

SEACOAST KIDNEY & HYPERTENSION SPECIALISTS, P.L.L.C.

Külli Barrett, MD
Shiv Kumar, MD

Michael C. Danielski, MD
Sucharit S. Joshi, MD

Naresh V. Matta, MD
Denise Prisby, APRN

DATE: _____ DOB: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

FAMILY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

MARITAL STATUS: _____ SS#: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____

RELATIONSHIP: _____ PHONE: _____ CELL: _____

INSURANCE COMPANY NAME: _____

INSURANCE ID #: _____ GROUP #: _____

NAME OF INSURED: _____ DOB OF INSURED: _____

DO YOU HAVE AN ADVANCED DIRECTIVE: YES NO

EMAIL: _____

WHITE: OTHER: ETHNIC BACKGROUND/RACE: _____

PHARMACY NAME: _____ PHONE: _____

ANY KNOWN MEDICATION ALLERGIES: _____

SIGNATURE: _____ DATE: _____

SEACOAST KIDNEY & HYPERTENSION SPECIALISTS, P.L.L.C.
NEW PATIENT QUESTIONNAIRE

Küllli M. Barrett, MD
Shiv Kumar, MD

Michael C. Danielski, MD
Sucharit S. Joshi, MD

Naresh M. Matta, MD
Denise Prisby, APRN

DATE: _____

NAME: _____

DOB: ___/___/___

1. CURRENT MEDICAL PROBLEMS
Problems

Date Started

2. MEDICATIONS (Please include all medications and dosages that you are currently taking, including non-prescribed medications):

3. HOSPITALIZATIONS

Have you had any hospitalizations? ___ Yes ___ No If yes, please list below:

4. GENERAL QUESTIONS (Please answer all to the best of your knowledge):

Do you smoke? _____ If yes, how many years? _____ What: Cigarettes, Cigars or Pipes.

Former Smoker? _____ How many years? _____ Amount Daily: _____

Do you drink alcohol? _____ If yes, how much per week? _____ What: _____

Do you have any allergies to medications? _____ If yes, please list allergies below:

5. FAMILY HISTORY (Please list family medical history, i.e. coronary disease, hypertension, kidney disease, diabetes, etc., and the persons relationship to you):

SEACOAST KIDNEY WAIVER

**You have permission to confirm my appointments or relay any of my healthcare information with
(please check all boxes that apply):**

Our office will call to remind you of your appointment and will leave a message if you do not answer. Please indicate the phone number(s) you would like us to call for these reminders:

Phone: () _____

Phone: () _____

Phone: () _____

Person/Persons allowed to receive information regarding care from our office (choose one and please give their name):

- Husband: () _____
- Wife: () _____
- Daughter: () _____
- Son: () _____
- Sister: () _____
- Brother: () _____
- Boyfriend: () _____
- Girlfriend: () _____

Signature: _____ Date: _____



***Guarantor or Representative Party (if patient is a minor)**

Name: _____

Address: _____

Phone Number: _____

Social Security#: _____

Relationship to Patient: _____

SEACOAST KIDNEY & HYPERTENSION SPECIALISTS—PRACTICE FINANCIAL POLICY

If you have medical insurance, we will be happy to bill most insurance companies if you provide our office with all the necessary information. Any balance, however, is ultimately your responsibility. Your co-payment or co-insurance is due at the time of our visit. If you have no insurance, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, and Visa.

MEDICAL INSURANCES:

We participate with the majority of the insurance companies. Please check with your insurance company or the office before your appointment to make sure we are on your insurance company's network.

For other insurance companies that we do not participate with, we will make a reasonable effort to bill. However, there may not be any benefits or there may be limited benefits for services by our physicians. Please be advised that it is your (the patient's or insured's) responsibility to contact your insurance company to see what your plan covers prior to treatment. In cases of liability, we do not bill third party insurances or attorneys; payment in full is expected at the time of your visit.

If your insurance has not paid within 60 days, the balance will be come your responsibility and we recommend that you contact your insurance company.

MANAGED CARE INSURANCES:

As a specialty practice, our physicians are not authorized to provide services for patients with managed care insurance without authorization from their primary care physician. The exception to this would be if our insurance includes a Point of service or option 2 plans, which allows you to choose treatment without a referral. In this case, you need to notify our office that you have chosen this option (if applicable). For all other HMOs, please be advised that it is your (the patient's or insured's) responsibility to make certain a referral authorization has been received in our office prior to your appointment or bring your referral with you at time of appointment. If you do not have the referral with you or the referral is not in our office the day of your appointment, you will be expected to pay for the office appointment at the time of visit.

ADDITIONAL INFORMATION:

If your insurance company requires that you provide them with signed claim form or accident details, it is your responsibility to do so. Failure to respond to requests from your insurance company will result in the balance becoming your responsibility.

In cases of divorced or separated parents, our policy is that the parent bringing the child into our office for services must be responsible for any balance.

I hereby authorize Seacoast Kidney & Hypertension Specialists to furnish my health information for purposes relating to treatment, payment, health care operations, and I hereby assign to Seacoast Kidney & Hypertension Specialists all payments for medical services rendered. I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered. I have read the information in this OFFICE FINANCIAL POLICY and verify that all insurance information is true and correct to the best of my knowledge.

I hereby agree to consultation with Seacoast Kidney & Hypertension Specialists and agreed-upon treatment. I understand that this signature is valid for any treatment for the duration of one year.

Patient Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Signature: _____

Date: _____



SEACOAST KIDNEY & HYPERTENSION SPECIALISTS, P.L.L.C.

875 Greenland Rd
Building C, Unit 10
Portsmouth, NH 03801
(With Satellite Offices in Exeter & Rochester)
Tel: (603) 436-3433 / Fax: (603) 427-5115

Külli Barrett, MD
Shiv Kumar, MD

Michael C. Danielski, MD
Sucharit S. Joshi, MD

Naresh V. Matta, MD
Denise Prisby, APRN

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION**

I _____ acknowledge receipt of the Notice of Privacy
(Patient's Name)

Practice for PHI (Protected Health Information) from Seacoast Kidney & Hypertension
Specialists, P.L.L.C.

I understand this notice contains important information about how my protected health
information may be used and disclosed and how I can get access to this information. I
understand that Seacoast Kidney has the right to change this Notice at any time and I may
obtain a currently copy upon request.

Signature

Date

SEACOAST KIDNEY & HYPERTENSION SPECIALISTS offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. Because the connection channel between your computer and the Website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Website and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a Website, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the Website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Signature

Date

Printed Name

Email Address

SEACOAST KIDNEY & HYPERTENSION SPECIALISTS, P.L.L.C.

CANCELLATION POLICY

This office has a policy of charging a fee for missing an appointment or cancelling with less than one working day's notice. A fee of \$50.00 for first-time appointments; \$25.00 for return visits.

The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you. If you do not keep the appointment, other patients who need "same day" urgent visits or earlier appointments than the schedule permits are being obliged to wait longer than necessary. Excessive no-shows or late cancellations may jeopardize future appointments with our practice.

Obviously, acute health problems and family crises are expected. Cancellations of convenience or last minute schedule conflicts will be your responsibility. We remain available to discuss this policy in general or individual circumstances. Thank you for your understanding.

Külli M. Barrett, MD
Michael C. Danielski, MD
Sucharit S. Joshi, MD
Shiv Kumar, MD
Naresh V. Matta, MD
Denise Prisby, APRN

PATIENT'S SIGNATURE: _____ DATE: _____