ADULT HYPERTENSION &
KIDNEY SPECIALISTS, LLC

Pius Kurian, MD, FACP, FASN, FASH

BOARD CERTIFIED SPECIALIST IN:

- **KIDNEY DISEASE**
- **ADULT HYPERTENSION**
- **DIALYSIS THERAPY**
- **INTERNAL MEDICINE**

PRIMARY OFFICE LOCATION

2200 North Limestone St
Suite 114
Springfield, Ohio 45503
937-322-7364 (Phone)
937-322-3800 (Fax)

SATELLITE OFFICES

Urbana
Fairborn

DIALYSIS CENTERS

DaVita Midwest Dialysis Center
2200 N Limestone St Suite 104
Springfield, Ohio 45503

DaVita Midwest Dialysis Center
1266 North Broad St
Fairborn, Ohio 45324

DaVita National Trails Dialysis
167 Tuttle Rd
Springfield, Ohio 45505

DaVita Midwest Dialysis Center
1430 US Highway 36 E Suite A
Urbana, Ohio 43078

HOSPITAL AFFILIATIONS

Springfield Regional Medical Center
Mercy Memorial Hospital

Dear New Patient,

Welcome to Adult Hypertension and Kidney Specialists, LLC—a practice of Pius Kurian, MD—for your Hypertension and Kidney Disease care.

We are pleased that you and your doctor have entrusted your care to us.

Please complete the enclosed forms in advance of your first appointment with Dr. Kurian. This will help us to assemble all the necessary information to provide you with our best possible high-quality care and treatment.

Please use black ink to complete your forms. Please bring all insurance cards, pharmacy information, driver's license (or photo ID), and most importantly ALL OF YOUR MEDICATIONS (not a list) in their bottles/containers.

If you need assistance filling out your forms, do not hesitate to call our office at 937.322.7364.

Please arrive 30 minutes prior to your appointment, bringing with you all your completed forms, insurance cards, ID, and medications. This will help prevent any delay in your visit time.

If you have been treated by a physician or hospital recently, please notify our staff prior to your visit so we can contact the appropriate facility and obtain any medical records that will assist in your care.

Once again, welcome to our practice. We look forward to providing you with quality care.

Sincerely,

Adult Hypertension and Kidney Specialists, LLC

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Patient Registration Form

First Name_____MI_____ Last Name_____DOB_____

Address_____City_____State____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

SS#_____-_____-_____ Sex: M F Email Address_____

Ethnicity: (circle one) American Indian, Alaskan Native, Black/African American, Bi-Racial, White/Caucasian, Middle Eastern, Hawaiian/Pacific Islander, Unknown/Other

Employed: Y/N PT/FT Employer:_____Address:_____

Marital Status: M S D W Sep SO Spouse Name_____Spouse DOB_____

Do you have a Living Will? Yes No Preferred Language_____

Emergency Contact: Name_____Relationship_____Phone_____

If patient in NOT the subscriber (carrier of insurance) please provide the following:

Primary Insurance:_____Subscriber Name:_____Relationship:_____

DOB:_____ Employed: Y/N PT/FT Subscriber Name of Employer:_____

Secondary Insurance:_____Subscriber Name:_____Relationship:_____

DOB:_____ Employed: Y/N PT/FT Subscriber Name of Employer:_____

Primary Care Physician:_____Address:_____Phone:_____

Referring Physician: (if applicable)_____Phone:_____ Please read and initial each line. If you have questions, please ask/call for assistance.

1. _____ I have given the office my current and correct insurance information.
2. _____ I understand that I could be charged $30 for missed appointments if 24hr notice is not given.
3. _____ I understand that I could possibly be discharged from the practice for multiple missed appointments.
4. _____ I understand that my co-payment is due at each visit.
5. _____ I understand that I may be responsible for charges related to the completion of forms and letters.

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

Signature of Responsible Person_____Date_____

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Patient History Form

Name:_____DOB:_____Age:_____Date:_____

KIDNEY DISEASE:

Have you ever been told you have a kidney disease or had to see a nephrologist or urologist?	Yes	No
Have you ever had a kidney biopsy?	Yes	No
Have you ever been told you have blood or protein in your urine?	Yes	No
Have you ever had a kidney stone?	Yes	No
Have you ever had surgery on your kidneys, urinary bladder, or prostate?	Yes	No

DIABETES:

Have you been told you have diabetes?	Yes	No
If yes, how long ago?	_____	
Do you take insulin?	Yes	No
Do you check your blood sugar levels?	Yes	No
Do you see an eye specialist for diabetes?	Yes	No
Have you had a procedure to treat diabetic eye disease?	Yes	No

HIGH BLOOD PRESSURE:

Have you ever been told you have high blood pressure?	Yes	No
If yes, how long ago?	_____	
Do you take blood pressure medication?	Yes	No
Have you ever been hospitalized or in the emergency room due to high blood pressure?	Yes	No
Do you check your blood pressure?	Yes	No

PLEASE DESCRIBE IF YOU HAVE HAD ANY BLOOD PRESSURE MEDICATIONS THATY YOU HAVE NOT TOLERATED WELL OR HAD A REACTION TO WHILE TAKING.

