METROPOLITAN NEPHROLOGY ASSOCIATES

SAMIR F. SHABSHAB, MD • MANOJ S. REDDY, MD • ADAM M. PEARLMAN, MD
MARC F. BRAZIE, MD • MITESH V. SHAH, DO • HARSHAL P. SHAH, DO
ERICA N. DAVIS, PA-C • ELINE L. MUL, PA-C • TYLER C. GORMAN, PA-C
BOARD CERTIFIED

Welcome to Our Practice,

You have an upcoming appointment with us soon and we look forward to partnering with you in your healthcare. Please complete the new patient registration packet which is also available online at http://www.mnakidney.com. Please print it, complete it, and return it to the office where your appointment is scheduled, one week prior to your appointment, or bring the completed packet with you on your appointment day. You may mail or fax your packet to:

MARYLAND OFFICE	VIRGINIA OFFICE	WALDORF OFFICE (Mailing Address)
Metropolitan Nephrology Associates 8926 Woodyard Road Suite 602 Clinton, MD 20735 Fax: (301) 868-6055	Metropolitan Nephrology Associates 2616 Sherwood Hall Lane Suite 209 Alexandria, VA 22306 Fax: (703) 360-6117	Metropolitan Nephrology Associates 8926 Woodyard Road Suite 602 Clinton, MD 20735 Fax: (301) 868-6055

On the day of your appointment please do the following:

1. **BE ON TIME**
2. Bring a photo ID
3. Bring your insurance cards
4. Bring your referral (if required by your insurance company). You must have it in hand at the time of your appointment, or we will be unable to see you
5. Be prepared to submit your co-pay, if required by your insurance provider (All major credit cards are accepted)
6. Bring a list of all of your medications
7. Be prepared to leave a urine specimen

We will call to confirm your appointment approximately one week prior to your appointment date. However, if you are unable to keep your appointment, please call the office in which your appointment is scheduled to cancel with as much notice as possible (Maryland: (301) 868-9414 or Virginia: (703) 360-3100). There will be a no-show fee of $25.00 if you do not show for your appointment and have not called within 24 hours of the appointment to cancel. We look forward to seeing you. Thank you for your cooperation.

Sincerely,

Metropolitan Nephrology Associates

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our Duties
We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms at any time,changes made will be effective for all medical information we have about you as well as information we receive in the future. A copy of a revised notice will be available at our office or from our Privacy officer in our Virginia office by calling 703-360-3100 or Maryland office by calling 301-868-9414 or by writing to one of the corresponding addresses above. You may also address questions regarding our privacy practices, your rights or request for additional information.

Information Collected About You
In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- Your social security number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care", such as referring physicians, other doctors, your health plan, and family members or close friends.

How We May Use and Disclose Information About You
We may use and disclose personal and identifiable health information about you in different ways. All of the ways in which we may use and disclose information will fall within one of the following categories, but not every use or disclosure in a category will be listed.

Permitted Uses
We may use and disclose your medical information for specific reasons:

- **Treatment:** We will use health information about you to treat you, order tests and furnish services and supplies to you. For example, we will use your medical history, such as any presence or absence of heart disease, to assess your heath and order appropriate diagnostic services. We may contact you before your visit to remind you of your appointment.
- **Payment:** We will use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give your payer information about your current medical condition so that it will pay us for the services we have furnished you. We may also need to inform your payer of the tests that you are going to receive in order to obtain prior approval or to determine whether the service is covered.
- **Health Care Operations:** We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for accreditation organizations, auditors or other consultants to review our practice, evaluate our operations, and tell us how to improve our services.

