NAMV NEPHROLOGY ASSOCIATES OF THE MERRIMACK VALLEY

DOUGLAS E. MESLER, MD
JOSEPH P. ROSSACCI, MD
ASHISH MAHAJAN, MD
NEERAJ JAIN, MD

Welcome to Nephrology Associates of the Merrimack Valley!

- Our office is located at **600 Clark Road, 2nd floor, Tewksbury, MA 01876**. If you are using a GPS to get to our office, we suggest putting in 500 Clark Road instead. Once you reach 500 Clark Road, our building will be the next one over, the brown building with 600 sign in the front. We are finding that putting in 600 Clark Road into the GPS will not bring you to the correct location.
- Please arrive **30 MINUTES BEFORE** your appointment. This will allow us enough time to register you before you are seen.
- We will also be asking for you to **leave a urine sample during your visit.**
- Enclosed you will find your new patient packet with the documents necessary to register with our practice.

  The contents of this packet are as follows:

  - NOTICE OF PRIVACY PRACTICE: Please read this and keep for your records.

Please complete these forms and bring them with you to your appointment

- MEDICATION LIST: Please list all medications, vitamins, herbals, and allergies.
- MEDICAL HISTORY FORM: Please complete as much as possible.
- REGISTRATION FORM: Verify your demographic information.
- OFFICE POLICY FORM: Please read and sign.
- PATIENT AUTHORIZATION FORM: This form allows us to request your medical information from your physician(s).
- ASSIGNMENT OF BENEFITS FORM: This form allows us to bill your insurance company.
- APPOINTMENT CANCELLATION AND NO-SHOW POLICY FORM: Please read and sign.
- CONSENT TO OBTAIN RX HISTORY FORM: Grants us permission to view prescription history from your pharmacy.
- ELECTRIONIC HEALTH RECORD FORM: Gives consent for us to share information electronically with your physician(s).

PLEASE BRING YOUR CURRENT INSURANCE CARD(S) AND A DRIVER'S LICENSE OR PHOTO ID.

Please feel free to contact us anytime with your questions at (978) 453-1811.

We look forward to providing your medical care!

The Physicians and Staff at Nephrology Associates of the Merrimack Valley

NAMV NEPHROLOGY ASSOCIATES OF THE MERRIMACK VALLEY

OFFICE USE ONLY

Entered by: _____

Appointment Date: _____

PATIENT'S NAME: _____ PATIENT'S DOB:_____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

NAME OF MEDICATION	STRENGTH	DIRECTIONS	ORDERING PHYSICIAN

(PLEASE LIST ANY ADDITIONAL MEDICATIONS ON THE BACK OF PAGE)

ARE YOU TAKING ANY VITAMINS, MINERALS, OR HERBAL SUPPLEMENTS? IF YES, PLEASE LIST.

NAME	STRENGTH	DIRECTIONS	ORDERING PHYSICIAN

ARE THERE ANY OTHER MEDICATIONS THAT YOU HAVE TAKEN IN THE PAST BUT NO LONGER TAKING?

IF YES, PLEASE INDICATED: _____

WHICH PHARMACY DO YOU USE?

PHARMACY: _____

ADDRESS CITY, STATE

DO YOU PREFER MAIL ORDER? IF YES, WHICH ONE: _____

DO YOU HAVE ANY **ALLERGIES**? IF YES, PLEASE LIST: _____

WHERE DO YOU PREFER TO GET LAB WORK AND RADIOLOGY PROCEDURES DONE? CHECK ONE:

LABCORP ☐ WHICH LOCATION? _____

QUEST DIAGNOSTICS ☐ WHICH LOCATION? _____

OTHER ☐ PLEASE INDICATE: _____

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PATIENT'S NAME: _____ PATIENT'S DOB:_____

- SYMPTOMS -

CHECK CONDITIONS YOU CURRENTLY HAVE OR HAD IN THE PAST YEAR.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss Of Sleep
- ☐ Loss Of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

PAIN, WEAKNESS, NUMBNESS IN:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

- ☐ Genital-Urinary
- ☐ Blood In Urine
- ☐ Frequent Urination
- ☐ Lack Of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL

- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling Of Ankles
- ☐ Varicose Veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss Of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing In Ears
- ☐ Sinus Problems
- ☐ Vision – Flashes
- VISION – HALOS

