NORTHERN FLORIDA
KIDNEY CARE
by NPS

Don Henry Esprit, MD

221 SW Stonegate Terrace, #105
Lake City, FL 32024
Phone: 386-752-6707
Fax: 386-755-6950

2216 NW 40th Terrace
Gainesville, FL 32605
Phone: 352-888-7500
Fax: 352-372-1364

Welcome to our practice!

We are both privileged and honored to be partnering with you for your kidney care. A Northern Florida Kidney Care, our mission is to inspire hope and enhance lives through compassionate, patient-centered health and well-being, provided by an integrated clinical practice with an emphasis on hypertension, kidney disease and kidney transplantation. We look forward to working closely with you and your primary care provider to offer state of the art kidney care.

In the enclosed information, you will find a practice overview, a medical history questionnaire, and practice policies that you may find helpful.

We look forward to serving your medical needs. In the interim, please do not hesitate to call the office with any questions that may arise.

Warm regards,

Dr. Don Esprit & the team at

Northern Florida Kidney Care

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Practice Overview

Important Reminders

Please bring to EVERY appointment:

- Your photo ID and current insurance card(s),
- A complete list of your current medications (or medication bottles) including dose, route and frequency information and, pharmacy name and phone number
- Primary Care & Other Physician names and addresses
- Co-pays and balance payments (cash, check, VISA, MC accepted).

Office Hours

Northern Florida Kidney Care is open 7am-4:30pm

Our physicians and staff make every effort to return non urgent calls within 24 hours, Monday – Friday. Urgent calls or requests will be returned within 24 business hours. If it is an emergency, we request that you go to the nearest Urgent Care Facility or hospital Emergency Room.

Laboratory Orders & Policy

If your physician orders lab work, you will receive an order at your appointment. The order will list any lab studies that need to be done *prior* to your appointment. Please take the order to a lab/clinic of your choice *5-7 days prior* to your appointment to ensure the results have been faxed to us. Your physician will review the results with you at your appointment. Should an appointment not be required, the physician or staff will call you. If orders are lost or misplaced we'd be happy to send you a duplicate or fax them directly to the lab. Please note we are **unable** to create, fax or send any orders outside of normal business hours.

Cancel/No Show Policy

Coming to your scheduled appointments is very important to your health. Additionally, no-shows and late cancellations inconvenience your fellow patients who otherwise may have been able to use that appointment time. As such, we reserve the right to charge you a fee for missed appointments and any cancellations/reschedules *without 24 hour advance notice*. Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice at the discretion of the provider.

Medication Refill Policy

We ask our patients to monitor their prescription medication closely, and to assess supplies before each office visit. We request that patients get their medications refilled at the time of their appointments or call their pharmacy several days in advance of running out of medication. We will review and respond to all medication refill requests within 2 business days. However, certain classes of medications, such as pain medicines (narcotics), may require a visit to the office. Our on call providers will **not** refill any narcotic prescription written/ordered by another provider.

Reminder calls and mailings

As a courtesy to all of our patients, we provide automated reminder calls to all of our patients starting 2 days prior to the scheduled appointment. Please notify one of the office teammates at check-in if you would like to opt out of our automated reminder call system.

Northern Florida Kidney Care is dedicated to our patients' health and satisfaction. To help us ensure we are meeting our patients personal and health needs, we send Patient Satisfaction Surveys to all of our patients twice a year. Please notify one of our office teammates if you would like to opt out of receiving them.

Practice Website and Patient Portal

We encourage our patients to visit our website, https://www.northernfloridakidneycare.com, 24 hours a day 7 days a week for patient educational materials, physician bios, pay your bill, and much more.

We also encourage our patients to take an active role in their health care by using our patient portal at https://www.healthcompanion.com/falcon. Please contact an office teammate to get your PIN number today.

