Samir Sutaria, MD
Samir Rajan, MD – Namrata Baxi, MD
NEPHROLOGY & HYPERTENSION

2177 Oak Tree Rd, Suite #204
Edison, NJ 08820

Ph: (908) 769-4735
Fax: (908) 769-4736

PATIENT REGISTRATION FORM

Patient Name: _____
(Last) (First) (Middle)

Birth Date: ___/___/___ **Social Security #:** ___/___/___

Age: _____ **Gender:** (circle) male - female

Race: _____ **Ethnicity:** _____

Language Preference: _____ **Marital Status:** _____

Home Address: _____
(Number) (Street) (Apt #) (City) (State) (Zip Code)

Work Address: _____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

Home Phone No. (___)_____ **Cell Phone No.** (___)_____

Work Phone No. (___)_____ **Email:** _____

Emerg. Contact: _____ **Emerg. Phone No.** (___)_____

Preferred Pharm: _____ **Pharm. Phone No.** (___)_____

Primary Care Phys: _____ **Referring Phys:** _____

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Primary Insurance: _____
Subscriber Name: _____

Subscriber Birth Date: _____/_____/_____
Subscriber Social Security #: _____/_____/_____

Employer: _____ **Effective Date:** ____/____/_____
(Mo) (Day) (Year)

ID #: _____ **Group/Policy#:** _____

Insurance Address: _____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

Secondary Insurance: _____
Subscriber Name: _____

Subscriber Birth Date: _____/_____/_____
Subscriber Social Security #: _____/_____/_____

Employer: _____ **Effective Date:** ____/____/_____
(Mo) (Day) (Year)

ID #: _____ **Group/Policy#:** _____

Insurance Address: _____
(Number) (Street) (Suite #) (City) (State) (Zip Code)

☐ INSURANCE ASSIGNMENT & RELEASE: I certify that I (or my dependents) have insurance coverage with the above listed companies and assign directly to Dr. S. Sutaria all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all financial charges whether or not paid by the insurance company. I authorize the use of my signature of all insurance submissions. Dr. S. Sutaria may use my health care information and may disclose such information to the above named insurance company (ies), and their agents for the purposes of obtaining payment for services rendered and determining insurance benefits, or the benefits payable for related services.

☐ MEDICARE/MEDIGAP AUTHORIZATION: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits made either to me or on my behalf to Dr. S. Sutaria, for any services furnished to me by the provider. To the extent permitted by law, I authorize any holder of medical or other information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Representative_____

PRINT NAME_____DATE:_____/_____/_____

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HISTORY FORM

MEDICAL HISTORY:

Please Circle Medical Problems Listed Below
(Please Include The Duration or Date The Medical Problem Was Diagnosed)

Diabetes	COPD/Lung Disease	Cancer
High Blood Pressure	Leg Swelling/Edema	Lupus
Kidney Disease	Hepatitis B or C	Gout
Protein In Urine	Recurrent Sinusitis	Liver Disease
Blood In Urine	Polycystic Kidney Disease	Heart Attack
Kidney Stones	HIV/AIDS	Congestive Heart Failure
High Cholesterol	Urinary Tract Infection (s)	Enlarged Prostate

Please List Other Medical Problems Not Listed Above:

_____

_____

_____

_____

SURGICAL HISTORY:

Please Circle Procedures/Surgeries Listed Below
(Please Include The Date/Location The Procedure Was Performed)

Kidney Artery Stent	Gall Bladder Surgery	Kidney Biopsy
Bypass Surgery	Colon Surgery	Leg Bypass Surgery
Angioplasty	Carotid Surgery	Bladder Surgery
Coronary Stent	Eye – Laser Surgery	Cystoscopy
Heart Valve Surgery	Prostate Surgery	Urinary Stent Placement
Amputation(s)	Kidney Artery Stenting	Kidney Removal/Surgery

Please List Other Procedures/Surgeries Not Listed Above:

_____

_____

_____

_____

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MEDICATIONS/ALLERGIES:

Please List Your Medications Below

MEDICATION NAME	DOSE (gm, mg, mcg, units)	TIMES PER DAY
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

PLEASE LIST ANY DRUG ALLERGIES:

_____

_____

FAMILY HISTORY:

Please Circle If Any Family History Of Medical Problems Listed

RELATION	AGE	ALIVE or DECEASED	MEDICAL PROBLEMS	CAUSE OF DEATH
Father				
Mother				
Sibling(s)				
Children				

SOCIAL HISTORY:

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Smoking History

_____ Cigs or Packs (Circle) Per Day Total Years _____ Still Smoke: ☐ Yes ☐ No

Tried to Quit: ☐ Yes ☐ No Quit Date:___/_____/____ Want to Quit:☐ Yes ☐ No

Alcohol History

_____ Drinks Per Day for Total Years _____ Still Drink: ☐ Yes ☐ No

Tried to Quit: ☐ Yes ☐ No Quit Date:___/_____/____ Want to Quit:☐ Yes ☐ No

Drug History

Drug Use ☐ Yes ☐ No Type of Drug(s) _____ Still Using: ☐ Yes ☐ No

Tried to Quit: ☐ Yes ☐ No Quit Date:___/_____/____ Want to Quit:☐ Yes ☐ No

Education/Occupational History

Education: ☐ High School ☐ College Degree ☐ Post Graduate

Occupation_____ Retired: ☐ Yes ☐ No If Yes, When? _____

Lead Exposure: ☐ Yes ☐ No

Personal History

Married: ☐ Yes ☐ No Divorced: ☐ Yes ☐ No Widowed: ☐ Yes ☐ No Single: ☐ Yes ☐ No

Sexually Active: ☐ Yes ☐ No

Multiple Partners: ☐ Yes ☐ No

History of Sexually Transmitted Diseases: ☐ Yes ☐ No

History of Blood Transfusions: ☐ Yes ☐ No If Yes, When? _____

History of NSAID Use (Advil/Motrin/Aleve/Ibuprofen Etc..): ☐ Yes ☐ No

History of Herbal Medication Use: ☐ Yes ☐ No

_____

Signature of Patient, Guardian or Representative PRINT NAME DATE

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Associates in Kidney Disease & Hypertension LLC** to use and/or disclose certain protected health information (PHI) which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

This authorization permits **Associates in Kidney Disease & Hypertension LLC** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I understand that while this consent is voluntary, if I refuse to sign this consent, **Associates in Kidney Disease & Hypertension LLC,** can refuse to treat me. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Samir Sutaria, MD/Samir Rajan, MD at:
Associates in Kidney Disease & Hypertension LLC
2177 Oaktree Rd, Suite #204
Edison NJ 08820

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable

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LATE SHOW/NO SHOW POLICY

1. We require a 1 business day (24-hour notice) if you are unable to make your appointment.

2. There will be a $25.00 fee for any missed appointments without 24 hour notice. **Associates in Kidney Disease & Hypertension LLC**, will charge your credit card on file for the date of late show/no show. We make every attempt to remind a patient of their appointment but ultimately, it is **YOU** who is responsible for your appointment.

3. If more than 15-minutes late for your appointment without notice, you will be considered a no-show and be charged $25.00 by **Associates in Kidney Disease & Hypertension LLC** & charge your credit card on file for the date of late show. Your appointment will need to be rescheduled at that time.

4. You will not be seen by the physician if you are more than 15minutes late for your appointment unless if the physician is able to accommodate you later during the day.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable

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CREDIT CARD AUTHORIZATION FORM

CO-PAYS: Co-pays are due at the time of service in cash or check only. If your co-pay is not paid at the time of your visit, **Associates in Kidney Disease & Hypertension LLC**, will be able to charge your credit card on file for the date of service.

SELF-PAY: Payment in cash or credit card only is due in full at the time of service if the patient has no medical insurance. I agree that if I do not present an insurance card, I am assumed to be a self-pay and will be automatically charged the rate listed below. If insurance pays my bill at a later date, the money paid by me will be returned as soon as possible.

- NEW OFFICE VISIT: $150.00, FOLLOW UP VISIT: $90.00, NURSE VISIT: $25.00

DEDUCTIBLES/CO-INSURANCE: If your deductible/coinsurance is not met, you will be responsible for payment of services rendered. Our office will send you one statement bill for any unpaid balance by your insurance company. If remains unpaid, **Associates in Kidney Disease & Hypertension LLC** is permitted to charge your credit card on file for the balance due adjusted after insurance payments. If another provider meets your deductible, **Associates in Kidney Disease & Hypertension LLC** will reimburse you within 30 days of receipt of the explanation of benefits by your insurance company.

PRIMARY/SECONDARY INSURANCE: We may or may not be a participating provider (in-network) with your insurance company. We will bill all insurances that are provided to us at the time of service. It is your responsibility to update the office with any changes to your medical insurance and to find out if our services are in network and/or covered fully with your plan. You shall be responsible for any amounts not covered by your insurance company and **Associates in Kidney Disease & Hypertension LLC**, will be able to charge your credit card on file for the date of service.

REFERRALS/AUTHORIZATIONS: It is the patient's and/or guardian's responsibility to obtain a referral/authorization from their primary care physician and or insurance company. You must have a referral at the time of your office visit. If you fail to provide us with referral, you will be financially responsible for the charges that may occur. Your scheduled visit maybe rescheduled new to the absence of a referral/authorization.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Print Patient's Name — Date

_____
Print Name of Legal Guardian, if applicable

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CREDIT CARD AUTHORIZATION FORM

CARD TYPE: [ ] MASTERCARD [ ] VISA [ ] AMEX [ ] DISCOVER [ ] OTHER _____

CARDHOLDER NAME (as shown on card): _____

CREDIT CARD NUMBER: _____

CREDIT CARD EXPIRATION DATE (Month/Year): _____

CREDIT CARD BILLING ADDRESS:

Apt/House Number & Street: _____

City: _____

State: _____

Zip Code: _____

I, _____authorize **Associates in Kidney Disease & Hypertension LLC** to charge my credit card above for agreed-upon services. I understand that my information will be saved to file for future outstanding bills on my account.

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian, if applicable