NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.

JORGE C. BUSSE, M.D., F.A.C.P.
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EMILIO J. GOMEZ, M.D.
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YAINET VALLE, PA-C

WELCOME TO OUR PRACTICE

www.kidneydoctorsofmiami.com

1. There are 9 pages to complete. Please **print legibly** and make sure **ALL pages are signed**

2. Please make sure to include your email address for your Patient Portal Access.

3. Please make sure to include 2 contact phone numbers, for your result communications.

4. Please make sure you have your Picture ID and Insurance Card – **we cannot see you without this.**

5. **IF REQUIRED, Please make sure you have your Referral** - It is the responsibility of the patient to ensure that their Primary Care Physician has send this to us. **If YOU DO NOT have your referral, please contact your PCP immediately and have them fax it to us at 305-273-9385, we cannot see you without this or call you in to see the doctor until it is received.**

6. Co-pays, Deductibles, or any Past Due Balances are due and payable at the time of your visit- we cannot bill you for these. Thank you

7. Please remember to have your lab results and/or any ultrasound results, the list of your medications and the names of all your healthcare providers with you, as this will be needed for your Nephrology Consultation.

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PATIENT NAME: _____ DOB _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ HOME #: _____ CELL #: _____

SS# (**LAST 4 ONLY**) XXX-XX-_____ SEX: [ ] M / [ ] F **PRIMARY LANGUAGE**:_____

EMAIL ADDRESS:_____ **CONTACT PREFRENCE**: [ ] HOME PHONE [ ] CELL PHONE [ ] EMAIL

MARITAL STATUS: _____ RACE: _____ ETHNICITY: _____

EMERGENCY CONTACT: NAME: _____ RELATIONSHIP:_____ PHONE:_____

EMPLOYER: _____ WORK PHONE #: _____

HAVE YOU BEEN PREVIOUSLY SEEN IN OUR OFFICE? _____

WHAT DOCTOR REFERRED YOU TO OUR OFFICE? _____

WHO IS YOUR PRIMARY PHYSICIAN:_____ PHONE #:_____

HAVE YOU MADE ARRANGEMENTS FOR ADVANCE DIRECTIVES: YES ___NO: ___ (Please Provide Copies)

PRIMARY INSURANCE COMPANY: _____
PHONE #: _____
ADDRESS: _____
POLICY #: _____
NAME OF INSURED: _____
INSURED DATE OF BIRTH _____

SECONDARY INSURANCE COMPANY:_____
PHONE #: _____
ADDRESS: _____
POLICY #: _____
NAME OF INSURED: _____
INSURED DATE OF BIRTH _____

I hereby authorize and request payment of medical benefits directly to Nephrology Associates of South Miami, P.A., for their services. I understand that I am financially responsible for the charges not covered by my insurance company. I hereby understand and agree that if it is necessary to place my account with an attorney for collection, suit, or other legal action, I hereby agree to pay all costs of such collection, suite or legal action, including a reasonable attorney's fee at trial, and appellate levels. I further authorize the release of any medical information required by my insurance company.

Signed:_____ Date:_____
Patient or Responsible Party

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1. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the payment of my medical insurance benefits to be paid directly to Nephrology Associates of South Miami PA. I understand that I am financially responsible for ALL non-covered services and all charges not paid by my insurance, such as Co-Pays, Co-Insurance, and Deductibles. I authorize my physician to release any information required to process all claims to my insurance carrier and my medical care team.

2. CONSENT FOR PHOTOGRAPH

I authorize Nephrology Associates of South Miami P.A., to take my picture to be used as part of my medical records for identification purposes only.

3. MEDICATION HISTORY AUTHORIZATION

I authorize Nephrology Associates of South Miami P.A., to download my medication history automatically from pharmacy benefits manager to be used as part of my medical records history.

4. LAB's & TESTING ORDERED- (ABN "Advance Beneficiary Notice)

I have been informed that my physician may order laboratory and/or diagnostic studies that MAY NOT be covered by my insurance company; and that Quest, Lab-Corp, and/or these Out-Patient Centers will give me an "**ABN" - Advance Beneficiary Notice of Non-Coverage form** to sign**. I acknowledge and understand that my physician will NOT be responsible for any studies NOT covered by my insurance company.**

5. NEXT OF KIN COMMUNICATION CONSENT

I authorize Nephrology Associates of South Miami, P.A. to communicate with and release my medical information to the following person:

- Name of Person Assigned: _____
- Relationship to the Patient: _____
- Telephone Number: _____

Print Name: _____ Relationship if other than patient: _____

Patient's Signature ⊗_____ **Today's Date**:_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

RELEASE TO

I authorize **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.**; to release the health information indicated below to:
And for the purpose of alternative means of confidential communication the use of the following Email Address:

Person/Organization Name:	
Address:	
Telephone No:	**Email Address:**
Dates of Medical Record Release:	

NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., (NASM) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **NASM** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **NASM** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and I consent to the conditions outlined herein. Any questions I may have had were answered.