SKIN

- ☐ Bruises Easily
- ☐ Hives
- ☐ Itching
- ☐ Change In Mole
- ☐ Rash
- ☐ Scars
- ☐ Sore That Won't Heal

MEN ONLY

- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump In Testicles
- ☐ Penis Discharge
- ☐ Sore On Penis
- ☐ Other

WOMEN ONLY

- ☐ ABNORMAL PAP SMEAR
- ☐ BLEEDING BETWEEN PERIODS
- ☐ BREAST LUMP
- ☐ EXTREME MENSTRUAL PAIN
- ☐ HOT FLASHES
- ☐ NIPPLE DISCHARGE
- ☐ PAINFUL INTERCOURSE
- VAGINAL DISCHARGE
- ☐ OTHER _____

Date Of Last Menstrual Period

Date Of Last Pap Smear _____

Have You Had A Mammogram? _____

Are You Pregnant? _____

Number Of Children _____

- CONDITIONS -

CHECK CONDITIONS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ IV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Care
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

- FAMILY HISTORY -

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER				
SISTER				

Check if, your blood relatives had any of the following:

		DISEASE	RELATIONSHIP TO YOU
		ARTHRITIS	
		ASTHMA, HAY FEVER	
		CANCER	
		CHEMICAL DEPENDENCY	
		DIABETES	
		HEART DISEASE, STROKE	
		HIGH BLOOD PRESSURE	
		KIDNEY DISEASE	
		TUBERCULOSIS	
		OTHER	

- HOSPITALIZATIONS -

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION AND OUTCOME

Have you ever had a blood transfusion?
If yes, please give approximate dates ☐ YES ☐ NO

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

- PREGNANCIES -

YEAR OF BIRTH	SEX OF BIRTH	COMPLICATIONS IF ANY

- HEALTH HABITS -

Check which you use and how much you use.

	CAFFEINE	
	TOBACCO	
	STREET DRUGS	
	OTHER	

- OCCUPATIONAL -

Check If Your Work Exposes You To:

	STRESS		HAZARDOUS SUBSTANCES
	HEAVY LIFTING		OTHER

Occupation:

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REGISTRATION FORM

Please complete all sections of this form.

NAME:
DATE OF BIRTH:
ADDRESS:
CITY, STATE, ZIP:
HOME PHONE:
CAN WE LEAVE A MESSAGE? *Circle one:* **No Messages** **Brief Message Only** **Extended Message Okay**
CELL PHONE: CAN WE TEXT YOU? **YES** or **NO**
CAN WE LEAVE A MESSAGE? *Circle one:* **No Messages** **Brief Message Only** **Extended Message Okay**
WORK PHONE:
PREFERRED PHONE NUMBER FOR VOICE CALLS? *Circle one:* **HOME** **CELL** **WORK**
EMAIL: SIGN ME UP FOR PATIENT PORTAL? **YES** or **NO**
PRIMARY INSURANCE:
ID#:
SECONDARY INSURANCE:
ID#:
PRIMARY CARE PROVIDER:
MARITAL STATUS: *Circle one:* **MARRIED** **SINGLE** **DIVORCED** **WIDOWED**
EMERGENCY CONTACT NAME: RELATIONSHIP:
HOME/CELL PHONE:
RACE (optional) *Circle one:* **American Indian or Alaska Native / Asian / Black or African American Hispanic or Latino / Native Hawaiian or Other Pacific Islander / White / Other:**
ETHNICITY (optional) *Circle one:* **HISPANIC** ***NOT* HISPANIC**
PRIMARY LANGUAGE (optional):

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OFFICE POLICIES

APPOINTMENTS / OFFICE VISITS:

We will make every effort to see you when you need urgent care. Routine physicals will be scheduled within 4 to 6 weeks. Follow-ups are scheduled as your physician deems necessary. Please give us at least 48 hours' notice if you must cancel your appointment.

PAYMENTS:

Your co-payment is due on the day of your appointment. We prefer checks, Visa, MasterCard, and Discover although cash is accepted. Please make checks payable to: N.A.M.V. There is a $25.00 fee for any returned checks. All past due fees should be paid prior to your next appointment.

