ASSOCIATED NEPHROLOGY CONSULTANTS
Kidney disease and treatment

1997 Sloan Place Suite 17, Maplewood MN 55117
Phone: 651-772-6251 Fax: 651-224-9661

Dear_____,

Welcome to Associated Nephrology Consultants. Your appointment is scheduled with:

___Shannon Doyle, MD
___Maryyam Ali, MD
___Jennifer Nelson, PA-C
___Jennifer Mears, FNP, BC
___Ella Harpole, PA-C, RD
___Cara Walz, MD
___Nyan Pyae, MD
___M. Kate Schmidt, CNP
___Amy Sibley, CNP
___Alec Otteman MD
___Yekaterina Kuzmenko, MD
___Dane Rasmussen, PA
___Megan Washek, PA
___Kate Dynan, CNP

On M T W TH F _____ at _____am pm

Office Location: _____1997 Sloan Place # 17
Maplewood MN 55117

_____ 7300 147th St W, Ste # 500
Apple Valley, MN 55124
Foley Eye Clinic - 5th floor of Nystrom & Associates Building

You will find several forms enclosed in your new patient information packet. Please complete these and bring with you to your first visit – please do not mail. Your referring doctor has given us limited clinical information about your medical condition, however, the personal information you provide will allow us to better serve you.

Please arrive **20 minutes before your scheduled appointment** to complete the registration process or you may be asked to reschedule your appointment. You may be contacted by one of our staff members prior to your appointment to allow for pre-registration of some of your information.

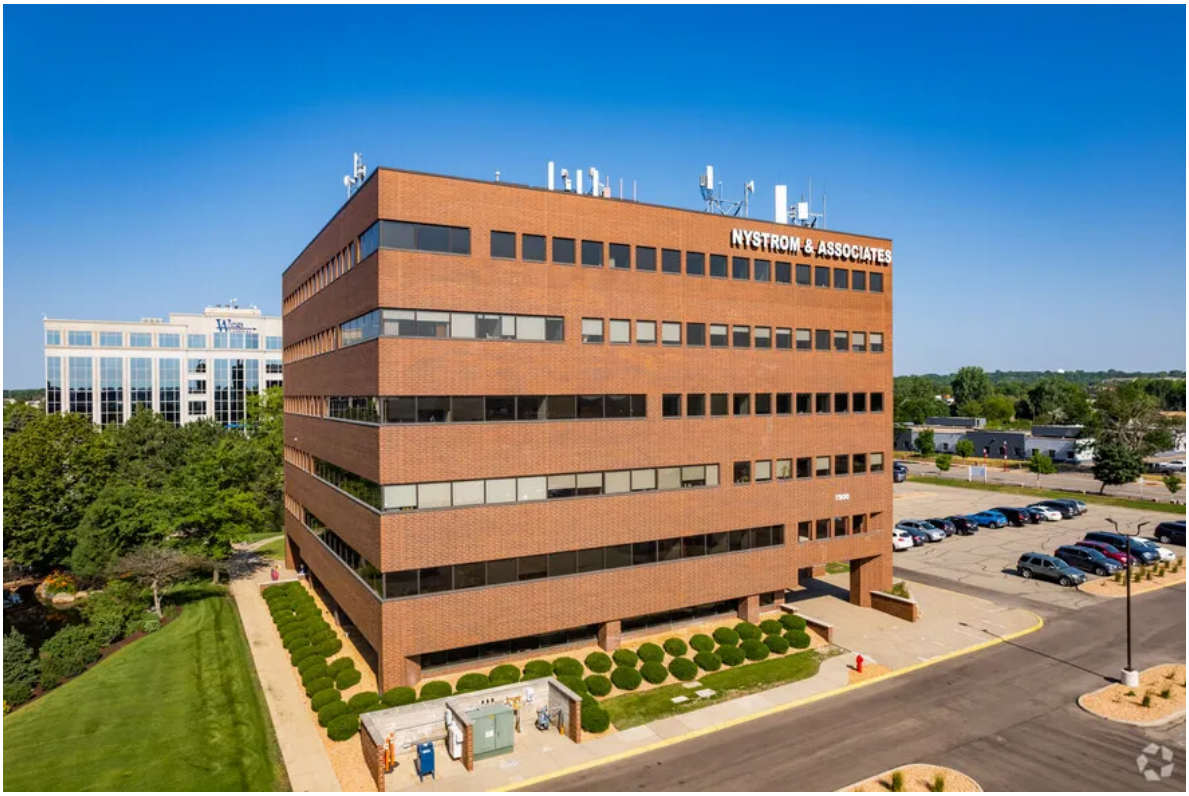
We look forward to serving your health care needs. If, for any reason, you are unable to keep your appointment, please call us as soon as possible to allow us to be of service to other patients needing care. **IF CANCELLATION IS NOT RECEIVED 24 HOURS IN ADVANCE TO YOUR SCHEDULED APPOINTMENT OR YOUR APPOINTMENT IS MISSED, YOUR REFERRING DOCTOR WILL BE NOTIFIED AND YOU WILL BE CHARGED $50.00. RESCHEDULED APPOINTMENTS MAY TAKE SEVERAL MONTHS TO ACCOMMODATE.**

