Kidney Medical Care
Rania Abdel-Rahman MD PLLC
4168 Southpoint Parkway Suite 103
Jacksonville, FL 32216
Office: 904-551-1185
Fax: 904-551-1184

New Health Care Consumer Questionnaire

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The **Health Care Consumer (HCC) - Health Care Provider (HCP)** relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

Reason for visit:_____ Date:_____

Patient Name _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Date Of Birth:_____ Social Security # _____

Patient Email Address:_____

Emergency Contact _____ Contact # _____

Referring / Primary Care Provider: _____

Please circle your current marital status:
Single Married Divorced Legally Separated Widowed Significant Other

Demographics:

___ American Indian or Alaska Native
___ Native Hawaiian or other Pacific Islander
___ White ___ Black or African American
___ Asian ___ Other
___ Hispanic ___ Non-Hispanic
___ Decline to answer

Primary Insurance Information--- if you have your insurance cards you can skip this section

Name: _____ Policy #_____

Sponsor/Subscriber Name:_____ Date of Birth_____

Secondary Insurance Information:

Name: _____ Policy # _____

Sponsor/Subscriber Name:_____ Date of Birth_____

Pharmacy Information:

Name: _____ Address: _____

Have you completed a **Living Will OR designated a Durable Power of Attorney** for Health Care? Y__N__
If yes, please provide a copy for your health care provider.

Please List Past Medical History:

_____ _____
_____ _____
_____ _____
_____ _____

Please list all of the medication you are taking. Include over the counter medications, herbs & vitamins.
*no need to fill out if you have a list

Medication Name	Dose	How Often

Please list and describe allergic reaction you have had to food, medications or insect stings.
____NKDA
Check if you allergic to ____IV contrast Dye ___Penicillin ____ Shellfish
Please list food, medication or Insect allergies

_____ _____
_____ _____
_____ _____
_____ _____

Surgical History—list all surgical procedure you have had (include surgeon and date of procedure)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you recently been hospitalized: Yes _____ No _____
If yes, please list hospital and dates

_____ _____

_____ _____

Family Medical History: Please list all known problems in your immediate family.
(Specify M-Mother, F=Father, B=Brother, S=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Diabetes: _____ Mental Illness _____

Hypertention: _____ Stroke:_____

Heart Disease: _____ Cancer: _____

Other: _____

Family history of Kidney disease: Yes_____ No _____

Kidney Transplant date:_____ Place: _____

Social History

Tobacco User: Yes ____ No _____ If So How often: _____ Type:_____

Former Tobacco User: Yes____ No_____ Quit Date: _____

Alcohol Use: Yes ____ No _____ Type: _____ How often_____

How much do you drink daily: Water _____ Soda: _____ Coffee: _____

Last Flu Vaccine: _____ Pneumonia Vaccine: _____

Kidney Medical Care
Rania Abdel-Rahman, MD PLLC
Patient Consent and Authorization

I authorize Rania Abdel-Rahman, MD PLLC DBA Kidney Medical Care (The Practice) to use and disclose my medical records for the purpose of treatment, payment, and health care operations.
Treatment includes activities performed by a health care provider, nurse, office staff, contractors, and other types of health care professionals providing care to you, coordinating, or managing your care with third parties and consultations with and between other health care providers.

This consent includes treatment provided by any physician or health care provider who covers Rania Abdel-Rahman, MD PLC DBA Kidney Medical Care practice in-person, by telephone, or any other means, The Practice facilities or any other health care facility or location, as the covering physician or health care provider.
Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization of management activities which may include review of health care services for medical necessity justification of charges, pre-certification and pre-authorization.
Health care operation includes all the necessary administrative functions of our office.

You agree that you have read the consent and authorization form and the above information and accept the conditions.

I authorize payment of medical benefits for any services rendered to me by Rania Abdel-Rahman, MD, Rania Abdel- Rahman MD PLC DBA Kidney Medical Care and any covering physician or other health care provider. I authorize the release of any medical information necessary to process this and al claims and request payment for services. I understand that I am responsible for co-pays, deductibles, and any amount not covered by my insurance. I understand that if I am a member of an HMO plan, I am responsible for obtaining authorization from my primary physician prior to any visits. I understand that fi I am a member of an HMO plan, Ima responsible for presenting my co-pay prior to services being rendered.