REFERRALS:

For Specialty Care Patients Only:

If your insurance requires a referral for your visit to this office, it is your responsibility that a referral is in place on the date of the visit. If your PCP's office has not completed the referral you will need to sign a Managed Care Agreement Form, or your appointment will be rescheduled. Although most Insurances will honor referral authorizations within 90 days from service date, it is your responsibility to request referrals within your insurance's allowed time frame to avoid denial of authorization.

For Primary Care Patients Only:

If you feel you need to see a specialist, please discuss this with your PCP. Referrals cannot be issued to patients that have not been seen within one year. Please allow our office at least one week's notice when requesting a referral. Although most Insurances will honor referral authorizations within 90 days from service date, it is your responsibility to request referrals within your insurance's allowed time frame to avoid denial of authorization.

PRESCRIPTION REFILLS:

Please allow 48 hours' notice for all prescription refills. You will need to provide us with the name of the drug, strength, direction, quantity, number of refills, and the name and location of the pharmacy.

If you have not been seen in our office with the past year, and require a prescription refill, you must schedule an appointment.

LAB/DIAGNOSTIC RESULTS:

Your physician will contact you with lab/diagnostic results that need follow-up treatment; otherwise, your results will be discussed during your next visit.

ADDRESS / INSURANCE CHANGES:

Please notify the office immediately when you have a change of name, address, telephone, or insurance information. You will be responsible for claims denied for incorrect information or late claim filing.

MEDICAL RECORDS:

The law requires that we have a signed medical release document from you to release any medical records to another provider or medical facility. Please allow 7 to 10 business days for completion of request.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES.

_____ _____

SIGNATURE DATE

PATIENT'S NAME: _____ PATIENT'S DOB: _____

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PATIENT AUTHORIZATION FORM

Because of the changes made by Congress, we are required to get your explicit permission regarding how your medical information is handled.

A copy of the Notice of Privacy Practices will be provided to all patients by our staff. Please read each authorization carefully and indicate your approval by initialing on the line provided.

I authorize the release of all medical records maintained by Nephrology Associates of the Merrimack Valley, which relates to services I have received from, or the results of tests ordered by Nephrology Associates of the Merrimack Valley. These records may be released as needed for my care for the processing of insurance claims, to satisfy the requirements of a managed care organization of which I am a member, and/or to my attorney regarding pending or anticipate litigation under a worker's compensation, motor vehicle accident, and/or third-party liability claim. Initials: _____

I am giving permission for Nephrology Associates of the Merrimack Valley to obtain my prior films, scans, labs, and any records that relate to services provided. I understand that it is my responsibility to obtain previous studies, if asked to do so. If it is necessary for an employee of Nephrology Associates of the Merrimack Valley to obtain my prior films, labs, and/or other re cords, I am giving my permission to call and/or fax on my behalf to get needed medical records and films. Initials: _____

I authorize direct payment of benefits from my insurance plan to Nephrology Associates of the Merrimack Valley. I understand that I am responsible for payment of professional fees charged by Nephrology Associates of the Merrimack Valley, which are not covered or not properly reimbursed under the terms of my insurance plan. Initials: _____

I will provide Nephrology Associates of the Merrimack Valley; with the phone numbers I authorize to be used to contact me. I authorize the use of any messaging person or system, voice mail and/or answering machine to convey information regarding my care. Initials: _____

I authorize the use of fax or e-mail to send my information to myself or other parties that have a right to receive my information.
I understand that every effort is made to protect my privacy; however, no absolute privacy guarantee is given when faxes or e-mails are used. Initials: _____

I understand that it is my right to request limited access to my records and to withdraw permission for the release of my records.
I understand that this request must be in writing and that limiting or withdrawing my permission may result in Nephrology Associates of the Merrimack Valley, discontinuing its relationship with me. In that case, I will need to seek care from another source.

_____ _____
SIGNATURE DATE

I have been offered a copy of Nephrology Associates of the Merrimack Valley's Notice of Privacy Practices for my own records.

