RENAL PHYSICIANS OF MONTGOMERY COUNTY, P.A.

Diplomate in American Board of Internal Medicine Nephrology

200 River Pointe Dr., Ste. 120
Conroe, TX 77304

17191 St. Luke's Way, Ste. 260
The Woodlands, TX 77385

116 Medical Park Ln.
Huntsville, TX 77340

425 Holderrieth Blvd., Ste. 105
Tomball, TX 77375

Phone: 936-756-2555 Fax: 936-756-2534

RPMCKidneydoc.com

We are happy that Dr. _____ referred you to our practice and we look forward to seeing you on _____ at _____ . To help insure the best possible result during your visit, please be aware that your previous medical records from the last 6 months are necessary. If we do not have these records, we will be unable to see you. Please contact your referring doctor's office and obtain copies of your records to bring with you or ask them to fax them immediately to our office at 936-756-2534.

Please bring the following items with you to your appointment

- Insurance and/or Medicare ID cards and a photo ID
- A referral from your primary physician if your insurance requires it
- All new patient paperwork filled out
- Arrive 10 minutes early to process new patient paperwork

Note: If you have NO insurance coverage, payment is due at time of services rendered. If unable to pay at that time, please inform our office staff to make payment arrangements.

MEDICATION REFILL POLICY

We ask our patients to allow 48 hours for medication refills. Please phone your pharmacy first, then they will contact our office for the approval of the refill.

Thank you.

RENAL PHYSICIANS OF MONTGOMERY COUNTY, P.A.

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Personal Information

Date _____

Birthdate _____ Email _____

SS # / SIN _____

Do you have an advanced directive? _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Employer _____ Occupation _____

Referred by _____

Contact Information

Home Phone _____ Pharmacy Phone # _____

Work Phone _____ Ext. # _____

Cell Phone _____ E-Mail _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell Phone

When is the best time to reach you? Time _____ Days _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

Insurance Information

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Employee/Cert. # _____

Ins. Co. Address _____

Deductible _____

Amount already used _____

Max. annual benefit _____

WELCOME

POS Reorder # 1721522

RENAL PHYSICIANS
OF MONTGOMERY COUNTY, P.A.

Patient Name _____ Date of Birth _____

ALLERGIES - DRUG REACTIONS

Pharmacy _____

Pharmacy Phone # _____

Pharmacy Fax # _____

----------(DATE)----------

MEDICATION	STRENGTH	DIRECTIONS	/ /	/ /	/ /	/ /	/ /

MEDICATION LIST

RENAL PHYSICIANS
OF MONTGOMERY COUNTY, P.A.

Welcome to Renal Physicians. Please fill out the information found below to the best of your ability.

Patient name _____ Date of Birth _____ SS # _____

Chief Complaint (reason you are coming to see us) _____

Present Illness: Location of problem _____ Signs/Symptoms _____

Past Medical History: Have you ever had any of the following?

Condition	Yes	No	Parent	Sibling		Condition	Yes	No	Parent	Sibling
AIDS or HIV +						Measles				
Anemia						Migraine/Headaches				
Any other disease						Mitral Valve Prolapse				
Arthritis						Mumps				
Asthma						Pneumonia				
Back trouble						Polio				
Bladder infections						Rheumatic fever				
Bleeding tendency						Scarlet fever				
Blood Transfusion						Smallpox				
Bronchitis						Stroke				
Cancer						Thyroid disease				
Chickenpox						Tuberculosis				
Diabetes						Ulcer				
Diphtheria						Venereal Disease				
Epilepsy						Whooping cough				
Glaucoma										
Heart Disease						Date of last Chest XRay				
Hemorrhoids						Other				
Hepatitis						Other				
Hernia						Other				
High blood pressure						Other				
Hives or Eczema						Other				
Infectious Mono						Other				
Kidney disease						Other				
Low blood pressure						Other				

Allergic/Immunologic:
(history of skin reaction or other adverse reaction)

Condition	Yes	No
Penicillin or other antibiotics		
Morphine, Demerol or other Narcotics		
Novocain or other Anesthetics		
Aspirin or other Pain Remedies		
Tetanus or other Serums		
Iodine, Merthiolate or other Antiseptic		
Other drugs/medications		

Do you use any tobacco products? ☐ Yes ☐ No

If yes, what type and how many each day?

