Valley Nephrology Associates
A Division of Physicians Care of Virginia, PC

Dear _____:

Welcome to Valley Nephrology Associates. Enclosed you will find forms we need for you to complete. It is very important to have these forms completed as accurately as possible **prior** to your appointment.

You have an appointment with Dr. _____

Date: _____

Time: _____ AM / PM

On the Day of Your Visit:

- Arrive **10 minutes before your scheduled appointment** so we can ensure all the appropriate information is completed prior to your appointment. Otherwise, you may need to be rescheduled.
- Bring all enclosed forms completed.
- Bring your insurance cards.
- Be prepared to make any necessary co-payment at time of visit.
- Bring all medications you currently take. ***It is requested you bring the actual bottle(s) of medication.***
- Bring any diet instructions you are following.
- Be prepared to give a urine specimen.

If you find that you will be unable to keep your appointment or need to reschedule, please call our office at (540) 344-1400 or (800) 333-5369 as soon as possible so another patient who is waiting for an appointment can be scheduled. Please feel free to call our office if you need assistance in completing your paperwork.

We look forward to seeing you and caring for your nephrology needs.

Sincerely,

Valley Nephrology Associates

Directions to:

Valley Nephrology Associates
2602 Franklin Road SW
Roanoke, VA 24014
Phone: 540-344-1400

Business Hours:
8:00 AM – 4:30 PM
Monday – Friday

From I-81 North / South:

- Take Roanoke (Airport I-581) exit.
- Go 7.6 miles and take Wonju/Franklin Road exit.
- Follow Wonju to the traffic light.
- Take a RIGHT onto Franklin Road.
- VNA is a one-story blue-gray building on the LEFT next to Burger King.

From Route 460:

- Go through traffic light at Orange Avenue and Williamson Road intersection to I-581 South (Downtown) exit.
- Go 2.8 miles on I-581 and take Wonju/Franklin Road exit.
- Follow Wonju to the traffic light.
- Take a RIGHT onto Franklin Road.
- VNA is a one-story blue-gray building on the LEFT next to Burger King.

From Route 419 (going East):

- Going past Tanglewood Mall, stay on Route 419 / Electric Road.
- Electric Road becomes Franklin Road.
- Stay straight for approximately 2 miles.
- VNA is a one-story blue-gray building on the RIGHT next to Burger King.

From 220 South:

- Take 220 North towards Roanoke.
- Take the ramp to BUS 220-N (Franklin Road) bearing to the RIGHT.
- Stay straight for approximately 2 miles.
- VNA is a one-story blue-gray building on the RIGHT next to Burger King.

ADULT

Valley Nephrology Associates
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PATIENT INFORMATION

First name: _____ Middle name: _____

Last name: _____ Preferred name: _____

Street address: _____

City: _____ State: _____Zip Code: _____

Home phone: _____ Mobile phone: _____

Preferred contact method (circle one): ▫ HOME ▫MOBILE

Date of birth: _____ Age: _____ Primary language: _____

SSN: _____ Gender (circle one): ▫MALE ▫FEMALE

Race (circle one): ▫AFRICAN AMERICAN ▫ASIAN ▫WHITE ▫AMERICAN INDIAN, ALASKA NATIVE ▫NATIVE HAWAIIN, OTHER PACIFIC ISLANDER

Ethnicity (circle one): ▫HISPANIC ▫NOT HISPANIC OR LATINO

Marital status (circle one): ▫SINGLE ▫MARRIED ▫DIVORCED ▫WIDOWED

Primary care provider: _____

EMERGENCY CONTACT

Emergency contact name: _____ Relationship to patient: _____

Phone number (please list a different number than above): _____

EMPLOYMENT INFORMATION

◯ DISABLED(D1) ◯ HOMEMAKER(H1) ◯ RETIRED(R1) ◯ SELF EMPLOYED(S2) ◯ STUDENT(S1) ◯ UNEMPLOYED(U1)

