Dear New Patient,

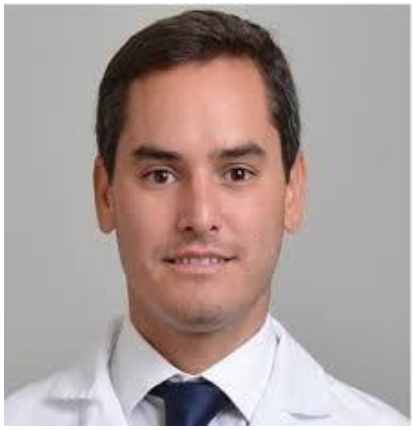
Welcome to We Care Nephrology! Thank you for choosing our care team to walk alongside you as you navigate your health journey. We are grateful for the privilege of participating in your care and will do everything possible to make your experience with us a positive one. As you prepare for your new patient appointment, feel free to reach out to us in the interim with any questions. Our vision is to empower you to take an active role in prioritizing your health. We're here to help you along the way.

Sincerely,

Jose M. Saez, DO

Mwangi Kamau, MD

Alonso Alvarado Orlandini, MD



17021 Old Orchard Road, Suite 1, Lewes Delaware 19958 (P) 302-503-3922 (F) 302-503-7986

Please PRINT

Last Name _____First Name _____ MI _____

Date of Birth ___/___/_____ Sex (circle one) Male Female Marital Status _____

Race (circle) Black American Indian/Alaskan Native Asian/Pacific Islander White Other

Are you Hispanic or Latino? Yes or No Preferred Language _____

Home Address: _____

City: _____ State: _____ Zip Code _____ SSN (optional) _____

Home Phone _____ Cell Phone _____

Email Address _____

By signing below, you consent to receiving occasional voicemails and/or text messages on the contact numbers listed above that may contain protected health information.

Signature of patient or authorized representative _____

Date _____

Your Primary Care Physician/Nurse Practitioner/Physician Assistant:

First Name _____ Last Name _____

Primary Care Practice's Name _____

Primary Care Practice's Phone Number (optional) _____

Check the box below if you do not currently have a primary care provider.

☐

Your Referring Physician/Nurse Practitioner/Physician Assistant:

First Name _____ Last Name _____

Referring Practice's Name _____

Referring Practice's Phone Number (optional) _____

If self-referred, how did you hear about us? _____

For insured patients *Please note you will be asked to provide a copy of your driver's license and insurance cards at the time of your new patient appointment.*

For self-pay patients *Payment will be required at the time of the visit. If you are completing this form in advance, feel free to call us at (302) 503-3922 to discuss payment plan options.*

Permission to Discuss Your Health Information

By signing below, I authorize We Care Nephrology to discuss information regarding my medical care with the following people:

Name: _____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature _____Date _____

Emergency Contact: _____Relationship: _____

Emergency Contact's Phone Number: (_____)_____-_____

Assignment of Benefits

By signing below, I authorize my insurance company (s) to act on my behalf and pay directly to We Care Nephrology any and all benefits due as a result of the services provided to me. I understand that I am responsible for any amount not covered by my insurance (s).

Signature: _____ Date: _____

OR

Put a checkmark here if you are a self-pay patient: _____

Office Financial Policy

1). **Check-In Payments**: Copays are due at the time of your visit.

2). **Returned Check Fee**: If payments made by check are returned by our bank due to non-sufficient funds, there will be a $20 fee.

3). **Cancellations/Re-scheduling/No-Shows**: Should you need to cancel or change your office visit appointment, you will be subject to a $25 fee for follow-up appointments and a $50 fee for new patient appointments if you not do so within a 24-hour business day advanced notice.

4). **Past-Due Accounts**: Please note that should your account remain past-due for greater than 90 days, it may be sent to a collection agency. Feel free to contact us regarding past-due bills so

we can work together to get a payment plan in place as needed.

HIPAA
NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact We Care Nephrology by mail at 17021 Old Orchard Road, Suite 1, Lewes DE 19958 or by phone.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect and have a copy of your protected health information (fees may apply). Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.