Thank you!

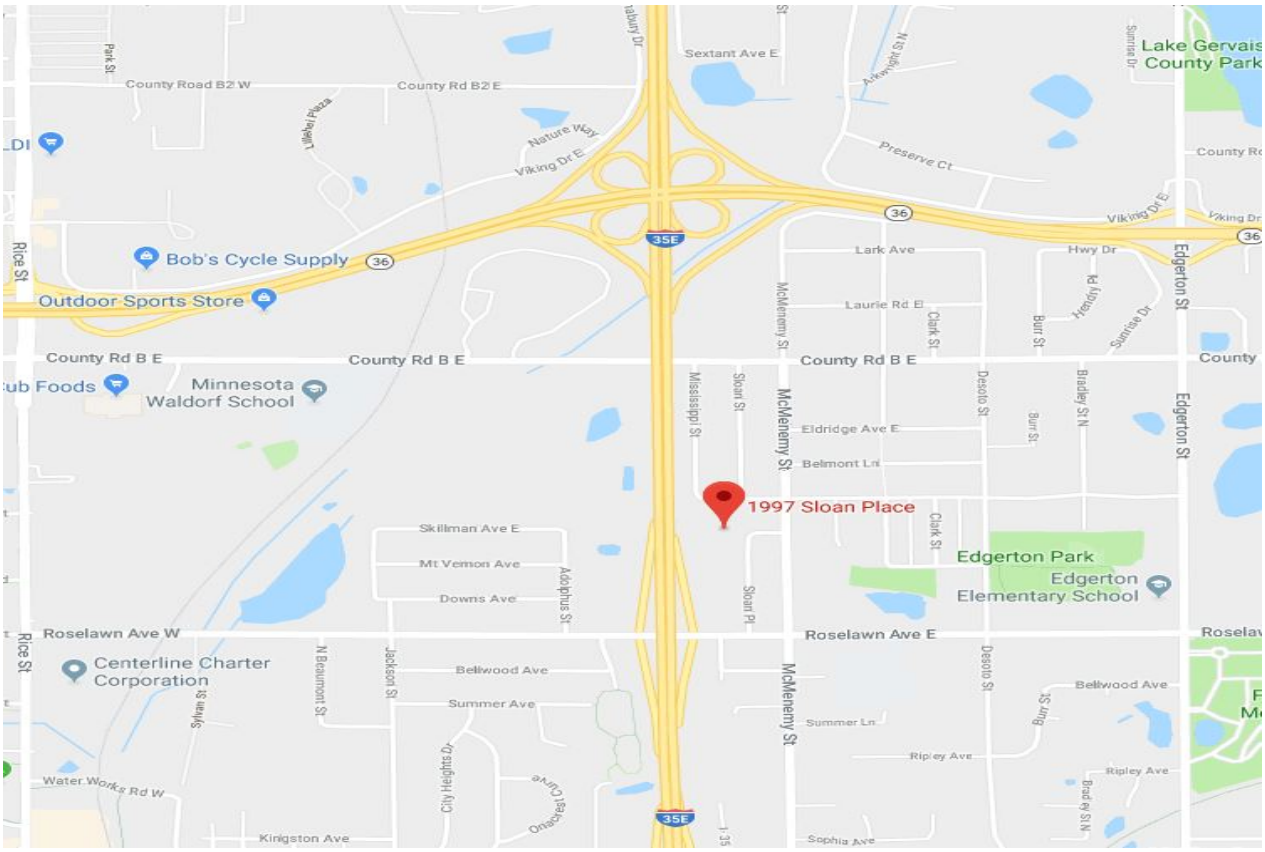
Locations

1997 Sloan Place, Maplewood

7300 147th St., Apple Valley



1997 SLOAN PLACE, STE 17, MAPLEWOOD



From Little Canada (North)
Take I-35E South
Take Exit 110B for Roselawn Ave
Turn Left onto Roselawn Ave E
Turn Left onto Sloan Place
Building will be on the left