I request that lifetime payment of authorized Medicare benefits be made to Rania Abdel-Rahman, MD, Rania Abdel- Rahman MD PLLC DBA Kidney Medical Care and any covering physician or other health care provider on my behalf for services rendered to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services [CMS] [HCFA] and its agents, any information needed to determine these benefits for related services. I authorize payment of medical benefits for any services rendered to me by
Rania Abdel-Rahman, MD, Rania Abdel-Rahman MD PLC DBA Kidney Medical Care and any covering physician or other health care provider. I authorize the release of any medical information necessary to process this and al claims and request payment for their services. I understand that I am responsible for my yearly deductible, non- covered charges, and twenty percent (20%) of the allowed charges.
I direct my insurance carrier that a photocopy, electronic copy, or faxed copy of this authorization shall be considered a valid assignment of benefits for all claims, in lieu of the original, which will be kept on file in my medical record.

Rania Abdel-Rahman MD PLC DBA Kidney Medical Care has a strict policy to collect insurance co-payments prior to the patient visit with a physician or health care provider. Patients who do not make their co-payment at the time of visit may be required to reschedule their appointments.
Medicare patients without secondary insurance will be required to pay at the time of visit the Medicare co-payment of 20% of the applicable Medicare Fee Schedule.

Patients/members of HMO plans must bring a referral or authorization form from their primary care physician, otherwise they will be required to make payment for services rendered at the time of visit. It is the patient/member responsibility to obtain a referral from his/her primary care physician.
I am aware that I can read the privacy policy for Rania Abdel-Rahman MD PLC DBA Kidney Medical online at: www.kidneymedicalcare.com under the "Patient Access" section.
I was provided the option to receive a printed copy of the privacy notice.

I have read the notice, consent, and authorization form and the above information and I accept the conditions.

Medical Records Requests

I understand that the Practice will charge $1.00 per page up to 25 pages and $0.25 per page for additional pages, for copying fees. There's no charge for viewing or reading the records online using the Patient Portal, or electronically at the Practice. Postage fees may apply for mailing the Requested Information.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.
I have read and understand the following statements:
1. I may revoke this authorization at any time by notifying the Practice in writing.

2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. The Practice will not condition my treatment, payment enrollment in health plans or my eligibility for benefits by signing this form.
5. I further agree to pay charges to provide the information request per Florida Statute
6. I understand that unless otherwise revoked, this authorization will expire 1 year from the date signed.

CHECKS SHOULD BE MADE PAYABLE TO: Rania Abdel-Rahman MD PLLC

I have read the consent and authorization form and the above information and I accept the conditions.

_____
Patient OR Legal Guardian Print Name

_____
Patient Or Legal Guardian Signature:

_____
Date:

Kidney Medical Care
Rania Abdel-Rahman, MD PLLC
Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.

It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

You will be charged $25.00 return check fee for any payment made by a check not honored by your financial institution (For Example: insufficient funds, closed account, etc.)

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____

Patient OR Legal Guardian Print Name

_____

Patient Or Legal Guardian Signature:

_____

Date:

Kidney Medical Care
Rania Abdel-Rahman, MD PLLC
No-Show Policy

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments our practice makes calls, sends text messages, and emails reminders in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice.

If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $50.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows and/or cancellations to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Rania Abdel-Rahman MD PLLC DBA Kidney Medical Care and agree to provide a credit card number, which may be charged $50.00 for any no-show of a scheduled appointment.

I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential no-show charge to the credit card provided.

_____

Patient OR Legal Guardian Print Name

_____

Patient Or Legal Guardian Signature:

_____

Date:

Rania Abdel-Rahman, MD PLLC
Kidney Medical Care
4168 Southpoint Pkwy, Suite 103
Jacksonville, Fl 32216
Phone: (904)551-1185 Fax: (904)551-1184

Authorization for Release of Patient information

Patient Name:_____ **DOB:**_____

I authorize you to release and furnish the following information:

_____ **Office Notes**

_____ **Procedure Notes**

_____**Hospital Procedure Notes**

_____ **Lab Work**

_____ **Other (HIV health information):**

_____ **Diagnostic Test**

From:

_____
_____
_____
_____

To:

Rania Abdel-Rahman, MD PLLC
Kidney Medical Care
4168 Southpoint Pkwy Ste 103
Jacksonville, FL 32216
Fax: 904-551-1184

I understand that this information may contain personal information from this physician and other health care providers as well as administrative data which is not strictly medical in nature. I additionally understand that once released you have no responsibility for any further release of information by those I authorize to receive it.

I release you from all responsibility and liability that may arise from authorization.

Signature:_____ **Date:**_____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Rania Abdel-Rahman MD PLLC (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until 12/31/2040 (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date