Peninsula Nephrology Associates, P.A.

MEDICAL HISTORY

Date_____

Name:_____ ☐ Male ☐ Female Date of Birth:_____

SS #_____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorce

Ethnicity: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other

Home #:_____ Wk #:_____ Cell #:_____

Physical Address: _____

City:_____ State:_____ Zip:_____

Emergency Contact:_____ Phone #: _____

E-Mail Address: _____

Primary Care Physician: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

Pharmacy:_____ Location/City:_____ Phone #: _____

Primary Ins Carrier:	Secondary Ins Carrier
Member/Subscriber ID:	Member/Subscriber ID:
Group# Rx	Group# Rx
Mailing Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
Contact Number:	Contact Number:

Check here is you have had any of the following. For relative, please list mother, father, sister, brother, child.

	YOU	RELATIVE		YOU	RELATIVE
Anemia			HIV/ Aids		
Anxiety			Hyperlipidemia		
Arthritis			Hypertension		
Asthma			Kidney/ Bladder/ Urinary		
Auto Immune Disease			Liver Problems		
Bleeding Problems			Lung Problems		
CAD			Nephrolithiasis		
CHF			Neuropathy		
CKD			Neuromuscular Disease		
Cancer			Retinopathy		
Depression			Seizures/ Fits		
Diabetes			Sleep Apnea		
DVT			Stomach, Bowel, GI Problems		
Gout			TB Positive Skin Test		
Hepatitis B or C			Thyroid		
Heart Disease			UTI		
High Blood Pressure					

Social History:
Alcohol: ☐ Never ☐ Daily ☐ Weekly
Tobacco: ☐ None
Cigarettes: _____ Packs Per Day: _____ How Many Years: _____
Cigars/Pipe: _____ Per Day for _____ Years

List all medications and dosages taken on a regular basis, including herbal supplements and over the counter:

Please list all surgeries

Please list any known drug allergies:

Peninsula Nephrology Associates, P.A.
1821 Sweetbay Drive, Suite 1
Salisbury, Maryland 21804
Phone: 410-546-4427 Fax: 410-546-2096

Authorization to Release Protected Health Information

Name (First, Middle, Last)	Date of Birth	SSN

Release Information To

☐ Peninsula Nephrology Associates, P.A.
☐ Other (specify healthcare provider/ facility/company/individual including phone/fax if known)

_____
_____
_____
_____

Release Information From

☐ Peninsula Nephrology Associates, P.A.
☐ Other (specify healthcare provider/ facility/company/individual including phone/fax if known)

_____
_____
_____
_____

Purpose of Release

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Disability Determination
☐ Payment of Insurance Claim ☐ Other:

Information to be Released (Required- check all that apply)

☐ Clinical Notes	☐Hospital Discharge Summary	☐ Lab Reports
☐ Radiology Reports	☐History & Physical ☐EKG'S	☐ Operative Notes
☐ Radiology Images	☐Hospital Notes	☐ Immunization Records
☐ Pathology Reports	☐Billing	☐ Other

My Rights

I understand that authorizing the disclosure of my health information is voluntary. I understand that I do not need to sign this form in order to assure treatment or payment. I may be charged for copies in accordance with state law. I understand that this authorization may include release of the following sensitive medical information unless I have initialed below to exclude such information:

____ - mental health information ____ - sexually transmitted diseases
____ - alcohol and/or drug abuse treatment ____ - AIDS/HIV treatment

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. I understand that I do have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to provider and/or facility releasing the information.

By signing, you agree that you understand and accept the terms of this from. If the patient is incapable of signing, a legally authorized substitute may sign and date the from with proper documentation.