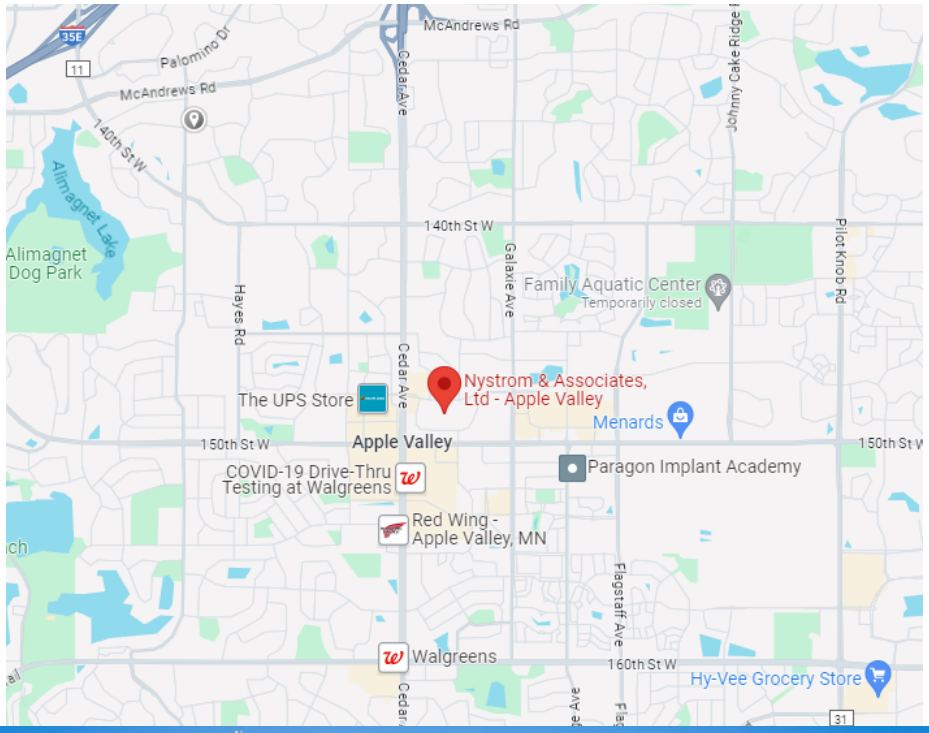
From St Paul (South)
Take I-94 W
Take Exit 242B for I-35E N/US 10 W
Merge onto I-35E N/US-10 W
Take Exit 110B for Roselawn Ave
Turn Right onto Roselawn Ave E
Turn Left onto Sloan Place
Building will be on the left

