Nephrology and Hypertension Associates, LTD.
phone 662-844-4711 ▪ fax 662-844-9619

Oxford Nephrology Associates, LLC
phone 662-236-2900 ▪ fax 662-236-2922

Thomas D. Wooldridge, M.D.

J. Martin Lee, Jr., M.D.

Tzonko V. Milev, M.D.

Morris R. Hamilton, M.D.

Chris D. Miller, M.D.

Marcus Louis Britton, M.D.

Son Lam, M.D.

Amita Maibam, M.D.

Patricia S. McKnight, CFNP

Christy Jaggers, NP

Kathy Thomas, AGACNP

Fred A. Rayburn, Jr., FNP-BC

DEAR _____,

YOU ARE SCHEDULED TO SEE DR._____

DAY: _____ DATE: _____

TIME: _____

LOCATION: _____

Tupelo Office
Nephrology and Hypertension
1542 Medical Park Circle
Tupelo, MS 38801

Oxford Office
Oxford Nephrology Associates
1790 Barron Street
Oxford, MS 38655

Corinth Office
Corinth Medical Specialists
3301 Tinnin Drive
Corinth, MS 38834

Charleston Office
Charleston Clinic
401 South Church Street
Charleston, MS 38921

Holly Springs Office
Williams Medical Clinic
1938 Crescent Meadow
Holly Springs, MS 38635

Starkville Office
Starkville Internal Medicine
107 Brandon Road
Starkville, MS 39759

Batesville Office
Batesville Clinic
107 Eureka Street
Batesville, MS 38606

New Albany Office
Baptist Memorial Hospital -5th Floor
200 State Highway 30 West
New Albany, MS 38652

West Point Office
NMMC-West Point
111 Medical Center Drive
West Point, MS

Senatobia Office
Parekh Medical Clinic
300 Main Street Plaza
Senatobia, MS 38668

WE HAVE LIMITED APPOINTMENTS FOR NEW PATIENTS, PLEASE CALL IN ADVANCE IF YOU WILL BE UNABLE TO KEEP THIS APPOINTMENT.

ENCLOSED YOU WILL FIND SEVERAL INFORMATION SHEETS THAT WE NEED YOU TO FILL OUT AND BRING WITH YOU TO YOUR VISIT. PLEASE BRING YOUR INSURANCE CARDS WITH YOU ALSO AS WELL AS **ALL** MEDICATIONS.

YOUR FIRST VISIT WITH THE DOCTOR WILL BE LENGTHY, SO PLAN TO BE HERE APPROXIMATELY 1-2 HOURS. YOU MAY EAT BEFORE YOU COME AS THERE WILL BE NO FASTING TESTS DONE THAT DAY. YOU MAY ALSO TAKE YOUR MEDICATIONS AT YOUR REGULAR TIME.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL OUR OFFICE.

NEPHROLOGY AND HYPERTENSION ASSOCIATES

OXFORD NEPHROLOGY ASSOCIATES

NEW PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE # _____ ALTERNATE # _____

MARITAL STATUS: _____ SEX: _____

AGE: _____ BIRTHDATE: _____ SOCIAL SECURITY #_____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT RELATIONSHIP: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE #: _____

SPOUSE NAME: _____

SPOUSE PLACE OF EMPLOYMENT: _____

SPOUSE WORK PHONE #: _____

PRESCRIPTION DRUG INSURANCE COVERAGE ☐ YES ☐ NO (IF YES, PLEASE PROVIDE FRONT DESK WITH A COPY OF YOUR CARD)

****

HEALTHCARE PROVIDER INFORMATION & AUTHORIZATION TO RELEASE MEDICAL INFORMATION

REGULAR PHYSICIAN _____ **CITY/STATE** _____

PHYSICIAN WHO ARRANGED THIS VISIT FOR YOU: _____

CITY/STATE _____

PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION STATEMENT:
I authorize Nephrology and Hypertension Associates, LTD, its employees or agents, to forward my medical information to those persons listed above, and other healthcare providers who may be responsible for continuing my care.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