Disclosures without Authorization
We may use and disclose medical information about you, without specific authorization:

- **Disclosures Required By Law:** We may be required by federal, state or local law to disclose your medical information.
- **Public Health Activities:** We may disclose your medical information to report communicable diseases, defective medical devices to the FDA, or work-related health issues.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may be required to disclose your medical information if we feel that you have been abused or neglected.
- **Health Oversight Activities:** We may be required to disclose your medical information to Medicare or a related agency if they select your case for a medical review. We may also be required to report to government agencies responsible for licensing physicians and other health care providers.
- **Coroner or Medical Examiner:** We may release personal health information to a coroner or medical examiner to identify a deceased person or determine the cause of death.
- **Tissue or Organ Donations:** We may have to disclose your medical information to organ procurement organizations,

transplant centers, and eye tissue banks.
- **Judicial and Administrative Proceedings:** We may have to disclose your medical information if we receive a subpoena from a judge or administrative tribunal.
- **Law Enforcement:** We may have to disclose your medical information in conjunction with a criminal investigation by a federal, state or local law enforcement agency.
- **Serious Threats to Health or Safety:** We may be required to disclose your medical information if, in our opinion, doing so will help avert a serious threat to the public.
- **Research:** We may use or disclose certain personal health information for research purposes where an Institutional Review Board determines that your privacy interests will be adequately protected. We may also use and disclose your protected health information to prepare or analyze a research protocol and or other research purposes.
- **Military Personnel:** We may disclose your medical information to the appropriate command authorities.
- **National Security/Intelligence Activities:** We may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.
- **Worker's Compensation:** We may disclose your medical information to comply with laws regarding worker's compensation.

Business Associates
We sometimes work with outside individuals and businesses that help us operate our business. We may disclose your health information to these business associates so that they can perform the tasks we hire them to do. Our business associates must guarantee us they will respect the confidentiality of your personal and identifiable health information.

Individuals Involved in Your Care or Payment for Your Care
We may disclose information to individuals involved in your care or in the payment for your care, but we will obtain your agreement before doing so. This includes people and organizations that are part of your "circle of care", such as your spouse, other doctors or an aide involved in your care. Although we must be able to speak with your other doctors and health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family.

CRISP- Chesapeake Regional Information System
We have chosen to participate in the Chesapeake Regional Information System for our patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers required to accept it.

Confidential Communications
You have the right to request in writing that you receive communications containing your protected health information from us by alternative means or location. For example, you may ask that we only contact you at home or by mail. We will consider your request but, are not required to accept it.

Inspect and Copy
You may request access to inspect and copy your medical information in our records, including medical and billing records. Your request must be in writing. We will act on your request within 30 days after we get it. If we must deny your request, we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.

Amendment
You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create the information.

Accounting of Disclosures
You may request a list of uses or disclosures of your protected health information for reasons other than your treatment, payment for services furnished to you, our health care operations, or disclosures you authorized that we have made over the previous six (6) years. You may not request an accounting for dates of service prior to April 14, 2003. Your first request within a 12-month period is free, but we charge for additional lists within the same 12-month period.

Paper Copy of This Notice
You are entitled to receive a paper copy of our Notice of Privacy Practices by using the contact information supplied on the first page.

File a Complaint
If you believe that we have violated your privacy rights, you may file a complaint directly with us using the contact information on the first page. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing.

Authorization for Other Uses and Disclosures
We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based on your original permission.

Patient's Rights
You have certain rights with respect to your medical information.

Requesting Restrictions
You have the right to ask in writing for restrictions on the ways in which we use or disclose your medical information beyond those imposed by law.

Effective Date: April 14, 2003

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Acknowledgement of Privacy Practice Notice

Metropolitan Nephrology Associates will use and disclose your personal health information to treat you, to receive payment for care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to protect health information. The terms of the notice may change with time and we will post the current notice at our facility and have copies available for distribution. By signing this, you acknowledge that you have received, read and understand the **NOTICE OF PRIVACY PRACTICES.**

_____

Patient Signature Date

_____

Printed Patient Name

Please list any individuals, other than medical providers, who you authorize to receive your protected health information from Metropolitan Nephrology Associates.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

8926 Woodyard Rd. #602, Clinton, MD 20735, P: (301) 868-9414 F: (301) 868-6055

11637 Terrace Rd. #103, Waldorf, MD 20602, P: (301) 868-4326 F: (301) 868-6055

2616 Sherwood Hall LN. #209, Alexandria, VA 22306, P: (703) 360-3100 F: (703) 360-6117

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APPOINTMENTS

At Metropolitan Nephrology Associates, we strive to make your visit to our offices as pleasant as possible. We recognize that seeing a physician is often quite stressful, especially for the first visit. We are also aware that your time and our time are very important. We NEVER overbook, meaning that no one else is scheduled for your time slot. This reflects our faith that you will arrive for your appointment on time. This system has worked for us with few exceptions, and we request your cooperation for its continued success. If you are unable to keep your scheduled appointment, please give our office 24 hours notice to avoid a charge of $25. If you arrive more than 15 minutes late for you scheduled appointment, you will need to reschedule.