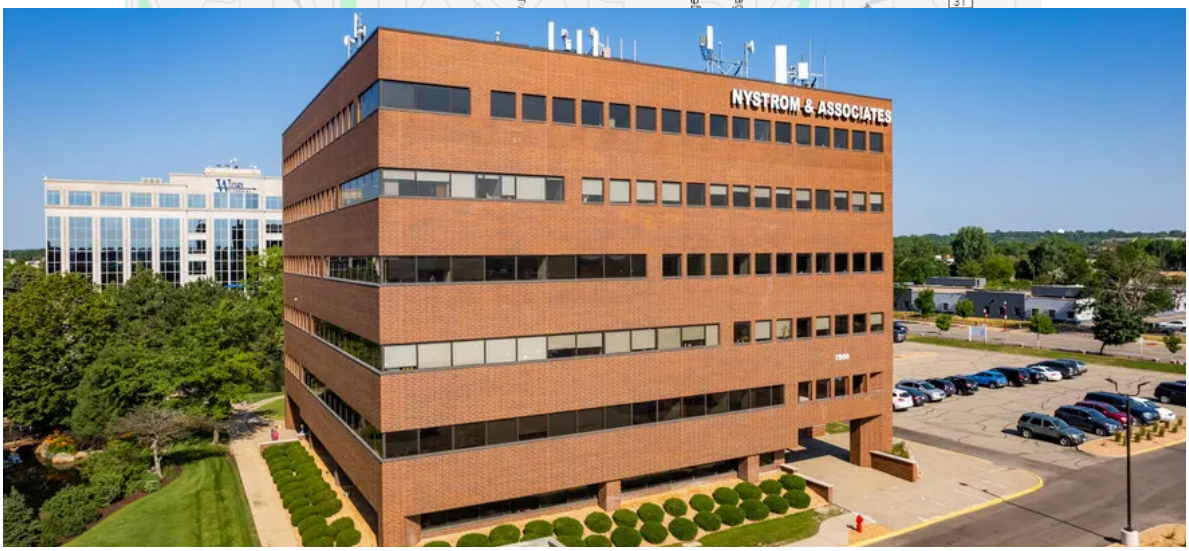
From Oakdale (East)
Take I-94 W toward St Paul
Take Exit 242B for I-35E N/US 10 W
Merge onto I-35 E N/US-10 W
Take Exit 110B for Roselawn Ave
Turn Right onto Roselawn Ave E
Turn Left onto Sloan Place
Building will be on the Left

From Minneapolis (West)
Take I-35 W N
Keep right at the fork to continue on MN-36 E
Take Exit onto I-35E S/US-10 E toward St Paul
Take Exit 110B for Roselawn Ave
Turn Left onto Roselawn Ave E
Turn Left onto Sloan Place
Building will be on the Left

Foley Eye Clinic - Apple Valley

Nystrom & Associates Building: 7300 147th St. W.
Suite 500 - 5th floor





From Minneapolis (North)
Get on I-35W S
Continue on I-35W S. Take MN-77 S to Cedar Ave in Apple Valley
Take Cedar Ave to 147th St. W
Left onto 147th St.
Building will be on the Right

From Farmington (South)
Head West toward Cedar Ave
Turn right onto Cedar Ave/Dakota County 50 W
Continue to follow Cedar Ave until 147th St W
Turn right onto 147th St W
Building will be on the Right.

From Hastings (East)
Take Hwy 55 W/8th St W
Turn Left onto 145th St
145th becomes 150th St W - continue
Turn Right on Galaxie Ave
Turn Left onto 147th St, building will be on the left

From Prior Lake (West)
Take I-35 N
Keep right at the fork to continue on I-35E N
Follow signs for St Paul
Take exit 88B for Co Rd 42, and turn right onto Co Rd 42.
Follow Co Rd 42/150th St. until 147th St W, take a left onto 147th St.
Building will be on the right.

ASSOCIATED NEPHROLOGY CONSULTANTS
Kidney disease and treatment

OFFICE POLICIES AND PROCEDURES
EFFECTIVE 2/1/18

Cancellation / No Show Policy
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 $25 for established patients that no show for their appointment or do not provide more than 24 hours cancellation notice.

Arrival Time/ Late Policy
We make every attempt to see you at your appointed time. To ensure that we run on time, we ask all patients arrive 20 minutes prior to appointment time. If you are late by 15 minutes or more, you will 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 health status, and information about other health services that you may have received. Our office uses a patient portal to enhance communication with our patients. At your visit, we will ensure that you have access to our portal. You may contact your doctor's medical assistant through the portal with health questions or medication refill requests. 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
We 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 copay or the full visit charge if you do not carry insurance. If you have an outstanding balance, our staff will notify you prior to your appointment. If your insurance company requires a referral for you to see us, it is your responsibility to call and get one. If you are not sure if you need a referral call your insurance company and find out. If your Primary Care Physician does not provide a referral, and you still want to be seen here, you will be responsible to pay for the full amount of the charges. If you have questions about what you will be expected to pay, 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. At your appointment, we will provide you with enough medication to last until your next appointment. If you need a refill between these visits, call your pharmacy for a refill and they will contact us. Or you may submit a request to our office through our patient portal (do not call for refills!). We will address refill requests within 48 hours. If you call after hours or on weekends, the on-call physician will 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.