Initials: _____

My signature above also gives my permission and consent for any and all medical information maintained in or generated by Nephrology Associates of the Merrimack Valley on my behalf to be released and/or discussed with the following person(s):

_____ _____ _____
PATIENT'S FAMILY MEMBER'S NAME RELATIONSHIP TO PATIENT TELEPHONE NUMBER

PATIENT'S NAME: _____ PATIENT'S DOB: _____

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ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

I request that payment of authorization Medicare, Medicaid, or private insurance benefits be made to Nephrology Associates of the Merrimack Valley (NAMV) for any covered services furnished by Nephrology Associates of the Merrimack Valley. I agree to pay Nephrology Associates of the Merrimack Valley the deductible and/or coinsurance on my claim.

I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid Services (CMS) and its agents, Champus/TRICARE, and its agents, or to any private insurance company and information needed to determine the benefits or the benefits payable for related services.

I further certify that the information provided by me is true, accurate and complete.

I understand and agree that I am responsible for the following expenses: any services my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

I acknowledge having received 1) a copy of Nephrology Associates of the Merrimack Valley's Notice of Privacy Practices (NPP), dated 2003, 2) Main Patient Packet which includes: Welcome Letter, Office Policies, Patient Information Form, Patient Medical History Form, and Patient Authorization Form.

_____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

If Responsible Party, please complete below:

_____

PRINTED NAME

_____

ADDRESS

_____

RELATIONSHIP TO PATIENT

_____

REASON FOR PATIENT'S INABILITY TO SIGN

_____

FOR NOTICE OF PRIVACY PRACTICES ONLY, DESCRIBE THE RESPONSIBLE PARTY'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT

PATIENT'S NAME: _____ PATIENT'S DOB: _____

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APPOINTMENT POLICY

We are always happy to be able to work with you and your health care needs and reserve a time in your providers schedule just for you. However, in consideration of others ***we require at least 48 hours' notice prior to cancellation of an appointment.*** We understand that there are circumstances that may prevent you from keeping your appointment, however, in providing us with at least 48 hours' notice; we may be able to contact another patient who needs to be seen.

Morning and afternoon appointments fill quickly and cancelling with less than 48 hours' notice does not allow us enough time to schedule another patient in need of treatment, therefore ***a cancellation or no-show fee of $50 will apply if our office is not notified at least 48 hours prior that you will be unable to make your appointment.***

• If you are running late for your scheduled appointment, please call the office immediately to see if we can accommodate you.

• If you are more than 15 minutes late for your appointment, you may need to be rescheduled to another day and time, in consideration of other patients and their scheduled appointment times.

• We greatly appreciate your understanding of and cooperation with our office policies and assisting us with accommodating our patients' scheduling needs.

I HAVE READ AND ACKNOWLEDGED THE ABOVE POLICY PROVIDED TO ME.

_____ _____

SIGNATURE DATE

PATIENT CONSENT FORM TO OBTAIN PRESCRIPTION HISTORY

I GRANT PERMISSION TO NEPHROLOGY ASSOCIATES TO VIEW MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES (PHARMACY).

_____ _____

SIGNATURE DATE

PATIENT'S NAME: _____ PATIENT'S DOB: _____

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CONSENT TO HEALTH INFORMATION EXCHANGE

Nephrology Associates of the Merrimack Valley participates in Health Information Exchanges (HIE) which are secure computer networks that allow participating health care and insurance providers nationwide to access information about you so that each provider has a complete picture of your health. Patient participation is intended to enhance coordination of care among multiple providers and may avoid the need for you to undergo duplicate tests. The information that may be provided to an information exchange includes both your medical and demographic information. Participation is optional. **Please opt in or out by checking a box below and signing.**

PLEASE CHECK ONE BOX ONLY:

☐ **OPT IN/AGREE TO SHARE** ☐ **OPT OUT/DO NOT SHARE**

By my signature below, I hereby confirm that I have been provided written information about the Health Information Exchanges and all my questions have been answered to my satisfaction. I understand that I may change my mind about participating in the network at any time by contacting Nephrology Associates of the Merrimack Valley. I understand that I have the right to request and receive an accounting of disclosures of access to my Information through the HIE at any time. I understand that Nephrology Associates of the Merrimack Valley will not condition treatment, payment, enrollment, or eligibility for benefits based on my decision to participate in this network.

Signature of Patient/Responsible Person	Relationship to Patient	Date

PATIENT'S NAME: _____ PATIENT'S DOB: _____

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