You have the right to request a restriction of your protected health information – You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications – You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You have the right to request an amendment to your protected health information – You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Acknowledgement of Receipt/Acceptance of Notice of Privacy Practices:

Patient Printed Name: _____ Patient Signature: _____

Relationship (if not patient): _____ Date: _____

Date_____

Patient History Form

List all surgeries with dates

Name (last) _____ **(first)** _____ **(mi)** _____

_____

Date of Birth ____/____/_____

_____

Preferred Pharmacy: _____
Pharmacy Address:

_____

Current Medications (include over-the-counter medicines like Tylenol, Advil, Motrin, Aleve, vitamins, supplements, etc.)

Medication Name/Dosage ***Please note you may skip this section if you are bringing a medication list with you***

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medical History (check all that apply)

☐ High blood pressure	☐ High cholesterol	☐ Stroke	☐ Depression
☐ Diabetes	☐ Asthma	☐ Neuropathy	☐ Arthritis
☐ Leg swelling	☐ COPD	☐ Anemia	☐ Spine disease
☐ Kidney stones	☐ GERD	☐ Ulcers	☐ Osteoporosis
☐ Heart disease	☐ Sleep apnea	☐ GI bleeding	☐ Frequent UTI
☐ Heart failure	☐ Allergies	☐ Hepatitis	☐ Irregular heart
☐ Heart valve problem	☐ Gout	☐ Gallbladder	☐ Seizures
☐ Heart murmur	☐ Vascular disease	☐ Cancer	☐ Thyroid

Other: _____

_____

Allergies _____

Social History (check all that apply)

Occupation_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Smoker? ☐ Yes ☐ No If yes, for how long? _____ # packs/day_____

Alcohol Use? ☐ Yes ☐ No If yes, how much? _____ Drug Use? ☐ Yes ☐ No

Preventive Screening (check box if yes, and include date)

☐ Colonoscopy Date _____ Other(s): _____ Date _____

Family Medical History(check all that apply)

Relative	Living	Deceased	Kidney Disease/ Dialysis	High Blood Pressure	Heart Disease	Diabetes	Cancer	Unknown
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐	☐	☐

Please note any additional family medical history. _____

_____

Review of Systems (Please indicate any personal history within the last three months)

General
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of energy

Eyes
- ☐ Sudden vision changes
- ☐ Double vision

Ears
- ☐ Sudden loss of hearing
- ☐ Ringing in the ears
- ☐ Frequent ear infections

Nose
- ☐ Nasal congestion
- ☐ Frequent sinus infection
- ☐ Frequent nose bleeds

Mouth/Throat
- ☐ Frequent throat infections
- ☐ Change in voice

Lungs
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath with activity

Heart
- ☐ Chest pain or pressure
- ☐ Heart palpitations
- ☐ Irregular heart beat
- ☐ Waking up short of breath
- ☐ Use many pillows to sleep
- ☐ Swelling: legs/ankles/feet
- ☐ Calf pain when walking

Stomach/Intestines
- ☐ Difficult swallowing
- ☐ Heartburn/indigestion
- ☐ Stomach pain/discomfort
- ☐ Nausea or vomiting
- ☐ Vomiting blood
- ☐ Blood in stools
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Do you use laxatives?
- ☐ Black, tarry stools
- ☐ History of jaundice

Endocrine
- ☐ Excessive thirst
- ☐ Cold/heat intolerance
- ☐ Hot flashes

Genitourinary
- ☐ Prostate problems
- ☐ Weak/slow urine stream
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Wake at night to urinate

Nervous System
- ☐ Severe headaches
- ☐ Dizziness/lightheadedness
- ☐ Loss of balance
- ☐ Numbness or tingling

Bones/Muscles/Joints
- ☐ Painful joints
- ☐ Swelling of joints

Other Issues: (please list)

Skin
- ☐ Skin rash
- ☐ Easy bruising

Blood
- ☐ Anemia
- ☐ Blood loss
- ☐ Blood transfusion

Psychiatric
- ☐ Mood swings
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep problems

Patient Name & DOB:

_____