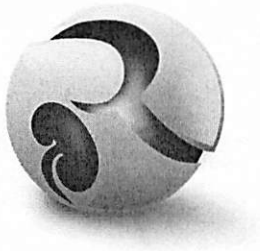

RENAL CONSULTANTS
MEDICAL GROUP

Patient Information

10605 Balboa Blvd #240
Granada Hills, Ca 91344
Phn: 818-366-4626
Fax: 818-366-4630

23928 Lyons Ave #105
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 #310
Thousand Oaks, Ca 91360
Phn: 805-496-5800
Fax: 805-834-1088

7301 Medical Ctr Dr #200
West Hills, Ca. 91307
Phn: 818-573-6755
Fax: 818-493-1231

Patient Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Alt: _____

Social Security: _____ Email: _____

Employer Name: _____ Work Phone: _____

Insurance #1: _____

Insurance #2: _____

Insurance #3: _____

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

Patient Name: _____

Signature: _____ Date: _____

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

RENAL CONSULTANTS MEDICAL GROUP

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

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_____

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, herby 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

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FAX: 818-349-7529

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

www.RenalConsultants.com

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	_____

MEDICATION LIST

Name: _____ DOB: _____

Allergies: _____

Pharmacy: _____ Phone #: _____

Medication name	Strength /dose	Frequency

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 DISESE/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 polices, 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_____

Updated 2015