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Patient Information

Last Name	First Name	MI	Date Of Birth
Address	City	State	Zip

Please Check Primary Phone	Home Phone □	Work Phone □	Cell Phone □

E-mail Address	Gender □ M □ F	SSN - -	Preferred Language

Marital Status	Preferred Contact	Ethnicity	Race
□ Married	□ Home Phone	□ Hispanic/Latino	□ American Indian
□ Single	□ Work Phone	□ Non-Hispanic	□ Asian
□ Divorced	□ Cell Phone	□ Filipino	□ Black or African American
□ Separated	□ *Opt out* of Reminder Calls	□ Other	□ White
□ Widowed	□ *Opt out* of Patient Satisfaction Mailings	□ Decline	□ Other
□ Life Partner			□ Decline

Primary Care Provider	Referring Provider

Primary Insurance Information

Insurance Company	ID#	Group #

Policy Holder Information ☐ Same As Patient

Insured Full Name	Date of Birth	Subscriber's SSN - -	Effective Date

Relationship to Patient

Secondary Insurance Information

Insurance Company	ID#	Group #

Policy Holder Information ☐ Same As Patient

Insured Full Name	Date of Birth	Subscriber's SSN - -	Effective Date

Relationship to Patient

Emergency Contact

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please Check Primary Phone	Home Phone □	Work Phone □	Cell Phone □

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Northern Florida Kidney Care or insurance company to release any information required to process my claims.

Patient signature	Date

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Patient Name_____

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Medications – *List all medications you take, prescriptions and non-prescription, and the dosage*

□ I do not take any medications

Medication Name	Dosage	Medication Name	Dosage

Allergies – *List all know allergies*

□ No Known Allergies

Medical History – *Check (✓) if you have ever experienced the following conditions*

□ None	□ Deep Venous Thrombosis	□ Kidney Stones
□ Anemia	□ Eye Disease	□ Neuromuscular Disease
□ Asthma	□ GI Disorders	□ Neuropathy
□ Bleeding Problems	□ Gout	□ Peripheral Vascular Disease
□ Broken Bones	□ Hearing Problems	□ Retinopathy
□ Coronary Artery Disease	□ Heart Disease	□ Sleep Apnea
□ Cancer – Type_____	□ Hepatitis – Type_____	□ Stroke
□ Congestive Heart Failure	□ High Blood Pressure	□ Thyroid
□ Depression	□ Hyperlipidemia	□ UTI's

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□ Diabetes	□ Kidney Disease	□ Other_____

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Patient Name_____

Surgical History - *Check (✓) if you have received the following procedures, and year preformed*			
Surgical Procedure	Year	Surgical Procedure	Year
□ None		□ Hernia Repair	
□ Angioplasty		□ Hip Replacement	
□ Angioplasty w/Stent		□ Knee Replacement	
□ Appendectomy		□ LASIK	
□ Arthroscopy Knee		□ Liver Biopsy	
□ Back Surgery		□ Kidney Biopsy	
□ CABG (Heart Bypass		□ Pacemaker	
□ Carpal Tunnel Release		□ Small Bowel Resection	
□ Cataract Extraction		□ Thyroidectomy	
□ Cholecystectomy		□ Tonsillectomy	
□ Colostomy		□ Other_____	
□ Gastric Bypass		□ Other_____	

Hospitalizations		
Type of hospitalization & reason	Hospital	Year

Immunization History - *Check (✓) if you have received the following*	
Immunization	Date/Year
□ Influenza	
□ Pneumonia	
□ Hepatitis	
□ Tetanus	
□ Chickenpox	
□ MMR (Measles, Mumps, Rubella)	

Personal and Social History	
Personal	What is your Occupation?
	Who do you live with? □ Alone □ Spouse □ Partner □ Child(ren) □ Other_____
Children	Do you have Children? □ Yes □ No Number of Sons_____ Daughters_____

