



RENAL CONSULTANTS

— MEDICAL GROUP —

Patient Information

Patient Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell# _____ Alternative # _____

Social Security #: _____ Email: _____

Employer Name _____ Work # _____

Check here if you have no insurance (Cash Account)

Insurance #1: _____

Insurance #2: _____

Insurance #3: _____

I, the undersigned, hereby authorize payment directly to Renal Consultants Medical Group for the medical services rendered. I understand that I am financially responsible for all charges not covered or authorized by my insurance company

Printed Name: _____

Signature: _____ Date: _____

****Please be advised that you will be required to complete this sheet at your first office visit of each year. The information you provide is updated yearly and ensures we have accurate information to file a claim on your behalf**

VINOD M. ASSOMULL, MD	KAMAL V. GANDHI, MD	ANANT J. DESAI, MD	BRIAN B. AYUSTE, MD
KALYANI N. MEHTA, MD	DAYAN K. GANDHI, MD	WILLIAM YANG, MD	PUJA GOSWAMI, MD

10605 BALBOA BLVD # 240
GRANADA HILLS, CA. 91344
PHN: 818-366-4626
FAX: 818-366-4630

23928 LYONS AVE # 205
NEWHALL, CA. 91321
PHN: 661-254-0193
FAX: 661-254-2248

18433 ROSCOE BLVD # 202
NORTHRIDGE, CA. 91325
PHN: 818-349-1262
FAX: 818-349-7529

227 W. JANSS RD #210
THOUSAND OAKS, CA. 91360
PHN: 805-496-5800
FAX: 805-834-1088

Physician List

Patient Name: _____ DOB: _____

Physician/Specialist Address

Phone & Fax Number

Primary Care Physician

Cardiologist

Pulmonologist

Endocrinologist

Neurologist

Gastroenterologist

Hematologist

Urologist

Other

Other

Other

Other

Other

Other

MEDICAL HISTORY

NAME: _____ DOB: _____ DATE: _____

Please indicate if you have any of the following conditions below with a CHECK or an X:

CARDIOLOGY

- Hypertension
- Angina
- Heart Attack
- Heart Failure
- Atrial Fibrillation
- Irregular Heart Beat
- Heart Murmur
- Peripheral Vascular Disease
- Aortic Aneurysm

PULMONOLOGY

- Asthma
- Chronic Bronchitis
- Emphysema
- COPD
- Pneumonia
- Pulmonary Hypertension
- Clot in lungs
- Sleep Apnea
- Lung Cancer

ENDOCRINE

- Diabetes Type 1
- Diabetes Type 2
- Thyroid Problems
- High Low
- Addison's Disease
- Crushing's Disease
- Pituitary Adenoma
- High Cholesterol
- Obesity

GASTROINTESTINAL

- Acid Reflux
- Ulcer Disease
- Gall Bladder Disease
- Vomiting Blood
- Blood in Stool
- GI Cancer
- Diverticulosis
- Polyps

LIVER DISEASE/PANCREAS

- Hepatitis Type _____
- Cirrhosis
- Liver Cancer
- Gallbladder Stones
- Pancreatitis
- Pancreatic Cancer

GENTIOURINARY

- Recurrent UTI
- Kidney Stone
- Chronic Kidney Disease
- Nephritis
- Prostate Problem
- Kidney Cancer
- Bladder Cancer

HEMATOLOGY

- Anemia
- Leukemia
- Bleeding Disorder
- Blood Clots- legs
- Multiple Myeloma
- Varicose Veins
- HIV

NEUROLOGY

- Neuropathy
- TIA
- Stroke
- Migraine
- Seizure
- Parkinson's Disease
- Alzheimer's/ Dementia

ARTHRITIS & MUSCULOSKELETAL

- Rheumatoid Arthritis
- Fibromyalgia
- Osteoarthritis
- Gout
- Osteoporosis/Osteopenia
- Lupus (SLE)
- Scleroderma
- Sjogerns Syndrome

OTHER MEDICAL CONDITIONS:

1. _____

3. _____

2. _____

4. _____

NAME: _____ DOB: _____ DATE: _____

FAMILY HISTORY

Please check all that apply:

	Status: (A: Alive or D: Deceased)		High Blood Pressure	Diabetes	Heart Disease	Kidney Disease	Stroke	Cancer
Father	A	D						
Mother	A	D						
Brother(s)	A	D						
Sister(s)	A	D						
Son(s)	A	D						
Daughter(s)	A	D						

SOCIAL HISTORY

	Current Use	Frequency	If quit, when
Smoking			
Alcohol Use			
Illicit Drug Use			

Married: **Yes** **No**
 Living with: **Spouse** **Alone** **Other:** _____
 Flu Shot: **Yes** **No** **Date received:** _____
 Pneumococcal Vaccine: **Yes** **No** **Date received:** _____

HOSPITALIZATIONS / SURGICAL HISTORY

	Date/ Year	Hospital Name/ Surgeon	Reason for Hospitalization or Surgery
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PROCEDURES

	Date/ Year	Performed by	Results
Upper GI Endoscopy			
Colonoscopy			
Biopsy (any)			
Cardiac Stress Test			
PAP Smear			
Mammogram			

ACKNOWLEDGMENT OF PRIVACY PRACTICES

According to the Health Insurance Portability Act of 1996 (HIPPA), patients have certain rights to privacy regarding their protected health information. By signing below, you, the patient, acknowledge the following regarding the management of you protected health information. Your protected health information will be used to:

- Conduct, plan and direct treatment by the physicians employed with Renal Consultants Medical Group and will be shared in cooperation with healthcare providers who are involved in your care.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physicians certifications.

By signing below you agree that you have either received or waived your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information

Do we have permission to:

1. Leave messages at your home regarding and/or treatments? __Yes __No
2. Leave a name and call back number at your home or place of employment? __Yes __No
3. Mail test results and appointment information (if needed) to you home address? __Yes __No
4. Email you at the email address currently on file regarding appointments and treatment? __Yes __No
5. Discuss your personal information, including appointments and treatment with someone other than yourself? (If yes, please list name, relationship and contact number below) __Yes __No

Name	Relationship	Contact Number

Print Patient Name: _____

Patient Signature: _____

Date: _____

FINANCIAL POLICY

RENAL CONSULTANTS MEDICAL GROUP

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment, therefore if you have any questions or concerns about our payment policies, please feel free to speak to one of our office staff. We ask that all patients read and sign our financial policy as well as complete our patient information form prior to seeing the doctor. The following is our financial policy:

Please Initial

_____ Payment for services are due at the time services are rendered. We accept cash, checks, and debit/credit cards in form of Visa, Mastercard and Discover. We do not accept American Express. There will be a service fee for all returned checks.

_____ We accept assignment of insurance benefits, which means your insurance company will send payments directly to us.

_____ We bill your insurance as a courtesy to you. If your insurance company does not pay your balance within a reasonable amount of time, we may contact you and ask that you call your insurance company to help with the processing of the claim.

_____ All charges are your responsibility whether or not your insurance company pays. Not all services/procedures are covered benefits.

_____ Any balance left on your account that is the responsibility of the patient will be billed as such, with notice of the balance due. Each month we will send you a financial statement reflecting that balance, and requesting payment. After the third statement, if no payment is received and you have not contacted the office to set up a payment plan, your account will be sent to collections. If your account does go to collections, our office will attach an additional 30% charge to your account balance to cover our collection costs.

_____ There will be a \$25.00 fee for missed or canceled appointments without 24 hour prior notice.

We understand that financial hardships may affect timely payment, so we encourage you to communicate any such problems with our office staff so that we may assist you in the management of your account. Again, thank you for choosing us as your healthcare provider.

Patient Signature _____ Date _____

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ASSIGNMENT OF BENEFITS

I authorize release of all medical information necessary to process my insurance claims and is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above physician or clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient Signature _____ Date _____
(Parent, if minor)

Witness _____ Date _____