REASON FOR DISCLOSURE

☐ **Continuing Care**	☐ **Legal**	☐ **Other Purpose** *(please specify)*
☐ **Insurance**	☐ **Personal Use**	

INFORMATION TO BE RELEASED

☐ **Complete Medical Record**	☐ **Operative Reports**
☐ **Lab Reports**	☐ **Pathology *Reports***
☐ **Radiology Reports**	☐
☐	☐
☐ **Other** *(please specify)*	

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Mental Health Treatment or Psychotherapy Notes** (*The release of Psychotherapy Notes requires a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. ***This authorization and consent will expire one year from the date of authorization written below.*** Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e. court appointed guardian, durable power of attorney for health care).*

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES

PATIENT INFORMATION	
Patient Name:	**Date of Birth:**
Social Security No:	**Telephone No:**
Address:	

REQUEST TO	
Name of Healthcare Facility from which Records are Requested:	
Telephone No.:	**Fax No.:**
Address:	
Dates of Treatment Requested:	**Reason For Disclosure:**

I hereby authorize **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.; to obtain** the health information indicated below ***AND*** for the purpose of alternative means of confidential communication the use of their email address. **NASM** offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. **NASM** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **NASM** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Mail Information To:	**NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.**	**Address: 9193 SUNSET DRIVE STE 200 MIAMI, FL 33173**
Or Fax To:	**305-273-9388/305-273-9385**	**Email: info@kidneydoctorsofmiami.com**

INFORMATION TO BE RELEASED

☐ **Complete Medical Record**	☐ **Operative Reports**
☐ **Radiology Reports**	☐ **Pathology Reports**
☐ **Lab Reports**	☐
☐	☐

☐ **Other** *(please specify)*

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ **Drug/Alcohol Abuse or Treatment**	☐ **Genetic Testing Information**
☐ **HIV/AIDS, Sexually Transmitted Disease (STD) Test Results or Diagnoses**	☐ **Mental Health Treatment or Psychotherapy Notes** *(The release of Psychotherapy Notes require a separate authorization)*

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your healthcare information by the recipient may no longer be protected by law.

Patient Signature: *(Guardian/Legal Representative)*	**Date Signed:**
Print Name: *(Please Print)*	**Relationship If Other Than Patient:**

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (i.e., court appointed guardian, durable power of attorney for health care). For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18. **For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the documents naming the administrator or executor of the estate.*

HIPAA – PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICIES

*HIPAA – CONSENTIMIENTO DEL PACIENTE PARA USAR Y COMPARTIR INFORMACION PERSONAL DE SALUD Y CONFIRMACION DE RECIBO DE LA NOTA DE PRACTICAS DE PRIVACIDAD

I acknowledge that I have been provided with **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., "**Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

Confirmo que se me ha proveído con la "Nota De Practicas De Privacidad" de* **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., *y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.*

Patient Name: *(please print)*

**Nombre Del Paciente: (nombre en letra de molde por favor)*

Patient Signature *(or legal representative; proof may be requested)*

**Firma Del Paciente: (o representante legal; prueba puede ser requerida)*

Date:

**Fecha:*

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM
*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., (NASM)** offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. **NASM** will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, **NASM** cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between **NASM** and I, and consent to the conditions outlined herein. Any questions I may have had were answered.

***Propósito:** Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. **NEPHROLOGY ASSOCIATES OF SOUTH MIAMI, P.A.., (NASM)** ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Trasmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. **NASM** usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, **NASM** no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre **NASM** y yo, y consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is:

**Mi Correo Electrónico Consentido Es:*

My Consented Mobile Number For Text Messaging is:

**Mi Numero Móvil Para Mensaje De Texto Consentido Es:*

Patient Signature: **Date:**

Firma del Paciente* ****Fecha*

IN CASE OF EMERGENCY: *Please call 911 or proceed to the nearest emergency room.* ***Do not use this way of communication for that purpose.***
****EN CASO DE EMERGENCIA:*** *Por favor llame al 911 or proceda al centro de emergencia mas cercano.* ***No use esta forma de comunicación para este propósito.***

Rev.09/19

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NAME: _____ **DATE:** _____

Date of Birth : _____ Age : _____ M / F :____ Marital Status: _____

Symptoms: _____

ALLERGIES : _____

MEDICATIONS:

Name:	Doses:	Indication:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS:

YEAR	REASON	HOSPITAL	DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SURGERIES:

YEAR	TYPE OF SURGERY:
_____	_____
_____	_____

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FAMILY HISTORY	**FAMILY MEMBER**
HEART DISEASE	[ ] _____
HIGH BLOOD PRESSURE	[ ] _____
DIABETES	**[ ]** _____
STROKES	[ ] _____
KIDNEY PROBLEMS	[ ] _____
KIDNEY STONES	[ ] _____
HEPATITIS OR LIVER PROBLEMS	[ ] _____
PNEUMONIA	[ ] _____
PSYCHIATRIC PROBLEMS / DEPRESSION	[ ] _____
TUBERCULOSIS	[ ] _____
PLEURISY (INFLAMMATION OF LUNG TISSUE)	[ ] _____
ARTHRITIS	[ ] _____
CANCER	[ ] _____
CIRCULATORY PROBLEMS / BLEEDING TENDENCY	[ ] _____