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Patient Name_____

Personal and Social History Continued	
Alcohol and Drug Use	Do you drink alcohol? □ Yes □ No If Yes, How often? □ Daily □ weekly □ Monthly □ Occasionally
	Recreational or street drug use? □ Yes □ No
	Analgesic/Painkiller drug abuse? □ Yes □ No
Transfusions	Have you ever had a blood transfusion? □ Yes □ No If Yes, When_____
Smoking Status	Current Smoking Sat? □ Current Every Day Smoker □ Current Some Day Smoker □ Heavy Smoker (11 or more cigarettes/day) □ Light Smoker (less than 11 cigarettes/day) □ Former Smoker □ Never Smoker □ Smoking status unknown
	Quantity_____/per_____ Start Date _____ Quit Date_____
Advanced Care Plan	*Do you have a Surrogate Decision Maker? □ Yes □ No If Yes, Who_____ Do you have a Documented Advanced Care Plan? □ Yes □ No If Yes, please provide copy to the office Do you have DNR or Living Will? □ Yes □ No If Yes, please provide copy to the office Do you have a Durable Power of Attorney or health care proxy? □ Yes □ No If Yes, please provide copy to the office *Surrogate Decision Maker: A surrogate decision maker, also known as a health care proxy or as agent, is an advocate for your healthcare if you become incapacitated. If you are unable to make decisions or decide your personal health care, someone else must provide direction in decision-making, as the surrogate decision-maker.

Family Health History – Check (✓) if any family member(s) has had any of the following conditions

	No History	Father	Mother	Brother	Sister	Son	Daughter	Other
Anemia	□	□	□	□	□	□	□	□
CAD	□	□	□	□	□	□	□	□
Cancer-Type_____	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□
Hyperlipidemia	□	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□	□	□
Kidney Stones	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□

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PERMISSION TO DISCUSS HEALTH INFORMATION WITH OTHER INDIVIDIUALS

Purpose: The purpose of this document is to provide permission for Northern Florida Kidney Care to discuss your healthcare with the other people listed on the form as it relates to their involvement in your care. You must provide the names, relationships and numbers of those individuals you wish to be on the form and you can update or revoke it at any time. If you wish for us not to speak with any individuals, please do not complete the form.

Instructions:

1. Write the name of the family members or other individuals who are involved in the patient's health care, and have the patient or the patient's Personal Representative sign and date the form.

2. If the patient's Personal Representative is signing the form on behalf of the patient, the Personal Representative must also sign and date the acknowledgement that he or she has the legal authority to do so.

1. Individuals to whom Northern Florida Kidney Care may disclose my PHI for coordination of care purposes

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I hereby grant Northern Florida Kidney Care permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

Name	Relationship (friend, relative, etc.)	Phone #
1 .		
2 .		
3 .		
4 .		
5 .		

1. I understand that if I do not list anyone and I am not present or is incapacitated, Northern Florida Kidney Care may share my information with family, friends, or others that Northern Florida Kidney Care has determined, based on professional judgment, is in my best interest and necessary for coordination of care and/or payment for health care services I have received from Northern Florida Kidney Care.
2. I understand that I may revoke or change the list of people with whom my provider may share my information by notifying the facility in writing.
3. I understand that a revocation is not effective to the extent that any person or entity has acted in reliance on my authorization.
4. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law.
5. I understand that my treatment, payment, or eligibility for benefits will not be conditioned on signing this authorization.
6. This authorization/permission form will remain in effect for ten (10) years or the day my treatment relationship with Nephrology Medical Associates of Georgia d/b/a Northern Florida Kidney Care ceases or I revoke my permission, except for patients treating in Maine, Maryland, whose authorization/permission form will remain in effect for one (1) year or Montana whose authorization/permission form will remain in effect for six (6) months or the day I revoke my permission.

This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

Signature of Patient or Legal Representative _____ Date of Signature _____

2. Personal Representative Acknowledgement

If the patient is a minor or has a personal representative, I represent that I am the legal Personal Representative of the patient named above and I have the legal authority to act on behalf of the patient in making decisions related to health care.

Signature of Patient or Legal Representative _____ Date of Signature _____

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NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document a patient's acknowledgement of receipt of our Privacy Practices or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

PATIENT NAME: _____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

❑ I acknowledge that I received the Privacy Practices Notice of this health care provider.