Employer name: _____ Employer phone number: _____

Employer address: _____

Valley Nephrology Associates
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PRIMARY INSURANCE

Insurance name: _____

Group number: _____

Policy number: _____

Policy holder name: _____

Date of birth: _____

Social security number: _____

Employer's name: _____

Employer's phone number: _____

Employer's address: _____

SECONDARY INSURANCE

Insurance name: _____

Group number: _____

Policy number: _____

Policy holder name: _____

Date of birth: _____

Social security number: _____

Employer's name: _____

Employer's phone number: _____

Employer's address: _____

LEGAL REPRESENTATIVE (if yes is selected, a copy must be provided)

Do you have a living will or medical advance directive? ◯ Yes ◯ No

Do you have a power of attorney? ◯ Yes ◯ No

MRN (office use only)**:** _____

Valley Nephrology Associates

A Division of Physicians Care of Virginia, PC

PATIENT NAME: _____ DOB: _____

1. **CONSENT TO TREAT:** I hereby authorize the physicians and staff of Valley Nephrology Associates, Ltd., a division of Physicians Care of Virginia, P.C. ("Provider"), to perform and hereby consent to such medical treatment and examinations including diagnostic procedures, as may be, in the opinion of *my/the* patient's physician(s), deemed necessary and advisable. If *I/the* patient fails to follow the direction of the health care providers or to carry out the recommended follow-up medical care, *I/the* patient do so at my own risk.

2. **NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, testing or examinations.
I understand that the risks of treatment may include, but are not limited to, infections.

3. **DEEMED CONSENT FOR BLOOD TESTING:** I understand that, under Virginia state law, if a health care provider or a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. For example, exposure could occur due to an accidental needle stick. Patients who have a confirmed positive test result will be given the opportunity for individual face-to-face disclosure of results and appropriate counseling.

4. **ASSIGNMENT OF PAYMENT:** In consideration of medical services to be rendered to *me/the* patient or at *my/the* patient's request, I assign payment to Provider for medical service rendered to *me/the* patient or at *my/the* patient's request paid by my health insurance or liability policy, or other arrangements or plan with a third party that provides payment for medical or health care services or policy of insurance or from any settlement or judgment that comes from any related incident that caused the medical treatment. Pursuant to this assignment, I recognize and understand that if Provider has a contractual relationship with my insurer, Provider will bill my insurer and accept payment in accordance with that contractual agreement. If Provider does not have a contractual relationship with my insurer, I acknowledge and understand that Provider may choose not to accept assignment and/or not to bill my insurer directly. Without a contractual relationship I may be responsible for all service charges, regardless of any representations made by my insurer, and it will be my responsibility to seek reimbursement from my insurer. If I have any questions as to whether my insurer has a contractual relationship with Provider, I may direct those questions to PCV Central Billing Office.

5. **REFERRAL/AUTHORIZATION AND NON-COVERED SERVICES:** I understand that *my/the* patient's insurance, HMO or health benefit plan may require a referral and/or authorization prior to the delivery of this service. I also understand that *my/the* patient's insurance, HMO or health benefit plan may deny payment for services that are not covered or for which the patient is not eligible under the plan or coverage at the time the services are rendered or a determination under the plan or coverage that the services were not medically necessary. I acknowledge and agree that, in the event payment for these services is denied based on the provisions of *my/the* patient's insurance, HMO or health benefit plan, I am fully personally responsible for payment of charges for these services and will be billed directly.

6. **PROMISE TO PAY:** I understand that I owe and unconditionally agree to pay to Provider the full amount charged for the services rendered to myself, my child and/or any patient for which I am legally responsible that are not paid on *my/the* patient's behalf by a third party within sixty (60) days from billing of medical services rendered. I understand that separate bills may be generated for some services. Examples included but are not limited to: physician, diagnostic studies, laboratory, radiology, and/or anesthesia. Additionally, I agree to pay my insurance co-payment, co-insurance or known out-of-pocket expenses, at the time of service. I agree that if Provider must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered, I will pay to the extent permitted by law: (a) any and all costs incurred by Provider in pursing collection including, but not limited to, reasonable attorneys' fees; and (b) any court costs or other costs of litigation incurred.

