Dear Patient:

Enclosed in the letter you will find our new patient paperwork. We ask that you complete the following paperwork and bring it with you to your appointment. If you have any questions, please phone us at 864-885-7881. You will receive a reminder call approximately1 day before your appointment.

Appointment checklist: (please be sure to bring to your appointment)

_____ Completed paperwork

_____ Detailed medication list completed (prescription and over the counter medications) or you may bring your medications in their original bottles with you.

_____ Insurance card(s) and a picture ID

Your appointment is scheduled for _____ at _____ am/pm with

Dr. Kevin O'Brien.

***Copays will be collected at the time of your appointment.

Thank you,

Oconee Kidney Center

100 Omni Drive Suite A, Seneca SC 29672 Phone (864) 885-7881 Fax (864) 885-7885

OCONEE
Kidney Center

HOW TO PREPARE FOR YOUR NEW PATIENT VISIT

The New Patient Pack that you received in the mail or picked up at our office will need to be filled out completely and returned at the time of your first appointment.

Please be sure to bring all your medication bottles to each of your appointments. This should include all prescription drugs, over the counter medications and/or any herbal remedies you have been taking.

WHAT TO EXPECT AT YOUR NEW PATIENT VISIT

At check in you will be asked to provide your current insurance card and photo identification. Also be prepared to pay any copayment that is printed on your insurance card at that time.

OFFICE COURTESIES

A 48 business hours notice is required for all call in prescriptions. Please do not wait until you are out of a medication to call for a refill.

If you need to cancel an appointment please call our office 24-48 hours a head of time. This will allow an opening for the physician to see other patients that may be in need of an appointment.

You can reach office staff Monday through Thursday from 8:30 a.m. to 12:00 p.m. and 2:00 p.m. to 5:00 p.m., we are closed on Fridays.

Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location. Completely

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

PLEASE FIND BELOW A LIST OF ALL OUR PRACTICES:

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes Community Care
Mountain Lakes ENT and Allergy Center
Mountain Lakes Internal Medicine
Oconee Heart Center
Oconee Kidney Center
Oconee Multi-Specialty Clinic
Rheumatology Consultants
Seneca Medical Associates
Upstate Family Medicine
Upstate Surgical Associates

OCONEE
Physician Practices

Patient Information

Last Name				Social Sec #	
First Name				Birth Date	
Middle Name				Sex (M or F)	
Street Address				Race	
Suite / Apt #				Primary Language	
City		State		Zip		Marital Status	
Mailing Address				Legal Guardian	
City		State		Zip		Legal Guardian's Primary Phone	
Home Phone		Work Phone		Cell Phone	
Email Address					

Guarantor Information (Person Responsible For Bill)

Last Name				Social Sec #	
First Name				Birth Date	
Middle Name				Sex (Male or Fem)	
Street Address				Relationship	
City		State		Zip		Home Phone:	
Mailing Address				Work Phone:	
City		State		Zip		Cell Phone:	

Employment Information

Patient's Employer		Employer Phone	
Spouse's Employer			

Emergency Contact Information

Name		Relationship		Phone	

Physician Information

Name of Family Physician		City/State	
Name of Referring Physician		City/State	

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)

Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

I give permission to the provider's to treat the patient. _____
Signature of Responsible Party/Self

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> _____ **Date:** _____

Patient History Information

Name_____ **DOB**_____

Reason for today's visit_____
Who referred you to our Practice? _____

Please List ALL ALLERGIES to Medications and Environment:

_____
_____

Please Check ALL that Apply

Past Medical History

___Acute Renal Failure
___Chronic Kidney Disease
    ___Stage I
    ___Stage II
    ___Stage III
    ___Stage IV
    ___Stage V
___High Blood Pressure
___Renovascular Disease
___Hyperkalemia
___Hypokalemia
___Hypercalcemia
___Hypocalcemia
___Congestive Heart Failure
___Diabetes
___HX Acidosis
___Alkalosis
___Anemia
___Vasculitis
___Diarrhea
___Kidney Transplant
___Urinary Obstruction
___Kidney Stone
___Proteinuria
___Hematuria

Additional Past Medical History

_____
_____
_____

Please Check ALL that Apply

Past Surgical/Procedures History

___Cataract Surgery
___Eye Laser for Diabetes
___Open Heart Surgery (Bypass or Valve)
___Coronary Stenting (Heart Artery)
___Removal Gallbladder
___Removal Appendix
___Amputation of Limb/Digit
___Removal of Kidney
    ___Left Partial
    ___Left Total
    ___Right Partial
    ___Right Total
___Removal of Kidney Stone

Additional Past Surgical/Procedures History

_____
_____
_____

Please Check ALL that Apply

FAMILY History Kidney

___Chronic Kidney Disease
___Kidney Stones
___Kidney Failure
___Kidney Transplant
___Bright's Disease
___Cystic Kidneys

Additional Family History

_____
_____
_____

Please Check ALL that Apply

Social History

Alcohol

___No Use
___Social
___Minimal
___Heavy
___Heavy, Past

Tobacco

___No Use
___Smoke
___Smoke, Past
___Chew, Current
___Chew, Past

Substance

___No Use
___Current Yes
___Past Use

Additional Social History

_____
_____
_____

- o **Between the Lakes**
- o **Blue Ridge Women's Center**
- o **Clemson-Seneca Pediatrics**
- o **Keowee Family Urology**
- o **Mountain Lakes Community Care**
- o **Mountain Lakes ENT & Allergy Center**
- o **Mountain Lakes Internal Medicine**
- o **Oconee Geriatric & Palliative Medicine**
- o **Oconee Heart Center**
- o **Oconee Kidney Center**
- o **Rheumatology Consultants**
- o **Seneca Medical Associates**
- o **Upstate Family Medicine**
- o **Upstate Surgical Associates**

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient's financial information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

☐ YES _____
What Phone Number

☐ NO

With whom may we discuss patient's medical information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

_____
Print Patient Name

_____
Patient Date of Birth

_____ _____
Signature of Guarantor/ Patient/ Legal Guardian Date

This authorization is in effect until revoked in writing.

OCONEE
Physician Practices

FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company. OPP also offers a 20% discount to uninsured patients if the balance is paid at the time of service or within 30 days of the visit.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a $15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

This notice is yours to keep.

301 Memorial Drive, Suite F ● Seneca, SC 29672 ● (864) 885-7989 ● FAX (864) 885-7867