Disability and Non-Insurance forms:
Due to the complexity and time involved we charge a fee of $100 for completing these forms that must be paid prior to form completion. Please allow 10 working days for the forms to be completed.

Handicap Sticker Forms:
We charge $5 to complete this form which must be paid in advance.

Family Medical Leave Act (FMLA) Forms
If you have a FMLA form to be completed, please allow up to 10 working days for completion. Due to the complexity of these forms, we charge a fee of $50 that must be paid prior to form completion.

Returned check fee:
There is a $35 additional fee for any check that is returned by the bank.

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.

All charges listed above are the patient's responsibility and will not be sent to your insurance company.

I acknowledge receiving and reading this information:

_____ Date: _____
(Patient/guardian signature)

Associated Nephrology Consultants, PA

REGISTRATION INFORMATION

DATE:

Shannon Doyle, MD • Alec Otteman, MD
Cara Walz, MD • Maryyam Ali, MD
Yekaterina Kuzmenko, MD
Nyan Pyae, MD • Dane Rasmussen, PA
Amy Sibley, CNP • Jennifer Mears, NP
M. Kate Schmidt, CNP • Ella Harpole, PA-C
Jennifer Nelson, PA • Megan Washek, PA

Referring Provider _____ **Clinic Phone** _____

Primary Care Provider _____

Pharmacy Name/ Location / Phone_____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX: ❑ MALE ❑ FEMALE

DAY PHONE #	EVENING PHONE #	PREFERRED # FOR CALLS ❑ DAY ❑ EVENING	MARITAL STATUS ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ SEPARATED ❑ WIDOWED

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:	OCCUPATION (Job Title)	EMPLOYMENT OR STUDENT STATUS:
		❑ FULL-TIME ❑ NOT EMPLOYED ❑ RETIRED ❑ PART-TIME ❑ SELF EMPLOYED ❑ ACTIVE MILITARY

PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS:	CITY	STATE	ZIP

EMERGENCY INFORMATION

Emergency Contact	Relationship	Phone Number

RESPONSIBLE PARTY INFORMATION/INSURANCE POLICY HOLDER

RESPONSIBLE PARTY NAME LAST	FIRST	MI	DATE OF BIRTH	RESPONSIBLE PARTY HOME PHONE

RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY SOCIAL SECURITY #

RESPONSIBLE PARTY EMPLOYER	OCCUPATION (Job Title)	RESPONSIBLE PARTY WORK PHONE

RESPONSIBLE PARTY EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ❑ SELF ❑ SPOUSE ❑ SON ❑ DAUGHTER

PRIMARY INSURANCE

EFFECTIVE DATE	GROUP NUMBER	ID NUMBER

INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE

EFFECTIVE DATE	GROUP NUMBER	ID NUMBER

INSURANCE COMPANY NAME	INSURANCE COMPANY PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

SUBSCRIBER NAME	SUBSCRIBER SSN	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO PATIENT

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

1. **Assignment of Benefits and Related Release of Information.** I request payment of authorized benefits directly to the provider for services furnished to me at this facility. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care reviews.
2. **Release of Information to Health Care Providers.** I consent to the release of my health records created, received and maintained by Associated Nephrology Consultants, PA for my treatment to other health care providers who are involved in my treatment. This consent does NOT include release of information obtained by or created in a drug or alcohol abuse treatment unit.
3. **Important Information for Patients.** Initial Received

_____ Notice of Privacy Practices (unless received during previous visit)

This consent will expire one year from the date signed unless you cancel it by writing us at: Associated Nephrology Consultants, PA, 1997 Sloan Place, Ste 17, Maplewood, MN 55117. If consent is cancelled, it will not change releases that have already been made.

_____ _____

Signature of Patient, or if Patient is unable to sign, a Representative of the Patient — Date

_____ _____

Relationship to Patient (if patient is unable to sign) — Reason Patient Unable to Sign

4. **Guarantee and Agreement to Pay**

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that 6% interest per year may be added if the account balance goes to a collection agency.

