CONNECTICUT
KIDNEY & HYPERTENSION
SPECIALISTS

www.ctkidneyspecialists.com

PATIENT INFORMATION *(please complete each section completely- PRINT)*			
Patient Name			**Date of Birth**
Sex	Marital Status	Ethnicity	Language (if other than English)
Home Address			**City, State, Zip**
Billing Address (**if different)**			City, State, Zip
Home Phone #		**Cell Phone #**	**Work Phone #**
Preferred form of contact **Text Phone Email**		**Email**	
Referring Physician		Primary Care Physician	Other Provides/Doctor to include:
Preferred Pharmacy		**Location**	**Pharmacy Phone #**
EMERGENCY CONTACT INFORMATION			
Contact Name			**Relationship**
Home Phone #		**Cell Phone #**	**Work Phone #**
PRIMARY INSURANCE			
Insurance name		Address	City, State, Zip
Phone #		Policy #	Group #
SECONDARY INSURANCE			
Insurance name		Address	City, State, Zip
Phone #		Policy #	Group #
SUBSCRIBER INFORMATION FOR INSURANCE			
Name		DOB	SEX
Billing Address		City, State, Zip	Phone #
INTERNET ACCESS			
Do you have access to the Internet [] YES [] NO		If Yes, have you visited our website at ctkidneyspecialists.com [] YES [] NO	
HIPPA-NOTICE OF PRIVACY PRACTICE			

The HIPPA Privacy Rule was created to give individuals the right to restrict the release of their medical information and to designate to whom their information may be given. We are required by State and Federal laws, including the HIPPA rules, to safeguard general and health related information about you. We have created a Notice of Privacy Practices that explains how your protected health information is handled. The Notice of Privacy Practices is provided to patients and or their authorized representatives when they first become a patient in our office. By signing, you are acknowledging that you were offered or received a copy of the Notice of Privacy practices.

I acknowledge that CT Kidney and Hypertension Specialists, LLC has offered or provided me a copy of its Notice of Privacy Practices, describing how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the officer manager: **Grace Butkevicius (203597-9733).** I also understand that I am entitled to receive updates upon request if CT Kidney and Hypertension Specialists, LLC amends or changes its Notice of Privacy Practices in a material way. For additional information please see website: ***ctkidneyspecialists.com*.**

X____ ____________________________________

Signature of Patient or Patient's Representative Date

Printed Name of Patient or Patient's Representative Relationship

INSURANCE AUTHORIZATION - FINANCIAL RESPONSIBILITY POLICY

I request that payment of authorized Medicare benefits be made on my behalf directly to CT Kidney and Hypertension Specialists for services rendered to me. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

CT Kidney and HTN Specialists, LLC participates in a multitude of insurance and health plans to better serve you. With the overwhelming complexity to collect fees from all these plans, we must ask you to take responsibility for understanding your own coverage. We expect co-payments and deductibles to be made at the time of service. The office asks: The patient will be responsible for any or all portions of his or her bill that is not covered by the insurance carrier or if erroneous insurance or health plan information prevents collection of fees from the insurance carrier or health plan. If your insurance requires that you have a referral from your Primary Care provider, it is your responsibility to ensure that our office receives the referral before your visit.

X____ ____________________________________
Signature Date

Witness Date

AMBULATORY BLOOD PRESSURE MONITOR (only) RESPONSIBILITY

By signing below, I am responsible for any damage (s) or loss to the Blood Pressure Monitor while it is in my possession.

Signature ____________________________________ Date____________________________________

CONNECTICUT
KIDNEY & HYPERTENSION
SPECIALISTS

www.ctkidneyspecialists.com

PAST MEDICAL HISTORY: Please check any of the following illness you have or are suffering from:

ACUTE KIDNEY FAILURE		CONGESTIVE HEART FAILURE		THYROID DISORDER	
ANEMIA		CVA/STROKE		VALVE REPLACEMENT	
ATRIAL FIBRILLATION		DVT/BLOOD CLOT		KIDNEY STONES	
CANCER-____________________		DIABETES MELLITUS		SLEEP APNEA	
CHRONIC KIDNEY DISEASE		HEPATITS		PROTEIN IN URINE	
HEART DISEASE-HEART ATTACK		GOUT		PERIPHERAL VASCULAR DISEASE	
COPD/ EMPHYSEMA/ASTHMA		HIGH CHOLESTEROL		SEIZURE DISORDER	
AUTOIMMUNE DISEASE (LUPUS) (SJOGRENS) (RHEUMATOID)		HIGH BLOOD PRESSURE		URINARY TRACT INFECTION	
Other (please list)		Other (please list)		Other (please list)	

SURGERIES: Operation and Date (approximate)

ALLERGIES TO MEDICATIONS/ REACTIONS: (please list)

MEDICATIONS: Please list below or attach a list of meds

Medication	Dose	Frequency		Medication	Dose	Frequency
1.				6.		
2.				7.		
3.				8.		
4.				9.		
5.				10.		

