Please fill out this form along with all the documents included in the patient packet and bring it with you for your upcoming appointment.

Be sure to bring your insurance card(s) and your copayment if applicable. We accept copayments in the form of cash, personal check or credit card.

Please call your primary care physician for a referral should your insurance plan require a referral for the visit.

Please complete this form by legibly printing all current medications below.

**CURRENT MEDICATIONS:**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>How Often Taken</th>
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Pharmacy ___________________________ Town ___________________________

Mail Away Pharmacy ___________________________ Phone ___________________________

Preferred Lab Drawing Station ___________________________ Town ___________________________
SOUTH SHORE NEPHROLOGY, P.C.
Patient Registration

Name:_________________________________________________ Gender:___________
Date of Birth___________________________________________ Cell Phone:_____________________
Home Phone__________________________ Address:____________________________________
City:________________________ State:_____ Zip:________
SS#__________________________________ Patient Portal __ Yes __ No
Email:_________________________ Primary Care Physician:________________________
Referring Physician:________________________________________
Emergency Contact:________________________ Relationship:________________________
Emergency Contact Phone:________________________________________

Which best describes your race?  __ White  __ Hispanic  __ Black or African American  __ Asian
__ American Indian/Alaska Native  __ Native Hawaiian or other Pacific Islander  __ Other

Which best describes your ethnicity?  __ Non-Hispanic or Latino  __ Hispanic or Latino  __ Other

Do you have a language preference?  __ English  __ Spanish  __ Portuguese  __ French  __ Other

Authorization for Use and Disclosure of Health Information

If I am referred to another physician by this office, I authorize the release of information necessary to the other physician’s office and, in turn, I authorize their office to send my reports or results to this office. This authorization also applies to any Hospital or Clinic. I authorize that my medical records can be faxed to another physician or hospital, if it is in my best interest.

I authorize general messages and appointment notices to be left on my answering machine if I cannot be reached personally. I authorize that all appointment information can be released to my spouse, partner or significant other.

I authorize the staff of South Shore Nephrology, PC to speak with the following individual regarding my current care and treatment:

Name:_________________________________________ Phone:________________________
Relationship to Patient:________________________________________
Patient Signature:________________________ Date:________________________

Notice of Privacy Practices Acknowledgement and Consent

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by South Shore Nephrology, P.C. and how I may obtain access to and control of this information. Your medical record is protected under HIPAA federal law.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Signature of Patient (or Personal Representative) Date

Description of Personal Representative Authority

Financial Policy

I acknowledge that I have read and understand the terms listed in the Financial Policy of South Shore Nephrology, PC.

Signature of Patient (or Personal Representative) Date
Patient History Form

Name ________________________________
Date of Birth _______________ Age ______
Primary Care Physician____________________________
Which doctor referred you here?____________________
What is the reason your doctor sent you to see a Kidney Specialist_____________________
How long have you known about this problem?
What other doctors have you seen for this problem?
List any medication Allergies

Check the following symptoms that you have/had
___ blood in the urine ___ urine frequently
___ protein in the urine ___ pain on urination
___ foamy urine ___ urinary infection
___ waking to urinate ___ incontinence
___ bedwetting ___ kidney stones
___ prostate problems ___ kidney failure

Past Medical History

Check the following illnesses that you have/had
___ Diabetes ___ Seizures
___ High blood pressure ___ Stroke
___ Heart disease ___ Nerve Damage
___ Heart failure ___ Anemia
___ Heart valve problem ___ Bleeding problems
___ Heart murmur ___ Ulcers
___ High cholesterol ___ GI bleeding
___ Asthma ___ Hepatitis
___ COPD ___ Gallbladder
___ GERD ___ Cancer
___ Sleep Apnea ___ Thyroid disease
___ Tuberculosis ___ Depression
___ Allergies ___ Arthritis
___ Gout ___ Spine disease
___ Vascular disease ___ Osteoporosis