_____ _____

Patient, Legal Representative or Guarantor Signature — Date

☐ Directed by Patient to sign on their behalf (having read this document to them)

ASSOCIATED NEPHROLOGY CONSULTANTS
Kidney disease and treatment

PERSONAL & FAMILY HEALTH HISTORY

Patient Name_____ Date_____

Birth Date_____

Primary Physician_____Preferred Hospital_____

PERSONAL SOCIAL HISTORY

Marital Status: ___Single ___Married ___Divorced ___Widowed

Exercise: ___Yes ___No: ___Doesn't ___Occasionally ___Regularly

Please answer with an "X"	Yes	No	How Much/Frequency	Age Started	Age Quit
Tobacco					
Alcohol					
Medical Marijuana					
Illicit Drugs					

PERSONAL MEDICAL HISTORY

	Yes	No	Explanation/Complications/When
Bleeding Disorder			
Blood Clots			
Cancer - Type			
Diabetes			
Heart Attack			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Lupus			
Tuberculosis			
Congestive Heart Failure			
Other:			

SURGERIES

	Yes	No	Explanation/Complications/When
Vascular Surgery			
Appendectomy			
Gall Bladder			
Hysterectomy			Ovaries still present?
Heart Surgery			
Other:			

PERSONAL & FAMILY HEALTH HISTORY

Page 2

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions to medicine? _____Yes _____No If yes, please specify below:

Name of Medication	Describe Allergic Reaction

OTHER ALLERGIES

Allergy To:	Describe Allergic Reaction

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal Grandparents Mother	Maternal Grandparents Father	Paternal Grandparents Mother	Paternal Grandparents Father	Aunt	Uncle
Cancer										
Heart Attack										
Diabetes										
High Cholesterol										
Stroke										
Hypertension										
Kidney Stones										
Kidney Disease										
Other										

Anything not mentioned above?_____

Patient Signature_____ Date_____

Guardian Signature_____Relationship_____

ASSOCIATED NEPHROLOGY CONSULTANTS
Kidney disease and treatment

MEDICATION LIST

Patient Name_____ DOB_____ Today's Date_____

Pharmacy Name_____
Location/Address_____
Phone_____ Fax_____

Please list all prescribed medications you are currently taking:

Name of Medication	Dose (total mg)	How many times per day?	Who prescribed it for you (Dr last name)	Why do you take it?	Do you have any side effects? Please describe.

ASSOCIATED NEPHROLOGY CONSULTANTS
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MEDICATION LIST

Patient Name_____ DOB_____ Today's Date_____

Pharmacy Name_____
Location/Address_____
Phone_____ Fax_____

Over the counter medications, herbal remedies, supplements and vitamins

List ALL drug allergies

Updated 2-1-18

ASSOCIATED NEPHROLOGY CONSULTANTS
Kidney disease and treatment

REVIEW OF SYSTEMS

(Please circle all that apply to your condition in the last 6 months)

Today's Date_____

Patient Name: _____Birth Date: _____

Constitutional
Fever
Night sweats
Loss of appetite
Unintentional Weight loss

Eyes
Loss of vision
Double Vision
Cataracts
Laser surgery for bleeding

Ear/Nose/Mouth/Throat
Hearing Loss
Dizziness or "spinning" sensation
Ringing in ears
Sinus problems
Nosebleeds
Strep Throat
Recent dental problems

Respiratory
Chronic cough
Sputum production
Coughing up blood
Asthma or wheezing
Exposure to TB
Current smoker
Snoring
poor quality sleep

Cardiovascular
Chest pain or short of breath with activity
Fainting spells
Palpitations or fluttering in chest
Short of breath at night
Leg or ankle swelling
Calf pain with walking

Gastrointestinal
Nausea
Frequent vomiting
Heartburn
History of ulcers
Chronic diarrhea
Hepatitis
Bloody stools
Black stools
Colonoscopy in past 2 years

Musculoskeletal
Arthritis
Joint replacement
Osteoporosis
Chronic back pain
Muscle pain
Trouble getting out of a chair or climbing stairs
Use of a walker of cane
Fractures requiring surgery for repair

Hematologic/Lymphatic
Easy bruising
Anemia
Frequent infections
Swollen glands
Prior blood transfusion

Genitourinary
Bloody or tea-colored urine
Foamy urine
Frequent urination at night
Weak urine
Kidney stones
Kidney infections
Prostate problems

Neurological
Prior stroke
Seizures
Frequent headaches
Trouble with memory
Numbness of feet

Continued next page….