7. **AUTHORIZATION FOR RELEASE, DISCLOSURE AND USE OF PATIENT INFORMATION (including protected health information):** I understand that Provider uses an Electronic Medical Record. I authorize Provider to obtain *my/the* patient's health information from other health care providers and health care facilities and to release *my/the* patient's health information to any physician involved in my treatment; any health care facility to which *I/the* patient is discharged, transferred and/or presents for treatment; health care providers or others for the purposes of treatment, payment and health care operations including but not limited to billing, healthcare management, discharge planning, quality assurance, bill collection, defense of litigation or anticipated litigation, and/or to any insurance company, review organization or other entity, which is directly or indirectly responsible for payment or review of services provided by our practice. I consent to the use, release and disclosure of *my/the* patient's protected health information for all the above reasons. I understand that my health information may be transmitted in electronic or paper format or verbally. I authorize to access and use my patient prescription information from any health care provider or benefits manager including prescriptions that have been submitted for claims to any insurance plan. I understand that I have a right to request restrictions on how my health information is used or disclosed for treatment, payment and health care operations and that this practice is not required to agree to such a restriction request.

8. **MEDICARE LIFE-TIME SIGNATURE AUTHORIZATION AND ASSIGNMENT:** I request that payment or authorized Medicare/Medicaid benefits be made on *my/the* patient's behalf for any services furnished by Provider. I authorize any holder of medical or other information about *me/the* patient to release to the Centers for Medicare and Medicaid Services, the Virginia Department of Medical Assistance Services and their agents any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or

MRN (office use only)**:** _____

organization to submit claims to Medicare and/or Medicaid for payment. I understand that I am responsible for any deductibles, co-payments and/or any applicable amount of remaining charges.

9. **CONSENT TO WIRELESS TELEPHONE CALLS:** If at any time I provide a wireless telephone number to the practice at which I may be contacted, I consent to receive calls (including autodialed calls and pre-recorded messages, automated reminders) at that wireless number from Provider, its successors and assigns, and its affiliates, agents and independent contractors, including collection agents regarding the services rendered, and/or my related financial obligations.

10. **VALUABLES:** I understand that Provider will not be responsible for any valuables, money or other such personal property left unattended or retained by me/the patient. Accordingly, *I/the* patient assumes the risk of loss or theft of any personal property and agrees to hold Provider harmless from any and all liability which may result from the loss of any such personal property or valuables.

11. **ADDITIONAL PROVISION APPLICABLE FOR MINOR OR OTHER PATIENT FOR WHICH THE UNDERSIGNED IS LEGALLY RESPONSIBLE:** I, the undersigned, acknowledge and verify that I am the legal guardian, custodian or otherwise legally responsible for the patient.

12. **ACKNOWLEDGMENT:** I HAVE READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS AND AGREE TO FOLLOW AND BE BOUND BY THEM. I certify that all information supplied by me, as part of the registration process is correct. By signing this form, I acknowledge that I have been offered and/or received the PHYSICIANS CARE OF VIRGINIA, P.C. Notice of Privacy Practices.

I permit the release of my individually identifiable health information to:

(1) Name: _____

Relationship to patient: _____

(2) Name: _____

Relationship to patient: _____

I hereby authorize the use or disclosure of my individually identifiable health information to the parties identified below as described below. I understand that this authorization is voluntary. I understand if the person/organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I agree a copy of this form may be treated as a signed original.

The information released **may** include all health and information including information records regarding mental health, developmental disability, alcohol or drug abuse and/or infectious diseases (including HIV, AIDS, or AIDS-related conditions) unless specifically requested **not** to include these records.