Family Medical History

Which family members have/had
___ Heart disease _________________________
___ Diabetes _____________________________
___ High blood pressure___________________
___ Kidney disease_______________________
___ Stroke _______________________________
___ Cancer _____________________________
___ Blindness ___________________________
___ Deafness ____________________________
Other _____________________________________

Social History

___ Single ___ Married ___ Divorced ___ Widowed
Occupation_______________________________
Previous occupation_______________________
With whom do you live? _____________________
Have you ever smoked? ___ yes ___ no
If so, for how long? _______________________
When did you quit? ________________________

Explain any other Medical problems you may have.
Include dates and treatments if possible.
The physicians of South Shore Nephrology, PC are interested in maintaining a long and healthy relationship with all of our patients. Should you have any questions regarding a bill please call (508) 747-4883 x12.

**Patient Responsibility:**
It is the responsibility of the patient to know your insurance benefits and confirm with your insurance carrier that we participate within your plan. Should your insurance be denied due to inaccurate information or cancellation of coverage, payment in full will be expected for services rendered.

Should your insurance require a referral, it is the responsibility of the patient to obtain the referral from your primary care provider prior to each appointment to ensure our services will be covered. All patients who do not have a referral will be asked to sign a waiver accepting financial responsibility or we reserve the right to reschedule your appointment until a valid referral is on file.

**Appointment Cancellations:**
For patients who are unable to keep an appointment, please call the office within 24 hours of the scheduled visit. A fee of $50.00 will be charged for missing an appointment without prior notice.

**Copays, Coinsurance and Deductibles:**
In accordance with the requirements of your insurance carrier, copayments are due at the time of your visit. Each missed copayment will be assessed a Copayment Billing Fee of $5.00.

If you have a deductible as part of your plan, which applies to visits with our providers, you are responsible for paying this within 90 days. If you have Medicare and you do not have a supplemental insurance policy, the 20% coinsurance will be your responsibility. There is a $25.00 Non-Sufficient Funds Fee due for each check payment returned to us by your bank. The bank automatically charges us for each bounced check.

**Collections and Billing:**
One balance billing statement will be mailed to the patient after insurance payments have been received by our office. Patients who have an outstanding balance over 90 days will incur an additional $30.00 Collection Fee. The fee will automatically be applied to the patient account following 90 days from the date of service.

**Records:**
An Administrative Fee of $15.00 will be charged for forms which must be completed by our staff (medical records copies, disability, family medical leave, medical equipment forms, etc.). The patient requesting the forms will be responsible for this fee.

**Non-Covered Charges:**
All charges not paid by your insurance carrier will require payment in full upon notice of insurance claim denial. This practice is not responsible for services provided that are deemed non-covered. It is your responsibility to know what your insurance covers.

**Insurance/Medicare Patient:**
Medicare patients are responsible for deductible, co-insurance and all non-covered services at the time of service. Medicare assigns a reimbursement determination and the practice agrees to accept this determination allowed by Medicare. As a Medicare patient, I authorize payment of Medicare benefits to be made on my behalf to South Shore Nephrology, P.C. for any services furnished to me by South Shore Nephrology, P.C.

Please sign below to indicate that you have read and understand all of the above statements.