Signature:_____ Date(required) _____

Printed Name of Person Signing (if not the patient) please indicate legal authority:

Name:_____ Date(required)_____

OFFICE POLICY

Peninsula Nephrology Associates, P. A.
1821 Sweetbay Drive, Suite 1
Salisbury, MD 21804
410-546-4427

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality of care in a caring and pleasant atmosphere. To be fair to all our patients, we ask that you read and remember the following policies:

1. Always bring proof of insurance and a photo ID.
2. Let us know if there are any changes of address, phone numbers, etc.
3. Please be on time for your appointment. We have reserved a particular time for you, and we do our best to stay on schedule. Please keep in mind that situations do arise, and we may at times be a bit behind schedule based on patients' needs.
4. We bill to most insurance companies and ask if a referral is needed from your insurance for you to be seen that you take responsibility in making sure we have this prior to your appointment or you can bring one in at the time of your appointment. If we do not have the referral at the time of the appointment, the appointment will be rescheduled.
5. Co-Pays are due at the time of your visit. We accept cash, checks, Visa, Mastercard, and money orders.
6. There will be a $35.00 service fee for all returned checks.
7. Any balance on your account after an insurance payment is made is your responsibility. Payment is expected within 30 days of receipt of the statement sent to you.
8. Please note at times we must correspond with your primary care provider or other specialist in regard to your care and we may do this through email, electronic files and fax.
9. We ask that if you are unable to make your appointment that you call wihtin24 hours to reschedule so that we may get another patient scheduled. No shows present a problem in any office and we just ask as a courtesy that you call us. If you do not call us 24 hours in advance to reschedule or cancel your appointment:
    - ★ Your appointment will be considered a "NO SHOW".
    - ★ You will be charged $50 if it is a consultation and $25 if it is a follow up.
    - ★ We do understand that emergencies arise and do our best to work with our patients the best we can.

AUTHORIZATION

I have read and accept the above office policy, understand it and agree to the terms set forth regarding payment.

Signature: _____ Date: _____

PENINSULA NEPHROLOGY ASSOCIATES, P.A.

Patient Name **DOB**

Financial Agreement and Authorization Form

Consent to Treatment
I hereby consent to receive medical care and treatment as deemed necessary and appropriate by the healthcare providers of Peninsula Nephrology Associates. I understand that this consent applies to routine diagnostic procedures, examinations, and medical treatment. I acknowledge that no guarantees have been made regarding the outcome of such care. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Insurance and Release Authorization
I certify that the insurance information I have provided is accurate and complete. I authorize the release of any necessary information, including medical records, to process this or any related claims and request payment of benefits to be made directly to Peninsula Nephrology Associates. A copy of this authorization may be used in place of the original. I understand and agree that Peninsula Nephrology Associates may bill my insurance company for services provided. I understand I may revoke this authorization at any time by submitting a written request.

Financial Responsibility
I acknowledge that I am financially responsible for all medical services rendered, regardless of insurance coverage. This agreement does not relieve me of my obligation to pay any outstanding balances.

Payment Terms
Peninsula Nephrology Associates, P.A. will issue billing statements on or about the first business day of each month or following insurance payment posting. Payment is due within thirty (30) calendar days of statement receipt. Accounts not paid within this period will be considered past due and in default. A late fee of $10.00 per month may be applied to any unpaid balance.

Collections fees and costs:
If the customer/patient fail(s) to make any payments due hereunder, the customer/patient shall pay all costs of collection, including, but not limited to, court costs, reasonable attorney's fees, and any other collection fees which are incurred by or on behalf of the provider in enforcing payment after default.

Forum:
This Agreement and all matters related thereto, are governed by and construed in accordance with the laws of the State of Maryland. Any legal proceedings arising out of or relating to this Agreement shall be

held in the District or Circuit Courts for Wicomico County, Maryland and Each party irrevocably consents to the jurisdiction thereof.

Contract under seal:

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, execute this agreement under seal with the specific intention that this agreement constitutes a contract under seal.

_____(SEAL)	_____
(Patient's Signature)	Date
_____	_____
Representative's Name (Print)	Representative's Relationship to Participant
_____	_____
Representative's Signature	Date
_____	_____
Witness Signature	Date

Kazi S. Khan, M.D.
Muhammad O. Hanif, M.D.
Himani Pulivarthi, M.D.
Carrie Sterling, CRNP
Tracy R. Grupp, CRNP
Lisa C. Tuner, CRNP

Peninsula Nephrology
Associates, P.A.