I, the undersigned, understand that I have a right to revoke this authorization at any time, and that if I revoke this authorization, I must do so in writing and present my written revocation to Valley Nephrology Associates, Ltd. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with right to contest a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal HIPAA privacy rules or regulations. I need not sign this form to ensure healthcare treatment.

Please check one:

○ I would like to receive more information about PCV's free, online patient portal, Follow My Health.

○ I decline PCV's free, online patient portal, Follow My Health, at this time.

_____	_____	_____
Patient Printed Name	Date	Time
_____	_____	_____
Patient or Parent/Legal Guardian Signature	Date	Time
_____	_____	_____
Witness Signature (office staff must sign)	Date	Time

Valley Nephrology Associates
Prenatal New Patient History Form

Today's Date:_____

Last Name:_____ Primary OB doctor:_____

First Name:_____ Primary care doctor:_____

Middle or Maiden Name:_____ Date of Birth:_____ Age:_____

Chief Complaint (Why are you here today?):_____

Allergies (to food, medications, & other substances):_____

Current pregnancy

When is your estimated due date?_____

What are the complications with this pregnancy (kidney or other)?_____

How many pregnancies have you had? _____ Living children?_____ Miscarraiges?_____

Have you had complications with any of your other pregnancies?_____

Your Past Medical History (Have **YOU** ever had the following? Please circle No or Yes. Leave blank if uncertain.):

Diabetes	No	Yes	Back Trouble	No	Yes
Age Diagnosed:_____			Cancer	No	Yes
High Blood Pressure	No	Yes	Asthma	No	Yes
Age Diagnosed:_____			Emphysema	No	Yes
Kidney Disease	No	Yes	Bronchitis	No	Yes
Kidney Stones	No	Yes	Hives or Eczema	No	Yes
Bloody Urine	No	Yes	AIDS or HIV	No	Yes
Urinary Infections	No	Yes	Hepatitis	No	Yes
Angina	No	Yes	Eye Disease	No	Yes
Heart Attack	No	Yes	Blood or Plasma Transfusions	No	Yes
Heart Failure	No	Yes	Bleeding Tendency	No	Yes
Enlarged Heart	No	Yes	Blood Clots	No	Yes
Irregular Heartbeat	No	Yes	Gout	No	Yes
Stroke	No	Yes	Arthritis	No	Yes
Anemia	No	Yes	Liver Disease	No	Yes
High Cholesterol	No	Yes	Lung Disease	No	Yes
Thyroid Disease	No	Yes	Other Diseases:	No	Yes
Alcoholism	No	Yes	_____		
Drug Addiction	No	Yes	_____		

Past Surgical History (list type & date):_____

_____

_____

_____

Previous Hospitalizations (other than above, include date):_____

_____ _____

Review of Systems (please check any recent symptoms that you have been experiencing):

Constitutional
- ❑ Night sweats
- ❑ Weight loss or gain
- ❑ Food tastes like metal/bitter/cardboard
- ❑ Fatigue or weakness
- ❑ Headache

Eyes
- ❑ Blurred or double vision

Ears, Nose, Throat
- ❑ Abnormal noise
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Sinus pain
- ❑ Persistent hoarseness
- ❑ Swollen glands in neck

Cardiovascular
- ❑ Shortness of breath
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Swelling of ankles or feet

Respiratory
- ❑ Chronic cough
- ❑ Coughing blood
- ❑ Wheezing

Hematologic/Lymphatic
- ❑ Easy bruising
- ❑ Abnormal bleeding
- ❑ Past transfusion

Gastrointestinal
- ❑ Nausea or vomiting
- ❑ Abdominal pain
- ❑ Frequent constipation or diarrhea
- ❑ Loss of appetite
- ❑ Difficulty swallowing