___________________________________________  ______________
Name of Patient (please print full name)        Date

_________________________
Signature
As you may know, your Medical Care Provider is a member of a network of healthcare providers called New England Quality Care Alliance, Inc. (NEQCA) which is a not-for-profit organization. In this Consent Form, you are asked to choose whether or not you will allow a subset of your medical information from this Medical Care Provider, your other NEQCA and Tufts Medical Center (Tufts MC) providers to be viewed in a secure computer network operated by Tufts MC and NEQCA called the Tufts MC/NEQCA Health Information Exchange (HIE). This subset of information, which is further defined in the box below, could be accessed by providers within Tufts MC and NEQCA. Tufts MC and NEQCA may also send this subset of information through any secure means, including mail, fax, secure state-wide health information exchange known as the Massachusetts Health Information Highway (“Mass HIway”), or other secure electronic transmission to other external providers or organizations involved in your care in order to allow your care to be coordinated more comprehensively and seamlessly. Your Medical Care Provider, your other NEQCA and Tufts Medical Center (Tufts MC) providers may also request additional information from these other providers and organizations through any secure health information exchange for your care coordination. This subset of information may also be used to check whether you have health insurance and what it covers and to evaluate and improve the quality of medical care provided to you and other patients. The only individuals that will have access to this subset of your clinical information are your Medical Care Provider, providers in the Tufts MC/NEQCA network, other external providers or organizations involved in your care, authorized personnel of these providers or organizations, NEQCA’s quality and efficiency medical director and personnel, and others whose job it is to maintain, secure, monitor, and evaluate the operation of the Tufts MC/NEQCA HIE. The subset of information will not include your entire medical record. It will only include summary information in the following categories if the information exists in your medical record:

<table>
<thead>
<tr>
<th>Patient demographics</th>
<th>Insurance information</th>
<th>Advance directives</th>
<th>Problems/diagnoses</th>
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<tbody>
<tr>
<td>Allergies and alerts</td>
<td>Medication list (includes medications prescribed by providers outside the Tufts MC/NEQCA network)</td>
<td>Immunizations</td>
<td>Family history</td>
</tr>
<tr>
<td>Social history</td>
<td>Vital signs</td>
<td>Medical test results</td>
<td>Procedures</td>
</tr>
<tr>
<td>Encounters</td>
<td>Medical equipment</td>
<td>Plan of care</td>
<td>Health care providers</td>
</tr>
</tbody>
</table>

The information contained in the HIE is based on standards developed by the Massachusetts Medical Society, the Healthcare Information and Management Systems Society, the American Academy of Family Providers, and the American Academy of Pediatrics (among other organizations). It will include sensitive information from your medical record including, but not limited to, information related to mental health conditions and treatment for these conditions, venereal diseases/sexually transmitted diseases, abortion(s), domestic abuse, rape/sexual assault, substance (drug and alcohol) abuse and treatment for substance abuse, genetic diseases and genetic testing and test results, mammograms, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information and you acknowledge that you are waiving your legal rights under Massachusetts law to specifically authorize disclosure of this information.

You may use this Consent Form to decide whether or not to allow Tufts MC or NEQCA providers to view your medical information in the HIE. You can give consent or deny consent, and you can change your mind at any time by completing a new Consent Form and selecting a different option. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to providers in the Tufts MC/NEQCA network and other providers or organizations involved in your care and, as a result, these providers and organizations may have limits on their ability to coordinate your care.

If you check the “I GIVE CONSENT” box below, your Medical Care Provider, your other NEQCA and Tufts Medical Center (Tufts MC) providers may view your information in the secure computer network operated by NEQCA and Tufts MC, and this information may be accessed by, sent securely to, and requested from authorized individuals, including providers within the Tufts MC/NEQCA network and other providers and organizations involved in my care, for the purposes described in this form.

If you check the “I DENY CONSENT” box below, you are saying “No, Tufts MC and other NEQCA providers may not view my medical information from this Medical Care Provider in the secure computer network operated by NEQCA and Tufts MC. If you deny consent, only basic demographic information and your decision to deny consent will be seen in the HIE.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- I GIVE CONSENT for my Medical Care Provider, my other NEQCA and Tufts Medical Center (Tufts MC) providers to view my information in the secure computer network operated by NEQCA and Tufts MC. Tufts MC and NEQCA may also send my information through any secure means, including mail, fax, secure state-wide health information exchange known as the Massachusetts Health Information Highway (“Mass HIway”), or other secure electronic transmission to other providers or organizations involved in my care, for the purposes described in this form, including for emergency care. I also consent to allow this Medical Care Provider to request additional information from these other providers and organizations through any secure health information exchange. Providing consent today will override any previous denial of consent.