Many insurance companies will only pay for your visit with a paper referral issued by your primary care doctor. We must have this referral at the time of service. If you do not have a current referral, as may be required by your health insurance plan, you will be responsible for any resulting outstanding balance.

Thank You.

_____ _____

Signature Date

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Metropolitan Nephrology Associates as part of your healthcare team. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill the patient's insurance; however, the patient is responsible for providing the most correctand updated information regarding insurance.
- It is the patient's (or their guardian's) responsibility to understand their insurance benefits, including whether we are a contracted provider with their insurance company, the covered benefits and any exclusions in the insurance policy, and any pre-authorization requirements of the insurance company.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- 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 as part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks.
    - Charge for missed appointments without 24 hours' notice.

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 Name _____

Patient/Guardian Signature _____

Date _____

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PATIENT INFORMATION

DATE: _____

Demographics/Contacts

Last Name: _____ First Name: _____ MI: ____

Sex: ☐ Male ☐ Female DOB: _____/_____/_____ SSN: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State & Zip: _____

Employer: _____ Phone: _____

Referring/Primary Doctor: _____ Phone: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Spouse Name: _____

Emergency Contact Name: _____ Phone: _____

Person Responsible for Payment: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ Phone: _____

Insurance Information

Primary: _____ ID # _____ Group #_____

Subscriber Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ City: _____ State & Zip: _____

Relation to Patient: _____ Phone: _____ Employer: _____

Secondary: _____ ID # _____ Group #_____

Subscriber Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ City: _____ State & Zip: _____

Relation to Patient: _____ Phone: _____ Employer: _____

Other: _____ ID # _____ Group #_____

Subscriber Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ City: _____ State & Zip: _____

Relation to Patient: _____ Phone: _____ Employer: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize METROPOLITAN NEPHROLOGY ASSOCIATES, P.C. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

MEDICATION LIST

Patient Name: _____

Date of Birth: _____

Preferred Pharmacy Name and Address: _____

_____

Are you allergic to any medications? **YES** ☐ **NO** ☐

If yes, please list medication name and reaction.

_____

_____

Medications you are currently taking (prescription and over the counter):

Medication	Dosage	Times per day

Would you like to be registered for our "My Chart" online health records portal? Yes☐ No☐

If yes, please provide your e-mail address: _____

Preferred Laboratory: LabCorp☐ Quest ☐ Other (please specify) _____

_____

Patient Signature Today's Date

MEDICAL HISTORY

PLEASE SELECT ANY CONDITIONS THAT YOU HAVE EVER BEEN DIAGNOSED WITH

- ☐ Acute Kidney Injury
- ☐ Anemia
- ☐ Atrial Fibrillation (A-fib)
- ☐ Cancer (Please specify)_____
- ☐ Congestive heart Failure (CHF)
- ☐ Chronic Kidney Disease (Stage_)
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes Mellitus
- ☐ Diabetic Neuropathy
- ☐ End Stage RenaI Disease (ESRD)
- ☐ GERO
- ☐ Gout
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperkalemia
- ☐ Hyperlipidemia
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyponatremia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Myocardial Infarction (Heart attack)
- ☐ Nephrotic Syndrome
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Polycystic Kidney
- ☐ Pyelonephritis
- ☐ Renal Cyst
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TIA
- ☐ UTI
- ☐ Other (Please Specify)