_____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks each week? _____

Previous Hospitalizations/Surgeries/Serious Illnesses: When? Hospital, City & State

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

HEALTH HISTORY

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Patient Name: _____ DOB: _____ SSN: _____

Telephone: Home _____ Cell _____ Work _____

I authorize Renal Physicians of Montgomery County, P.A. to furnish information to insurance carriers concerning my illness and treatments as necessary to process my insurance claim(s). I hereby assign to Renal Physicians of Montgomery County, P.A. all payments for medical service rendered to myself. I understand that I am responsible for any amount not covered by any insurance including all office visits, procedures and injections.

_____ _____

(Signature of Patient) (Date)

There are times when a close friend, caregiver or relative calls our office to ask questions concerning your medical condition, treatment or account balance. We need your authorization to release this information. Without this information, we will not be able to give out your personal information.

(Name)	(Relationship)	(Phone Number[s])
(Name)	(Relationship)	(Phone Number[s])
(Name)	(Relationship)	(Phone Number[s])

I give my permission for information to be given to the people listed above. This information can include, but is not limited to, any and all medical information, including office or hospital visits, billing and account information, appointments and medical records. I understand this information will or could be released to any of my other physicians or any physicians I may be referred to.

Medical Records Release: I give my permission to Renal Physicians of Montgomery County, P.A. to request and release any of my medical records to any physician that requires them for treatment of my medical care.

_____ _____

(Signature of Patient) (Date)

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____ SS # _____

Address _____ Telephone _____

I Hereby Request and Authorize

Physician or Institution _____

Telephone _____ Fax _____

Address _____

TO RELEASE INFORMATION FROM THE MEDICAL RECORDS TO:

RENAL PHYSICIANS OF MONTGOMERY COUNTY, P.A. FAX: 936-756-2534

Treatment Dates _____ **of Medical Care.**

PLEASE SEND: PHYSICIAN DICTATED OR HANDWRITTEN CONSULT OR FOLLOW-UP NOTES, DISCHARGE SUMMARY, OP REPORTS, ALL LABWORK, MRI/MRA REPORTS, U/S REPORTS, CT, EKG, CXR, ALL RADIOLOGY, URINE TEST . . . .

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

I, the undersigned, have read the above and authorize the staff listed above to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected, This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, assigns and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health Information.

Date: _____ Signature: _____

Relationship to Patient: _____

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

(Signature of Patient)

_____

(Date)

_____

(Personal Representative)

_____

(Date)

_____ By initialing here, you are giving Renal Physicians of Montgomery County your permission to use your medical records for reporting purposes.

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It is your responsibility to inform our office if your insurance has changed or been canceled. If you do not inform the office of any insurance changes you will be responsible for the entire cost of your visit and all of the fees and charges related to any treatments, diagnoses, or procedures performed during your visit. The office will not be responsible for resubmitting the charges if you update your insurance at a later date. It will be your responsibility to submit the proper paperwork to your insurance company to recoup any payment that had to be made.

_____

Signature

_____

Date

RENAL PHYSICIANS OF MONTGOMERY COUNTY

Consent to Contact

Dear Sir/Madam,

We value your participation in our clinic and appreciate the trust you place in us for your healthcare needs. As part of our commitment to advancing medical knowledge and improving patient care, we occasionally conduct research studies within our clinic.

We believe that your involvement in these research opportunities could contribute to the development of new treatments and therapies that may benefit not only you but also patients worldwide. Your participation is entirely voluntary, and you have the right to decide whether to take part in any specific study.

If you are open to being contacted about potential research opportunities at our clinic, please provide your consent by signing the consent form below. This permission allows our site staff to inform you about upcoming research studies and discuss the details with you at your convenience.

Rest assured that your privacy and confidentiality are of the utmost importance to us. Any information shared will be handled with the strictest confidentiality, and your identity will remain protected.

Thank you for considering this opportunity to contribute to the advancement of medical knowledge and patient care. If you have any questions or concerns, please feel free to reach out to our research coordinator Dr. Gambo Dangwaran at gdangwaran@careclinresearch.com or by phone on 936-331-8457.

We appreciate your ongoing trust and partnership in our mission to improve healthcare outcomes.

Sincerely,

Dr Harini Bejjanki, MD

Director

Renal physicians of Montgomery County

Consent To be Contacted for Clinical Research

I, _____, hereby agree to be contacted by the staff of Renal Physicians of Montgomery County and Renal Research of Montgomery County, at my convenience, concerning likely clinical trials being undertaken by the clinic. I understand that this is entirely voluntary and does not interfere with my regular care in this clinic.

Full Name: _____ Date:_____