- I DENY CONSENT for Tufts MC and my other NEQCA providers to view my information from this Medical Care Provider in the secure computer network operated by NEQCA and Tufts MC for any purpose, even in a medical emergency. I also deny consent for this Medical Care Provider to request additional information from other providers and organizations involved in my care through any secure health information exchange (i.e. Mass HIway).

Print Name of Patient ___________________________ Patient Date of Birth ___________________________

Signature of Patient or Patient’s Legal Representative ___________________________ Date and Time ___________________________

Print Name of Legal Representative (if applicable) ___________________________ Relationship of Legal Representative to Patient (if applicable) ___________________________
Details about patient information in the Tufts MC/NEQCA HIE and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by providers in the Tufts MC/NEQCA network, other providers or organizations involved in your care, authorized personnel of these providers and organizations, NEQCA’s quality and efficiency medical director and personnel, and others whose job it is to maintain, secure, monitor and evaluate the operation of the Tufts MC/NEQCA HIE only to:
   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients
   - Perform administrative management of the Tufts MC/NEQCA HIE

**NOTE:** The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills.

2. **What Types of Information about You Are Included.** If you give consent, your Tufts MC providers, and your other NEQCA providers may view a subset of information that was placed into the Tufts MC/NEQCA HIE by your Tufts MC and NEQCA providers. Both Tufts MC and NEQCA are not-for-profit organizations. This subset of information could also be accessed by other providers and organizations involved in your care in order to allow your care to be coordinated more comprehensively and seamlessly. This includes information created before and after the date of this Consent Form. This subset of information will not include your entire medical record. It will only include summary information in the following categories if the information exists in your medical record:

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<td>Medical equipment</td>
<td>Plan of care</td>
<td>Health care providers</td>
</tr>
</tbody>
</table>

As part of this Consent Form, you specifically consent to the release of sensitive health information from your medical record, including, but not limited to, information related to mental health conditions and treatment for these conditions, venereal diseases/sexually transmitted diseases, abortion(s), domestic abuse, rape/sexual assault, substance (drug and alcohol) abuse and treatment for substance abuse, genetic diseases and genetic testing and test results, mammograms, and HIV/AIDS.

3. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: providers in the Tufts MC/NEQCA network, other providers or organizations involved in your care, authorized personnel of these providers or organizations, NEQCA’s quality and efficiency medical director and personnel, and others whose job it is to maintain, secure, monitor and evaluate the operation of the Tufts MC/NEQCA HIE.

4. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call your provider’s practice.

5. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by your medical care provider and others authorized to access this subset of information to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. If the receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

6. **Effective Period.** This Consent Form will remain in effect until the day you withdraw your consent.

7. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a new Consent Form and choosing to deny consent for your Tufts MC providers, other NEQCA providers, and other providers involved in your care to view your information in the computer network maintained by NEQCA and Tufts MC, and then giving this form to your Tufts MC or NEQCA Provider. By withdrawing your consent you are also choosing to deny consent for your Tufts MC and other NEQCA providers to: (a) share your information with your other providers and organizations involved in your care through other secure electronic means, including but not limited to secure state-wide health information exchange known as the Massachusetts Health Information Highway (“Mass Hiway”), and (b) request additional information from your other providers and organizations involved in your care through any secure health information exchange. You can also agree to consent in the future by signing a new Consent Form at any time. You can get the Consent Form from your Tufts MC or NEQCA provider’s office. You understand that denying consent will not have an effect on any actions taken prior to such denial.

**Note:** Providers that are directly involved in your care and other individuals authorized by this Consent Form may access your health information through the Tufts MC/NEQCA HIE while your consent is in effect. Providers that treat you at their Tufts MC or NEQCA practice may copy or include your information in your record in their practice. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

8. **Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it.