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My Chart Authorization Form
Completion of ALL Section is Required- Please Print Clearly

Your Information: (all section required – please print clearly)

Name (last, first, middle initial): _____

Last 4 Digits SSN: _____ Date of birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

MyChart terms and agreement

- I understand that MyChart is intended as a secure online source of confidential health information. If I share my username and password with another person, that person may be able to view my or my child's health information, and health information about someone who has authorized me as a MyChart proxy.
- I agree that it is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe confidentiality may have been compromised in any way.
- I understand that it is my responsibility to ensure that my email address is always current, and that if my email address is not current, I will not receive important messages from MyChart.
- I understand that MyChart contains selected, limited medical information from a patient's health record and that MyChart does not reflect the complete contents of the health record. I also understand that a paper copy of a patient's health record may be requested.
- I understand that my activities within MyChart may be tracked electronically and that entries I make may become part of the medical record.
- I understand that access to MyChart is provided as a convenience to patients and that MyChart Services has the right to end access to MyChart at any time, for any reason.
- I understand that my use of MyChart is voluntary, and I am not required to use MyChart or to authorize a MyChart proxy.

  - o Authorized: I have read, and I agree to the above condition, and I would like to sign up for MyChart.
  - o Opt-out: I have read, and I would like to opt-out of having access to MyChart.

Signature of patient/authorized person Date(required)

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1821 Sweetbay Drive
Suite 1
Salisbury, MD 21801
410-546-4427
Fax 410-546-2096

PENINSULA NEPHROLOGY ASSOCIATES, P. A.

Kazi Khan, MD
Muhammad Hanif, MD
Himani Pulivarthi, MD
Ali Arif, MD
Carrie Sterling, CRNP

Patient Communication Consent to Contact Form

By providing your contact information below and completing this form, you agree to the following:

I hereby consent and authorize Peninsula Nephrology Associates, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City, State, Zip Code: _____

Home Phone Number: _____ Mobile Phone Number: _____

May we leave voicemails or SMS Message on this line: YES or NO

Email Address: _____

May we leave voicemails on this line: YES or NO

Patient Signature: _____ **Date Signed:** _____

Patient Printed Name: _____

Contact Information:

Name of Person: _____ Relationship: _____

Home Phone Number: _____ Mobile Phone Number: _____

May we leave voicemails or SMS Message on this line: YES or NO

Email Address: _____

May we leave voicemails on this line: YES or NO

Administrative policy
Formal Cancellation & No-Show Policy

Purpose:
To ensure timely access to care for all patients and reduce unused appointment time.

Cancellation Requirement:
Patients must provide at least 24 hours' notice if unable to attend a scheduled appointment.
Notice may be provided by phone, patient portal message, or voicemail.

Fees:
- Established Patients: $25.00
- New Patients: $50.00

Fees apply when:
- Less than 24 hours' notice is provided, or
- The patient does not appear for the scheduled appointment ("no-show").

Late Arrivals:
Patients arriving more than 15 minutes late may be asked to reschedule and may be subject to the applicable cancellation fee.

Emergency Exceptions:
Fees may be waived at management discretion for documented emergencies, severe weather, hospitalization, or other extenuating circumstances.

Outstanding Fees:
Cancellation fees are the patient's responsibility and are not billable to insurance.
Outstanding fees must be paid prior to scheduling future appointments.
Three or more no-shows within 12 months may result in dismissal from the practice.

Approved By: Kazi S. Khan, MD (President)
Date:
Date Distributed:

PENINSULA NEPHROLOGY
ASSOCIATES, P.A.

1821 Sweetbay Dr Ste 1
Salisbury, MD 21804
PHONE 410-546-4427
FAX 410-546-2096

11107 Racetrack Rd
Berlin, MD 21811
PHONE 410-973-2731
FAX 410-973-2993

165 Market St Ste 6
Onancock, VA 23417
PHONE 410-546-4427
FAX 410-546-2096

Patient Cancellation Policy Acknowledgment Form

I acknowledge that I have received and understand the Appointment Cancellation & No-Show Policy.

I understand that:

- I must provide at least 24 hours' notice to cancel or reschedule an appointment.
- Established patient missed appointments will result in a $25 fee.
- New patient missed appointments will result in a $50 fee.
- These fees are not billable to insurance and are my personal responsibility.

I agree to comply with this policy.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____