(Please sign in the space indicated below)

TO THE TEAMMATE: Please complete the following if the patient is unable to sign and sign in the space below.

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

❑ Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

Please provide an explanation of the patient's refusal or inability to sign: _____

_____

❑ Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are therefore not required to obtain an acknowledgement.

THIS FORM HAS BEEN SIGNED BY: (please check one)

❑ PATIENT

❑ PATIENT'S PERSONAL REPRESENTATIVE

❑ TEAMMATE

I attest that the above information is correct.

_____ _____

Signature Date

_____

Printed name

_____

Witness signature

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FINANCIAL POLICY
(PRIVATE INSURANCE AND SELF-PAY PATIENTS)

Patient name: _____ DOB: _____
(Please Print)

Any healthcare insurance policy that you may have is a contract between you and your insurance company and/or employer. Northern Florida Kidney Care will assist you in obtaining payment from any healthcare insurance policy for medical services and goods that you receive at our practice; however, you remain primarily responsible to pay for all medical services and goods rendered from Northern Florida Kidney Care.

OUR FINANCIAL POLICY	
_____ Initial	**You are responsible for any and all applicable co-payments, coinsurance, and unmet deductibles.** It is the patient's responsibility to provide us with current insurance information at each visit. According to your insurance, payment is expected at time of your visit. Some insurance carriers charge a co-pay for each type of provider seen during one day; therefore, if you are seen by more than one provider on the same day, you may be responsible for more than one co-payment. You will also be responsible for any past due balances that may be remaining on your account. Patients with delinquent accounts will be required to make payment on the date of visit. If you are unable to make mutually agreeable payment arrangements your appointment may be rescheduled based on the clinical discretion of the provider.
_____ Initial	**Payment is Due When Services are Provided.** Northern Florida Kidney Care requires that all applicable co-payments, coinsurance, deductibles and any past due amounts on the account be paid on date of visit. In the event that you are not covered by a healthcare plan, full payment is required on date of visit.
_____ Initial	**Assignment of Benefits.** I hereby assign Northern Florida Kidney Care any insurance or other third-party benefits available for healthcare services provided to me. I understand that Northern Florida Kidney Care has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Northern Florida Kidney Care, I agree to forward the Practice all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.
_____ Initial	**Payment Methods and Returned Check Fee.** Northern Florida Kidney Care accepts MasterCard/Visa, personal checks, and cash. If the bank returns your check due to non-sufficient funds you will be charged a $25.00 service charge which will be due, along with the amount of the returned check, within three (3) business days. Your account will be placed on a "cash-only basis."
_____ Initial	**Prompt Payment of Mailed Invoices.** In the event that you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 14 days. Amounts for which you are liable may be identified as "*patient balance due*" on the invoice. Patients with an outstanding balance more than 90 days overdue must make payment arrangements prior to scheduling appointments. Call the billing number provided on your statement to make payment arrangements.
_____ Initial	**Non-covered Services.** While the filing of insurance claims is a courtesy that we extend to our patients, not all services provided by Northern Florida Kidney Care may be covered by every healthcare plan. Any service determined not to be covered by your plan will be your responsibility. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

ACKNOWLEDGEMENT

I HAVE READ AND UNDERSTAND the Financial Policy of Northern Florida Kidney Care and agree to be bound by it. I understand that healthcare insurance does not cover all medical goods and services and my responsibilities with respect to healthcare insurance as explained above. I understand that I am ultimately responsible for payment for medical goods and services provided to me by Northern Florida Kidney Care. I hereby grant Northern Florida Kidney Care the right to bill and collect from my healthcare insurance plan for medical goods and services provided to me. *If the patient is a minor (younger than 18 years old), the parent or guardian must sign below.*

X _____ _____

Responsible party/Guarantor Printed Name — Relationship

X _____ _____

Responsible party/Guarantor Signature — Date

Billing questions, concerns and payments may be directed to:

Nephrology Practice Solutions Revenue Cycle Management Team
1840 E. Ray Road
Chandler, AZ 85225
Phone: (844) 725-7665