HAVE YOU EVER TAKEN (Circle): Lithium Proton Pump Inhibitors Gentamicin Tobramycin Cisplatinum

FAMILY HISTORY: DO THEY HAVE ANY OF THE FOLLOWING CONDITIONS

Member	Alive	Age	Health Status or Cause of Death	Kidney Disease (Check)	High Blood Pressure (Check)	Kidney Stones (Check)	Diabetes (Check)
Mother	[]Y []N						
Father	[]Y []N						
Brother/Sister	[]Y []N						
Brother/Sister	[]Y []N						
Children	[]Y []N						
Children	[]Y []N						

SOCIAL HISTORY

Marital Status: (check)	[] Married	[] Single	[] Divorced	[] Widowed
Occupation:		[] Retired	[] Disabled	[] Stay-at-home
Hobbies:		Do you live alone?	[] YES	[]NO
Do/Did you smoke cigarettes, cigars or a pipe?		[] YES []NO		
How many do/did you smoke per day? (packs) _________ packs per day				
For how many years? ___________ years		When did you quit? ________________		
Do/Did you drink alcohol? [] YES []NO		# of drinks per day? ____	For how many years? ______	
Do you use illegal or recreational drugs? [] YES []NO		What kind? ____________	For how many years? ______	

IMMUNIZATIONS

PNEUMONIA	INFLUENZA	HEPATITIS B	COVID- 19	SHINGLES/SHINGRIX
Date:	Date:	Date:	Date:	Date:

CONNECTICUT
KIDNEY & HYPERTENSION
SPECIALISTS

www.ctkidneyspecialists.com

GENERAL MEDICAL HISTORY REVIEW: Do you have chronic difficulty with:

		Y	N			Y	N			Y	N
GENERAL	Appetite loss			CARDIOVASCULAR	Chest Pain			MUSCLOSKELETAL	Joint pain		
	Chills				Leg swelling				Muscle aches		
	Fatigue				Leg pain				Dry eyes		
	Fever				Shortness of breath				Dry mouth		
	Weight gain				Palpitations				Hair loss		
	Weight loss			GASTROINTENSTINAL	Constipation				Restless Legs		
SKIN	Rash				Diarrhea				Numbness/Tingling		
	Itchy Skin				Heartburn				Gout		
	Hives				Jaundice				Leg cramps		
HEAD, EARS, EYES	Blurred vision				Liver Disease			HEMATOLOGY	Anemia		
	Change in vision				Nausea				Bleeding Disorders		
	Dry eyes				Vomiting				Easy Bruising		
	Dental problems				Rectal Bleeding				History Blood clot		
	Hearing loss			KIDNEY/UROLOGICAL	Blood in urine			NEUROLOGICAL	Difficulty gait		
	Nose bleeds/Sinusitis				Foam in urine				Headache		
	Mouth ulcers				Frequent urination				Seizures		
RESPIRATORY	Chronic cough				Painful urination				Loss of consciousness		
	Coughing up blood				Urinating at night			ENDOCRINE	Weight Gain		
	Snoring at Night				Incontinence				Weight Loss		
	Difficulty Breathing				History Kidney Stones				Low Blood Sugar		

RENAL SPECIFIC QUESTIONS

Use of Nsaids? - Advil, Motrin, Aleve, Naprosyn, Celebrex, etc.	[] YES [] NO	Duration ____ per week
Use of Proton Pump Inhibitors?-Protonix, Prevacid, Omeprazole	[] YES [] NO	Duration ____ years
Have you ever developed acute kidney injury?	[] YES [] NO	Date
Have you ever required dialysis?	[] YES [] NO	Date
Were you born pre-mature (born before 38 weeks old)?	[] YES [] NO	Weeks
Does anyone in your family have kidney disease or need dialysis?	[] YES [] NO	Member
Have you ever had a kidney ultrasound or images of the kidney?	[] YES [] NO	Where / When

Reviewed: _______________

CONNECTICUT
KIDNEY & HYPERTENSION
SPECIALISTS

www.ctkidneyspecialists.com

Request for Sharing of Medical Information with Family and Friends

Your privacy is important to us. By signing this form, you are acknowledging that you have reviewed the *Notice of Privacy Practices of Connecticut Kidney & Hypertension Specialists* which outlines how Connecticut Kidney & Hypertension Specialists may use and disclose your protected health information. I am aware that I can go to www.ctkidneyspecialists.com to get a copy of the notice or request one at any time.

