly. You must obey all signs or notices regarding your route.