Dear ________________,

You have been referred by your physician to be seen at Cary Nephrology Associates.

Your appointment date: ________________________________

Appointment time: ________________________________

Your Provider will be: ________________________________

☐ Cary Office: 790 SE Cary Parkway, Suite 101, Cary, NC 27511
☐ Fuquay-Varina Office: 916 South Main Street, Suite 240, Fuquay-Varina, NC 27526
☐ Four Oaks Office: 5815 Hwy 301 South, Four Oaks, NC 27524

Enclosed is our new patient information packet. It is important that you complete and bring with you to your appointment, along with the following:

- Current Picture ID,
- Current Insurance Card(s),
- Specialist Co-Pay,
- List Of Your Current Medications

If you should need to cancel or reschedule this appointment, please contact our office at 919-235-0644, at least 24 hours prior to your appointment date. We do charge a $25 fee to all patients who do not give a 24 hour cancellation notice.

Please feel free to contact us if you should have any questions.

Thank you,
Section A

PATIENT’S LEGAL NAME: ____________________________________________________________

PREFERRED NAME: ________________________________________________________________

SEX/GENDER: MALE / FEMALE   DATE OF BIRTH: _____ / _____ / _____   SOC. SEC. #: _______ - _____ - ______

PATIENT’S HOME ADDRESS: _________________________________________________________

COUNTY: ________________________

PATIENT’S HOME PHONE # (w/area code): ____________________________

PATIENT’S CELL/MOBILE # (w/area code): ____________________________

EMAIL ADDRESS: _________________________________________________________________

RACE: ________________________

PREFERRED LANGUAGE: ________________________

PREFERRED METHOD OF CONTACT  (Select as many as apply ✓)

___ EMAIL

___ HOME PHONE

___ CELL

___ WORK

SPOUSE’S NAME: ______________________________________________________    DATE OF BIRTH: ______________________

SPOUSE’S ADDRESS: (if not the same as above) ______________________________________

EMERGENCY CONTACT PERSON: ___________________________    PHONE #: __________________________

EMERGENCY CONTACT RELATIONSHIP TO PATIENT: ________________________________

EMPLOYED: YES _____ NO _____

PATIENT’S EMPLOYER: ___________________________    WORK # (w/area code) ____________________ EXT. ______

EMPLOYER’S ADDRESS: __________________________________________________________

REFERRING PHYSICIAN: ___________________________    PHONE #: __________________________

PRIMARY CARE PHYSICIAN: ___________________________    PHONE #: __________________________

REASON FOR REFERRAL: __________________________________________________________

____________________________

____________________________
**INSURANCE INFORMATION**

We cannot file your insurance without complete information and a copy of your Insurance Cards. Please bring your Insurance Cards with you to every appointment.

### Section B

**PATIENT NAME:** ______________________________________

**PRIMARY INSURANCE COMPANY:** ______________________________________

ID # ___________________________________ GROUP # ______________________

**IF POLICY HOLDER IS DIFFERENT FROM PATIENT:**

**INSURED’S FULL NAME:** _______________________________ DOB: ___________ EFFECTIVE DATE: ___________

**INSURED’S SOCIAL SECURITY #:** ____________________________

**RELATIONSHIP TO PATIENT:** SPOUSE _____ CHILD _____ OTHER ____ (specify) ______________________

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**Office use ONLY**

**Date Verified:** _________________________________________

**Verified By:** ___________________________________________

**Active Coverage:** ___________ **Effective Date:** _____________

**Inactive Coverage:** ___________ **Date of Termination:** ___________

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**SECONDARY INSURANCE COMPANY:** ______________________________________

ID # ___________________________________ GROUP # ______________________

**IF POLICY HOLDER IS DIFFERENT FROM PATIENT:**

**INSURED’S FULL NAME:** _______________________________ DOB: ___________ EFFECTIVE DATE: ___________

**INSURED’S SOCIAL SECURITY #:** ____________________________

**RELATIONSHIP TO PATIENT:** SPOUSE _____ CHILD _____ OTHER ____ (specify) ______________________

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**Office use ONLY**

**Date Verified:** _________________________________________

**Verified By:** ___________________________________________

**Active Coverage:** ___________ **Effective Date:** _____________

**Inactive Coverage:** ___________ **Date of Termination:** ___________

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*I authorize Capital Nephrology Associates, P.A. to file claims to my insurance company on my behalf for services rendered to me by providers of Capital Nephrology Associates, P.A., Cary Nephrology Associates, or Capital Access Center.*

**Patient Signature:** _______________________________________ **Date:** ______________________
Patient Medical Health History

Patient Name: ___________________________ Date: ___________________________
Age: _______ Birth date: ___________________________ Date of last physical exam: ___________________________

What is your reason for your visit today?