Genito-Urinary
- ❑ Burning with urination
- ❑ Difficulty starting / ending urine stream
- ❑ Poor bladder control
- ❑ Sexual dysfunction
- ❑ Blood in urine
- ❑ Frothy urine
- ❑ Dark or tea-colored urine
- ❑ Excessive urinating at night
- ❑ Flank pain
- ❑ Frequent urination

Musculoskeletal
- ❑ Neck pain
- ❑ Joint pain or stiffness or swelling
- ❑ Muscle pain
- ❑ Back pain
- ❑ Leg pain
- ❑ Leg cramps
- ❑ Restless legs

Allergic/Immunologic
- ❑ Allergies
- ❑ Respiratory infections

Neurological
- ❑ Decreased sense of smell or taste
- ❑ Slurred speech
- ❑ Dizziness
- ❑ Seizures
- ❑ Burning feet
- ❑ Numbness or tingling of feet or hands

Mood/Sleep Problems
- ❑ Memory problems
- ❑ Depressed or sad
- ❑ Anxious
- ❑ Change in concentration
- ❑ Change in sleep patterns
- ❑ Daytime sleepiness

Endocrine
- ❑ Cold or heat intolerance
- ❑ Loss or gain of body hair
- ❑ Excessive thirst
- ❑ Abnormal menstrual periods

Skin
- ❑ Rash
- ❑ Itching
- ❑ Dry skin
- ❑ Lesions

Other:_____
_____
_____
- ❑ All others negative

Family History (Has **ANY BLOOD RELATIVE** had any of the following? Circle No or Yes.):

			Relationship				Relationship
Kidney Disease	No	Yes	_____	Birth defects	No	Yes	_____
Bladder reflux	No	Yes	_____	Genetic problems	No	Yes	_____
Kidney infections	No	Yes	_____	Anemia	No	Yes	_____
Kidney stones	No	Yes	_____	Bleeding Tendency	No	Yes	_____
Thyroid Disease	No	Yes	_____	Childhood deafness	No	Yes	_____
Dialysis	No	Yes	_____	Childhood blindness	No	Yes	_____
Transplant: _____	No	Yes	_____	Other Diseases: _____	No	Yes	_____

Social History (please check or circle the correct answers):

Last Flu Shot: _____ Last Pneumonia Shot: _____

Use of Tobacco: ❑ Never ❑ Previously but quit ❑ Current packs per day: ____

Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily: _____

Have you abused any drug? No Yes ❑ Cocaine ❑ Heroin ❑ Marijuana ❑ Prescription Pills ❑ Other: _____

Do you exercise? ❑ Regularly ❑ Sporadically ❑ Never

Do you add salt to food? No Yes

Do you need help with bathing, showering, dressing, going to the toilet, etc.? No Yes

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Who lives with you? _____

Education:_____

Occupation:_____ Current Employment:_____

Are you exposed to: ❑ Fumes ❑ Chemicals ❑ Dangerous Materials ❑ Other:_____

My signature signifies that I have read, answered, and understand the information included in this Patient History Form.

_____ _____

Patient / Parent / Guardian Signature Date NP / MD Reviewer Signature Date

VALLEY NEPHROLOGY ASSOCIATES **Patient Name:**_____

Patient Medication List **Current Medications as of Appointment Date:**_____

It is **VERY IMPORTANT** that we keep an accurate, up-to-date list of your medications to prevent possible complications or drug interactions. You must update this list and bring it with you each time you visit our office. Remember to include medications that are injections, drops, sprays, and lotions.

PRESCRIPTIONS

Name of Medicine	Strength (milligrams)	How many times per day?	When do you take it? Morning, Noon, Night? After Meals?	Who prescribed it for you? (Physician's last name)	Do you have any side effects? If so, explain.

OVER-THE-COUNTER MEDICATIONS, HERBAL REMEDIES, VITAMINS

Drug Allergies	Type of Reaction
1.	
2.	
3.	

Reviewed with Patient

Signature:_____

Date:_____

Rev. 7/5/11