Nephrology and Wellness
Kimberly Williams, MD
42286 Veterans Avenue, Hammond, La 70403
1970 N. Hwy 190, Covington, La 70433
309 W. Walnut St, Ste. E, Amite, La 70422
Phone (985)902-8853 Fax (985) 902-8854

PATIENT INFORMATION

Date: _____ Referring Physician: _____
Name:_____Date of Birth:_____
(Please circle): Male Female Marital Status: Married Single Widowed Divorced
Mailing Address: _____
_____ Home/Cell: _____
SSN:_____Driver's License :_____
Employer: _____
Emergency Contact: _____
Emergency Contact Phone: _____
RESPONSIBLE PARTY(IF DIFFERENT FROM PATIENT): _____
DATE OF BIRTH: _____ADDRESS:_____
_____
PHONE: _____
EMAIL ADDRESS: _____

INSURANCE COVERAGE Primary:_____Secondary:_____
Subscriber SSN (IF DIFFERENT FROM PATIENT):_____

PLEASE READ AND SIGN. I request that payment of authorized health plan benefits be made on my behalf to Dr. Kimberly Williams (Nephrology and Wellness) for any service furnished by the physician/ facility/ supplier. I authorize any holder of medical information about me to release to Dr. Kimberly Williams & its agents. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay any claim. Your signature authorizes release of information to the insurer or agency shown.

_____ _____
Print Name Signature

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Name: _____ Date of Birth: _____

Past Medical History (Circle all that apply)

Coronary Artery Disease	CABG
Tachycardia	Valve Replacement
Atrial Fib	Coronary Stents
Heart Failure	Angiogram
Hypertension	Angioplasty
Elevated Cholesterol	Pacemaker
Kidney Stones	Kidney Disease
Asthma	CVA/ TIA
Diabetes	Defibrillator

Other_____
_____

Social History(Circle all that apply)

Smoker Y N
If Y, How much _____
Quit Y N When: _____
Alcohol Use Y N How much_____
Street Drugs Y N When_____
Exercise _____
Employment _____
Race _____
Preferred Language_____

DRUG ALLERGIES Yes or No
List: _____

Chief Complaint(s) Circle all that apply

Weight Loss/ Gain	Weakness
Fatigue	Imbalance
Allergies	Vision Changes
Chest pain/Tightness	Loss of Consciousness
Palpitations	Neuropathy
Shortness of breath	Depression/Anxiety
Leg swelling	Mood Changes
Cough	Nausea/Vomiting
Wheezing	Stomach Pains
Rash	Post Nasal Drip
Itching	Sinus Congestion

Medication List (Dose/ Frequency)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Continue meds on back if needed

PHARMACY PHONE & ADDRESS:

_____

_____

RELEASE OF INFORMATION

KIMBERLY WILLIAMS, MD

Phone:

DATE: _____ To
Whom It May Concern:

I hereby authorize _____
To disclose any and all information with respect to any illness, injury, medical history, consultation, prescription or treatment, as well as copies of the following selective parts of my medical records to Dr. Kimberly Williams

→ Summary Sheet (History and Physical)
→ Most Recent two office visits
→ Most Recent two sets of lab results
→ Any x-ray, ultrasound, MRI reports for the past year

A photo static copy of this authorization shall be considered as effective and valid as the original.

Patient's Signature: _____

Patient's Name: _____

Patient's Date of Birth: _____

Witness: _____ Date: _____

_____

Physician's Name: KIMBERLY WILLIAMS, MD.

Address: 42286 Veterans Avenue HAMMOND LA, 70403
Phone 985-902-8853

Fax 985-902-8854

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AUTHORIZATIOIN TO RELEASE MEDICAL INFORMATION TO INDIVUDUAL(S)/FAMILY MEMBER(S)

In accordance with the Federal government's privacy rule implementation of the Health Insurance Portability and Accountability Act of 1996(HIPPA), in order for your physician or staff of Nephrology and Wellness to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I do not authorize the practice to release any or all information concerning my medical care to any individual except as set forth above
_____ I authorize the practice to verbally release any or all information concerning my medical care to The following Individual(s):

_____

_____

_____ _____
Name Relationship to patient

_____ _____
Patient Signature Date

_____ _____
Witness Date

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PATIENT PAYMENT RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Copayments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. If my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS I hereby authorize and direct payment of my medical benefits to **Nephrology and Wellness** on my behalf for any services furnished to me by the providers.

AUTHORIZATION TO RELEASE RECORDS I hereby authorize **Nephrology and Wellness** to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

MEDICARE REQUEST FOR PAYMENT I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in **Nephrology and Wellness**. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

24 Hour Cancellation and "No Show" Fee Policy Therefore, **Nephrology and Wellness** reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

_____ _____
Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____
Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

ADVANCED DIRECTIVE
(LIVING WILL)

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Patient: _____

Date of Birth: _____

A living will allow you to state your wishes about your medical care. If you become terminally and irreversibly causing you to no longer can make your own medical decisions. In addition, the living will declaration allows you to designate a person, known as an agent, to make your health care decisions for you in the circumstance that you become terminally and irreversibly ill. Your living will go into effect when your doctor(s) determine that you are terminal and are no longer able to make your own medical decisions.

_____ I DO Have a Living Will

_____ I DO NOT Have a Living Will

_____ _____

Patient Signature Date