SYMPTOMS check (✓) symptoms you currently have or have experienced in past years.

General
- Weight Loss
- Weight Gain
- Night Sweats
- TB Exposure
- Shortness of Breath
- Asthma/Emphysema
- Coughing up Blood
- Painful Breathing
- Chest Pains
- Chest Pressure
- Chest Tightness/Dizziness
- Lightheaded/Dizzy
- Blood Clots
- Calf Pain
- Cold Hands or Feet
- Smoker

Skin
- Nausea/Vomiting
- Constipation/Diarrhea
- Ulcers
- Hepatitis
- Body Pain
- Weakness
- Gout
- Loss of Appetite
- Increase of Appetite
- Hair Loss
- Thirsty
- Heavy Urination
- Blood In Urine
- Uncontrolled Urine
- Weak Stream

Conditions
- Rash
- Constipation/Diarrhea
- Ulcers
- Hepatitis
- Body Pain
- Weakness
- Gout
- Loss of Appetite
- Increase of Appetite
- Hair Loss
- Thirsty
- Heavy Urination
- Blood In Urine
- Uncontrolled Urine
- Weak Stream

Eye & ENT
- Blurred Vision
- Glasses
- Contacts
- Eye Surgery
- Nosebleeds
- Trouble Swallowing
- Ringing Ears
- Trouble Hearing

Family Medical History

Please identify who was affected by condition: Mother, Father or Siblings

High Blood Pressure ___________________________ Anemia ___________________________
Diabetes ___________________________ Arthritis ___________________________
Kidney Failure ___________________________ Gout ___________________________
Kidney Stones ___________________________ Lupus ___________________________
Thyroid Disease ___________________________ Cancer ___________________________
Heart Failure ___________________________ Liver Disease ___________________________
Heart Attacks ___________________________ Kidney Biopsy ___________________________
Kidney Ultrasound ___________________________

Last time you had blood drawn was when and where? ___________________________

List any allergies here: ___________________________

I hereby state, to the best of my knowledge, that these questions were answered truthfully. I understand the information is to be used to complete my medical history and to aid in my diagnosis and treatment process.

Patient Signature: ___________________________ Date: ___________________________
FINANCIAL ARRANGEMENTS AND INSURANCE

You will find that our fees for specialized care are comparable to other Nephrologist’s in this area. If you have medical insurance to cover your expenses we will as a courtesy to you file your insurance. We are anxious to help you receive your maximum allowable benefits, and in order to achieve these goals we need your assistance and your understanding of our payment policy.

If you do not have medical insurance you are expected to pay for services incurred at time of service. We realize that individual financial situations may affect timely payment of your account. If this is the case you will be asked to talk to one of our account representatives to set up a regular payment plan for services incurred.

We will make every effort to maximize your insurance benefits, but you must understand the following:

1.) Your insurance coverage is a contract between you, and the insurance company. We are not a part of that contract.

2.) Insurance companies often judge a fee as “usual and customary” (UCR). As specialists in Nephrology, our fees are grouped in with other nephrologists for UCR calculation.

3.) Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You are responsible for knowing what is and is not covered under your plan.

We must emphasize that our relationship is with you as a patient not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don’t hesitate to ask to speak to a billing staff member. We are here to help you.

I have read, understand, and agree to the financial terms above. I agree to accept full responsibility for the payment of all fees.

PATIENT/GUARDIAN’S PRINTED NAME: ________________________________________________________________

SIGNATURE: ___________________________________________ DATE: ____________________
AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient’s Name: _______________________________ Date of Birth: _______________________________
Previous Name: _______________________________ Social Security #: _______________________________

Authorized Individuals/organizations:
Name: _______________________________ Address: _______________________________
Name: _______________________________ Address: _______________________________
Name: _______________________________ Address: _______________________________

This request and authorization applies to:

☐ All healthcare information
☐ Healthcare information relating to the following treatment, condition, or dates: _______________________________

☐ Other (specify): _______________________________

Authorization: I understand that authorizing the disclosure of this health information is voluntary. This authorization remains in effect for 2 years, unless revoked. I can revoke this authorization at anytime. To revoke I must do so in writing. I understand that the revocation will not apply to information that has already been released under this authorization. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Patient Signature: _______________________________ Date Signed: _______________________________
RELEASE OF MEDICAL RECORDS

Patient’s Name: ___________________________ Date of Birth: ___________________________
Previous Name: ___________________________ Social Security #: __________________________

Physician Office Information:

Name: ___________________________
Address: ___________________________
City: ___________________________ State: _________ Zip Code: ___________

This request and authorization applies to:

☐ All healthcare information
☐ Healthcare information relating to the following treatment, condition, or dates:

____________________________________________________________________________________

☐ Other (specify):

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ___________________________ Date Signed: ___________________________