_____

_____

ILLNESS, PLEASE PLACE A CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING:

Heart Attack__	Congestive Heart Failure__	Stent Placement__	Angiogram__
Stroke__	Seizures__	Chronic Lung Disease__	Asthma__
Cancer__	Liver Disease__	Anemia__	Blood Transfusion__
Depression__	Blood Clots__		

Name:_____DOB:_____Age:_____Date:_____

FEMALE PATIENTS:

# of pregnancies_____ # of children_____

Were you treated for high blood pressure, toxemia, or eclampsia/preeclampsia during pregnancy? Yes No

SURGICAL HISTORY:

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

Surgery_____ Year_____ Hospital_____

***Please use other side of sheet to list additional surgeries as needed.**

DIET: Regular_____ Low Salt_____ Vegetarian_____

Foods to avoid as directed by Physician_____

Meals are: Cooked at home _____/per week, Restaurant_____/per week, Fast food_____/per week

DO YOU…

SMOKE: No Previously Currently

Usage: _____packs per day for _____years

DRINK ALCOHOL: No Previously Currently

I currently have _____drinks per Day or Week (circle one)

DRINK CAFFEINE: No Yes _____cup(s) coffee/tea/soda per day

EXERCISE: No Yes _____ times per week

FAMILY HISTORY: Have any relatives (especially parents, brothers, sisters, your children) been told they have kidney disease? Yes No

If yes, please explain:_____

Name:_____DOB:_____Age:_____Date:_____

MEDICATIONS:

Please note, it is very important for us to have a thorough and accurate list of your medication(s) at each and every visit. Please include medications that have recently changed or been stopped/started, also include over the counter medications and vitamins.

Medication	Dosage	Frequency

***Please use back of sheet to list additional medications/vitamins.**

Name:_____DOB:_____Age:_____Date:_____

ALLERGIES: Please list all medications/environmental allergies, use other side of sheet to list additional.

Allergen- (example: Penicillin)	**Reaction-** (example: Hives)

For the following questions please answer on a scale of 0-5, using the following ranking:

0=Not at all 1=Less than 1 time in 5 2=Less than half the time 3=About half the time

4=More than half the time 5=Almost all of the time

Over the past month, how often have you had a feeling of not emptying your bladder completely after you finished urinating?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how often have you had a weak urinary stream?	**0**	**1**	**2**	**3**	**4**	**5**
Over the past month, how many times did you usually get up to urinate from the time you went to bed at night until the time you got up in the morning?	**0**	**1**	**2**	**3**	**4**	**5**

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HIPAA

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner for appointments and results: (Check all that apply)

- Home/Cell Phone Home/Cell Number_____
  - Leave message with appointment date and time
  - Leave message with test results
  - Leave message with call back number only
- Work Phone Work Number_____
  - Leave message with appointment date and time
  - Leave message with test results
  - Leave message with call back number only
  - Do NOT leave message

Signature of Responsible Person_____Date_____

Printed Name_____Date of birth of patient_____

The Privacy Rule generally requires healthcare providers to use reasonable steps to limit the use of, disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in an emergency.

The following names listed are those that I give Adult Hypertension And Kidney Specialists, LLC the authorization to give health information regarding bloodwork, appointments, and test results to:

_____Relationship_____

_____Relationship_____

_____Relationship_____

_____DO NOT PROVIDE health information regarding blood work, appointments, and test results to anyone but me.

My signature below acknowledges that I have been provided a copy of the Notice of Privacy Practices (Version effective 9/9/2013)

Signature of Patient/Legal Guardian_____Date_____

If patient refuses to sign acknowledgement please indicate: Date:_____ Name of person providing notice:_____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your **protected health information (PHI)** to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information (PHI). PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosure of PHI

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits success to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any change. You then have the right to object or withdraw as provided in this notice.

Complaints: You may file a complaint with us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide this notice of our legal duties and privacy practices with respect to Protected Health Information (PHI). If you have any objections to this form, please ask to speak to our HIPAA compliance officer in person or by phone at our main phone number.