Entered in Clinix by: _____

PRIMARY INSURANCE

INSURED'S NAME: _____
INS. CO. NAME: _____ ID # _____ GROUP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF SOMEONE OTHER THAN YOURSELF CARRIES THE POLICY, PLEASE FILL OUT:
HIS/HER NAME: _____ RELATIONSHIP: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
PLACE OF EMPLOYMENT: _____
ADDRESS (IF DIFFERENT FROM PATIENT: _____

SECONDARY INSURANCE

INSURED'S NAME: _____
INS. CO. NAME: _____ ID # _____ GROUP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF SOMEONE OTHER THAN YOURSELF CARRIES THE POLICY, PLEASE FILL OUT:
HIS/HER NAME: _____ RELATIONSHIP: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
PLACE OF EMPLOYMENT: _____
ADDRESS (IF DIFFERENT FROM PATIENT: _____
****

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and other health plans to NEPHROLOGY AND HYPERTENSION ASSOCIATES, LLC. (Thomas D. Wooldridge, M.D.; J. Martin Lee, Jr., M.D.; Tzonko V. Milev, M.D.; Kenneth M. Kellum, M.D.; Morris R. Hamilton, M.D.; Christopher D. Miller, M.D.; Marcus Louis Britton, M.D.; Son G. Lam, M.D.; Patricia S. McKnight, CFNP; Christy Jaggers, NP; Kathy Thomas, AGACNP, Trenton Gray, FNP-BC). This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signed: _____ Date: _____

Responsible Party: _____ Date: _____

I have **no insurance coverage** of any type and I understand that I am fully responsible for any charges that may incur at Nephrology and Hypertension Associates, LTD.

Signed: _____ Date: _____

Responsible Party: _____ Date: _____

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CONSENT FOR RELEASE OF INFORMATION

1. I hereby authorize _____ to release the following information from the health records of:

   _____
   Patient Name

   _____
   Address

2. Information to be released:
   _____ Copy of complete health record
   _____ Copy of complete health record
   _____ History and Physical
   _____ Discharge Summary
   _____ Operative Report
   _____ Lab Results
   _____ Other _____

3. Information is to be released to _____

4. Purpose of disclosure _____

   _____

5. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6. I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

7. This facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed _____
Patient or Representative

_____
Relationship to Patient

_____
Date of Signature

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PATIENT NAME: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Nephrology and Hypertension Associates, LTD. Notice of Privacy Practices. **

SIGNATURE OF PATIENT:
_____

DATE: _____

PLEASE LIST THREE PEOPLE (FAMILY/FRIENDS) WHO MAY CONTACT US REGARDNIG YOUR PROTECTED HEALTH INFORMATION: PLEASE DO NOT INCLUDE OTHER PHYSICIANS IN THIS INFORMATION.

1. _____
2. _____
3. _____

☐ By checking I acknowledge that I do not want my health information discussed with anyone who may call this office with the exception of other healthcare providers.

FOR USE BY OFFICE PERSONNEL ONLY: (COMPLETE IF PATIENT ACKNOWLEDGEMENT NOT OBTAINED)

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the notice.

An acknowledgement was not obtained because _____

Signature of office personnel: _____ Date:_____

**if you would like a copy of the Privacy Policy for Nephrology and Hypertension Associates, LTD., this can be obtained as you check in for your visit or by calling our office and requesting.

NEPHROLOGY AND HYPERTENSION

OXFORD NEPHROLOGY ASSOCIATES

NEW PATIENT INFORMATION

DO YOU HAVE A LIVING WILL OR OTHER ADVANCE DIRECTIVE ( ) NO ( ) YES
TYPE _____

MEDICATIONS

Are you currently taking any prescription or nonprescription medications including vitamins, nutritional or "health food store" supplements, oral contraceptives, pain relievers, diuretics, or laxatives, and cold medicines?

Please list ALL medications that you are currently taking:

NAME OF MEDICTATION **STRENGTH** **HOW TAKEN**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: Have you every had an allergic reaction to Iodine or X-ray dye? ( ) YES ( ) NO

NAME OF MEDICATION **DESCRIBE ALLERGIC REACTION**

_____

_____

_____

_____

_____

Name: _____ Date: _____