Skin	**Endocrine**	**Psychiatric**	**Allergic / Immunologic**
Skin rash	Thyroid disease	Excessive sadness	Hay Fever
Ulcers of skin, legs	Parathyroid disease	Anxiety	Allergies to Medicines
or feet	Diabetes mellius	Thoughts of self-harm	Prednisone or other steroid use
Purple fingers or toes	Adrenal gland disease	Trouble sleeping	Treatment with immune suppressing drugs
Worrisome moles			for cancer or other illness
Skin cancer			
Bothersome itching			

Anything else:_____

Patient Authorization

Patient Name:_____ Date:_____

To respect your privacy, please indicate the phone number(s) we should use to contact you for appointment reminders, lab results etc. from our office.

Home #_____OK to leave a message? Yes No

Work #_____OK to leave a message? Yes No

Cell #_____OK to leave a message? Yes No

Email:_____

If we are unable to speak to you directly and must leave a message, please indicate who is authorized to receive the message for you:

Spouse:_____ Other:_____

****

Required collection of information as part of the ARRA, American Recovery & Reinvestment Act, 2009:

What is your preferred language?_____ Decline:_____

What is your race? Please circle: Native American or Alaskan Native Asian

Black or African American White or Caucasian Native Hawaiian or other Pacific Islander

Decline

What is your ethnicity? Please circle: Hispanic or Latino Not Hispanic or Latino

Decline

HIPAA

Notice to patient: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign below to acknowledge receipt of this notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of Associated Nephrology Consultants' Notice of Privacy Practices.

Patient Name_____
(Please print)

Patient/Guardian Signature:_____

Date:_____

****

For office use only:

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but could not obtain it because:

_____ Patient refused to sign

_____ We were unable to communicate with the patient.

_____ Other (Provide specific details):_____

_____

Staff initials_____ Date_____

Updated 2-1-18

CONSENT FOR RELEASE OF INFORMATION

Associated Nephrology Consultants
1997 Sloan Place, Suite 17
Maplewood, MN 55117
Phone: 651-772-6251 Fax: 651-224-9661

Patient Name:_____
Other Names:_____
DOB: _____Phone:_____
SSN:_____

Facility/Doctor:_____
Address:_____
_____
FAX: _____

○ **FROM**: The undersigned hereby authorizes the above identified provider to release to Associated Nephrology Consultants, information from the medical records on the above named patient. The information is to be released for the following purpose:

○ **TO**: The undersigned hereby authorizes Associated Nephrology Consultants to release records to_____ information from the medical record of the above-named patient. The information is to be released for the following purpose:

○ Continuing Care ○ Litigation ○ Insurance Claim ○ Transfer of care ○ Workers Comp
○ Specialist ○ Other (Explain)_____

This consent to release information is limited to the following:

○ Medical records regarding treatment for _____ (medical condition or injury) occurring on or about_____(date).
○ Including ○ Not including records related to alcohol and/or drug abuse treatment, psychiatric records and/or records relating to communicable diseases.

○ Specific information from my medical records:

○ History and physical	○ Discharge Summary	○ Operative Report
○ Pathology Reports	○ Consultation Report	○ Laboratory Report
○ Radiology Reports	○ Emergency Room Record	○ Complete Record
○ Certified Copy	○ All	○ Other_____

I UNDERSTAND THAT I MAY REVOKE THE CONSENT AT ANY TIME AND THAT THE CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF MY SIGNATURE.

I DO NOT AUTHORIZE FURTHER RELEASE TO ANY THIRD PARTY. I UNDERSTAND THAT ONCE INFORMATION IS RELEASED PURSUANT TO THIS AUTHORIZATION, THE HOSPITAL/CLINIC, THEIR EMPLOYEES AND MY PHYSICIAN(S) CANNOT PREVENT THE REDISCLOSURE OF THAT INFORMATION. I HEREBY RELEASE EACH OF THEM FROM ANY AND ALL LIABILITY ARISING DIRECTLY OR INDIRECTLY FROM DISCLOSURE AUTHORIZED BY THIS CONSENT AND ANY REDISCLOSURE OF THE INFORMATION.

_____ _____
Signature of patient or guardian Relationship to patient if signed by guardian

_____ _____
Date of signature Reason patient unable to sign

Medical Records were released by: _____ on _____
Name Date