_____

_____

_____

_____

_____

_____

_____

_____

Surgical History

Please Select and Describe Any Past Surgeries

- ☐ Abdominal Surgery: Year _____ Description_____
- ☐ Bladder Surgery: Year _____ Description_____
- ☐ Cardiac Surgery: Year _____ Description_____
- ☐ Cardiac Stent: Year _____ Description_____
- ☐ Dialysis Access: Year _____ Description_____
- ☐ Gall Bladder: Year _____ Description_____
- ☐ Hysterectomy: Year _____ Description_____
- ☐ Kidney Biopsy: Year _____ Description_____
- ☐ Kidney Removal: Year _____ Description_____
- ☐ Kidney Stone Removal: Year ____ Description_____
- ☐ Kidney Transplant: Year _____ Description_____
- ☐ Lithotripsy: Year _____ Description_____
- ☐ Parathyroid Surgery: Year _____Description_____
- ☐ Thyroid Surgery: Year _____ Description_____
- ☐ Any Additional Surgeries Not Listed Above: _____

_____

_____

Family History

Please Select Any Condition A Member of Your Has Been Diagnosed With

☐ **Hypertension**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Kidney Disease**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Stroke**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Heart Disease**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Dementia**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Gout**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Anemia**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Autoimmune Disease**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Cancer**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

☐ **Diabetes**
Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal GM ☐ Maternal GF ☐ Paternal GM ☐ Paternal GF ☐

Social History

Marital Status:

Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

Living Arrangement:

Alone ☐ Family Member ☐ Spouse In-Home ☐ Significant Other ☐ Caregiver ☐ Assisted Living ☐

Employment Status:

Employed ☐ Unemployed ☐ Retired ☐ Student ☐

Current Occupation: _____

Full-Time ☐ Part-Time ☐

Tobacco Use:

Current User ☐ Former User ☐ Never Used ☐

Length of Use? _____ Amount of Use _____

Length of Use Prior to Quitting? _____ Date of Quitting? _____

Alcohol Use:

Current User ☐ Former User ☐ Never Used ☐

If you are a current used, how many drinks do you consume?

Occasional/Social ☐ 1-2 drinks per day ☐ 3+ drinks per day ☐

If you are a former user, how many years did you consume alcohol? _____ Date of quitting? _____

Recreational Drug Use:

Current User ☐ Former User ☐ Never Used ☐

If you are a current or former user, please indicate the drug or drugs used:

Marijuana ☐ Amphetamines ☐ LSD ☐ Heroin ☐

Ecstasy ☐ Other: (please specify) _____

If you are a former user, how many years did you use? _____ Date of quitting? _____

Review of Systems

Please select any of the below symptoms you have experienced in the past 30 days

Constitutional

- ☐ Fever
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Chills
- ☐ Weakness
- ☐ Night Sweats

Head, Eyes, Ears Nose, and Throat

- ☐ Vision Impairment
- ☐ Eye Pain
- ☐ Redness
- ☐ Color Blindness
- ☐ Double Vision
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Headache
- ☐ Hoarseness
- ☐ Tinnitus
- ☐ Vertigo

Respiratory

- ☐ Shortness of breath
  - ☐ At Rest
  - ☐ With Activity
- ☐ Pain with Breathing
- ☐ Cough
- ☐ Wheezing
- ☐ Blood in Sputum

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Claudication
- ☐ Orthopnea
- ☐ Edema
- ☐ PND

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Heart Burn
- ☐ Vomiting
- ☐ Constipation
- ☐ Loss of Appetite
- ☐ Indigestion
- ☐ Trouble Swallowing

Genitourinary

- ☐ Urinary Urgency
- ☐ Urinary Burning or Pain
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Foamy Urine
- ☐ Incontinence
- ☐ Nocturia

Musculoskeletal

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Arm Weakness
  - ☐ Left
  - ☐ Right
  - ☐ Both

Skin

- ☐ Itching
- ☐ Scaling
- ☐ Dryness
- ☐ Color Change

Review of Systems

Please select any of the below symptoms you have experienced in the past 30 days

Neurological

- ☐ Numbness
- ☐ Tremors Seizures
- ☐ Tingling
- ☐ Fainting

Endocrine

- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination

Hematology

- ☐ Bleeding Gums
- ☐ Easy Bruising

Immuno/Allergy

- ☐ Seasonal Allergies
- ☐ Hives

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia

Please list any additional symptoms not listed above: _____

_____

_____

_____