Father: [ ] Deceased – Age ___ Cause of Death_____

Mother: [ ] Deceased – Age ___ Cause of Death_____

Brothers: #_____

[ ] Deceased – Age ___ Cause of Death_____

[ ] Deceased – Age ___ Cause of Death_____

Sisters: #_____

[ ] Deceased – Age ___ Cause of Death_____

[ ] Deceased – Age ___ Cause of Death_____

Children: #_____

[ ] Deceased – Age ___ Cause of Death_____

[ ] Deceased – Age ___ Cause of Death_____

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PHARMACY:

NAME:_____ PHONE: _____

LABORATORY:

[ ] QUEST [ ] LABCORP [ ] PCP / CLINIC : _____

NAME OF OTHER TREATING PHYSICIANS:

Cardiologist: Name:_____ Phone:_____

Endocrinologist: Name:_____ Phone:_____

Gastroenterologist: Name:_____ Phone:_____

Hematologist: Name:_____ Phone:_____

Oncologist: Name:_____ Phone:_____

Urologist: Name:_____ Phone:_____

Other Specialty: Name:_____ Phone:_____

WOMEN ONLY:

No. of Pregnancies: _____ No. of Children Born: _____ Miscarriages: _____

[ ] NATURAL BIRTH #_____ [ ] C-SECTION #_____

COMPLICATIONS DURING PREGNANCIES:

	YES	NO
High Blood Pressure	_____	_____
Albumin	_____	_____
UTI	_____	_____
Edema	_____	_____
Other Problems:_____	_____	_____

PAST MEDICAL HISTORY / HISTORIAL MEDICO

Abdominal Aortic Aneurysm Repair *Reparacion De Aneurisma Aortica Abdominal*	**YES / NO**	Kidney Cyst *Quiste Renal*	**YES / NO**
Acid Reflux (GERD) *Reflujo Gastrico*	**YES / NO**	Kidney Disease *Enfermedad Renal*	**YES / NO**
Anemia *Anemia*	**YES / NO**	Kidney Stones *Calculo Renal*	**YES / NO**
Arthritis *Artritis*	**YES / NO**	Liver Disease *Enfermedad del Higado*	**YES / NO**
Asthma *Asma*	**YES / NO**	Lupus *Lupus Eritromatoso*	**YES / NO**
Atrial Fibrillation *Fibrilacion Auricular*	**YES / NO**	Organ Transplant *Transplante de Organo*	**YES / NO**
Blood Clot *Coagulos Sanguineos*	**YES / NO**	Peripheral Vascular Disease - (Lower Extremity Circulatory Problems) *Enfermedad Vascular*	**YES / NO**
Blood Transfusion *Transfusion de Sangre*	**YES / NO**	Prostate Hypertrophy (Enlarged Prostate) *Hipertrofia Prostatica*	**YES / NO**
Cancer *Cance* r	**YES / NO**	Proteinuria - (Protein in the Urine) *Proteinuria*	**YES / NO**
Congestive Heart Failure (CHF) *Insuficiencia Cardiaca Congestiva*	**YES / NO**	Pulmonary Disease *Enfermedad Pulmonaria*	**YES / NO**
Coronary Artery Disease *Enfermedad Arterial Coronaria*	**YES / NO**	Seizures/ Epilepsy *Convulsiones/Epilepsia*	**YES / NO**
Depression *Depresion*	**YES / NO**	Sleep Apnea *Apnea del Sueño*	**YES / NO**
Diabetes *Diabete* s	**YES / NO**	Stroke *Ataque Cerebral*	**YES / NO**
Gout *Gota*	**YES / NO**	Thyroid Problems *Problema de Tiroides*	**YES / NO**
Heart Disease *Cardiopatia*	**YES / NO**	Tuberculosis *Tuberculosis*	**YES / NO**
Hematuria (Blood in the Urine) *Hematuria*	**YES / NO**	Urinary Track Infection *Infeccion Urinaria*	**YES / NO**
Hepatitis B *Hepatitis B*	**YES / NO**	Varicose Veins *Varices*	**YES / NO**
High Cholesterol *Colesterol Alto*	**YES / NO**	Vitamin D Deficiency *Deficiencia de Vitamina D*	**YES / NO**
Hypertension (High Blood Pressure) *Hipertension (Presion Alta)*	**YES / NO**		

Today's Date: _____
Fecha

Patient's Name: _____
Nombre del Paciente

Date of Birth: _____
Fecha de Nacimento

Doctor you are seeing Today/Medico que va a ver hoy:

[ ] Dr. Acevedo
[ ] Dr. Barreto
[ ] Dr. Busse
[ ] Dr. Farias
[ ] Dr. Gomez
[ ] Dr. Kusnir
[ ] Dr. Trespalacios
[ ] Dr. Trueba