I am providing permission to leave detailed messages or instructions on my personal cell phone number at ________________________________.

AUTHORIZATION TO RECEIVE MY MEDICAL INFORMATION

Connecticut Kidney & Hypertension Specialists may disclose my personal health information to the following:

Below please identify those individual(s) BY NAME to whom we may release information or speak with on your behalf.

Name	Relationship	Phone Number
	Legal Representative	( ) -

I understand that I may revoke this authorization at any time by providing written notice to Connecticut Kidney and Hypertension Specialists. I understand that the request will not apply to information that has already been released in response to this authorization. CT Kidney and Hypertension Specialists will not use or disclose personal health information beyond the scope of this authorization without my written consent or authorization. I understand that the recipient(s) I designated above may disclose my private health information. Should this occur, I will not hold CT Kidney and Hypertension Specialists responsible.

X________________________________ ____________________

Signature of Patient or Patient's Legal Representative **Date**

________________________________ ____________________

Patient's Printed Name or Patient's Legal Representative **Relationship (if signed by another person)**

CONNECTICUT
KIDNEY & HYPERTENSION
SPECIALISTS

www.ctkidneyspecialists.com

OFFICE POLICIES AND PROCEDURES

Cancellation / No Show Policy

At Connecticut Kidney & Hypertension Specialists, we do our best to schedule your appointment in a timely manner. We ask that you notify our office **more than 24 hours** prior to your scheduled appointment if you must cancel. It is our office policy to charge $50 for a new patient and $30 for established patients that **No-Show** for their appointment or do not provide more than 24 hours cancellation notice. Thank you for your understanding.

Arrival Time/ Late Policy

We make every attempt to see you at your appointed time. To ensure that we run on time, we ask that **new patients arrive 20 minutes and established patients arrive at least 5 minutes prior to their appointment time**. If you are running late we may need to reschedule your appointment. If your provider does agree to see you late, you will be handled as a work-in appointment and will be seen when the schedule allows so that other patients' appointments remain on time.

Patient Information/ Patient Portal

In order to maintain accuracy in your patient record, we require that you give our office current information at every visit. This includes your name, changes to address or telephone number, changes to your insurance, changes in your medications, and your pharmacy. At your visit, we will ensure that you have access to our portal. In addition, a summary of your visit and the results of any labs drawn in our office are available through the portal.

Insurance and Payments

Connecticut Kidney & Hypertension Specialists will file claims with most insurance companies. We ask that you pay any and all required payments at the time of service. Required payments may include your co-pay or the full visit charge if you do not carry insurance. If your insurance company requires a referral for you to see us, we will attempt to obtain this referral prior to your visit. If your Primary Care Physician does not provide a referral, we will contact you for your assistance or to reschedule your appointment. If you have questions about what you will be expected to pay or whether a referral is needed, please contact our billing department prior to your appointment. We accept the following forms of payments: cash, check or credit card (including MasterCard, Visa, Discover, and American Express).

Medication Refill Policy

We require that you bring all of your medications, including any over-the-counter medications, to your appointment. If you need a refill between these visits, you must ask your pharmacist to submit an electronic refill request, or you may call the office and leave a message on the recorded line. We will address refill requests within 48 hours. If you call after hours or on weekends, the on-call physician may only refill your prescription for up to 5 days. If the medication you take requires renewal of a prior authorization, your refill may be delayed. Our office is not responsible for the timing of prior authorization approvals by your insurance company but will work with them to get these approved as soon as possible.

Refund Policy

If you are due a refund on your account, and you have not received payment in a timely fashion, please call our billing department to assure that we have your account posted correctly.

Thank you for understanding. I acknowledge receiving and reading this information:

X____ ____________________________

Patient Signature / Guardian or Authorized Representative **Date**

____ ____________________________

Printed Name of Authorized Representative **Relationship to Patient**