Welcome to the Hypertension and Kidney Center of St Louis!

This packet contains important information to ensure a productive and thorough visit. In this packet, you will find the following:

- ✓ Patient Information Form
- ✓ Authorization for Treatment/Financial Responsibility/Financial Disclosure
- ✓ Medical History Form
- ✓ Medication Log
- ✓ Medical Records Request form
- ✓ Notice of Privacy Practices
- ✓ Notice of Privacy Practices Acknowledgement

Please take the time to complete these forms in as much detail as possible.

Please bring the following to your appointment:

- ✓ A list of your medications or the medication bottles (including vitamins and herbal supplements)
- ✓ A list of medication allergies
- ✓ A photo ID
- ✓ Your insurance card
- ✓ Completed/signed forms included with this letter

Attached are directions to our office. We look forward to meeting you. If you have any questions or concerns prior to your visit, please contact our office at 314-924-3924. Our office hours are 8:00am to 4:00pm on Monday and 8:30 am to 4:30 pm on Tuesday – Friday.

We look forward to meeting you.

Hypertension & Kidney Center Team

Offices

3009 North Ballas Road, Suite 142
Medical Office Building A
St. Louis, MO 63131

314-924-3924
Fax 314-548-2255
www.hkcstlouis.com

Missouri Baptist Outpatient Center
3844 South Lindbergh Blvd, Suite 125
Sunset Hills, Missouri 63127

Mailing Address

Hypertension and Kidney Center of St Louis • PO Box 411607 • St. Louis, MO 63141

Hypertension and Kidney Center of St. Louis, LLC **Today's Date: _____**

PATIENT INFORMATION (Please Print)

Patient: _____ Birth Date:_____ Age:_____
last name first middle

Home Address: _____
street address city/state/zip

Primary Phone:_____ Check One: ☐ Home ☐ Cell ☐ Work ☐ Other:_____

Secondary Phone:_____ Check One: ☐ Home ☐ Cell ☐ Work ☐ Other:_____

Email Address:_____ Preferred Correspondence Address: ☐ Email Address ☐ Mailing Address

Soc. Sec. No:_____ Check One: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Check One: ☐ Male ☐ Female

Employed by:_____ Occupation_____

Employer's Address_____ ( )_____
street address city/state/zip work phone

How did you hear about us: _____

Primary Care Physician: _____ Referring Physician_____

Person/ Persons Responsible for Payment: (If different from patient)

Name: _____ Relationship: _____ Soc. Sec. No. _____

Address: _____
street address city/state/zip

Primary Phone: ( )_____ Secondary Phone: ( )_____

SPOUSE OR GUARDIAN INFORMATION

Check one: ☐ Spouse ☐ Guardian: _____ Soc. Sec. No._____

Address: (street/city/zip) _____Home/Cell #( )_____

Employed By:_____ Work #( )_____

Address: (street/city/zip)_____

If above name is a parent, please complete the following for the other parent: Soc Sec No._____

Name:_____ Home #( )_____

Employed By: _____ Work # ( )_____

Address: (street/city/zip)_____

INSURANCE INFORMATION

1st Insurance:_____ 2nd Insurance:_____

Person Insured:_____ ☐ M ☐ F
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Person Insured:_____ ☐ M ☐ F
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent

Policy No._____ Group No._____

Policy No._____ Group No._____

Soc. Sec. No. _____ Birth Date_____

Soc. Sec. No. _____ Birth Date_____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled, to be made on my behalf to Hypertension and Kidney Center of St. Louis, LLC for any services furnished me. I authorize release of medical information needed to determine these benefits payable to related services.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that any information obtained from Hypertension and Kidney Center of St. Louis, LLC staff is not to be deemed as a guarantee of benefits. I also understand it is MY responsibility to determine my actual insurance benefit levels.

_____**Signature of Patient (or Legal Guardian)**

AUTHORIZATION FOR TREATMENT FINANCIAL RESPONSIBILITY FINANCIAL INTEREST DISCLOSURE

Hypertension and Kidney Center of St. Louis, LLC **Dr. Tricia V. Pavlopoulos, MD**

Patient Name: _____

1. CONSENT

I authorize my physician and other physicians that may treat me, their associates and assistants and Hypertension and Kidney Center of St. Louis, LLC, its staff, employees, agents and students to provide the medical care considered advisable by my physician. In consenting to treatment, I have not relied on any statements as to results. My physician will provide a clear description of the treatment ordered or recommended the material risks associated with the proposed treatment, excepted benefits of the treatment, a comparison of the benefits versus no treatment, and reasonable alternatives to the recommended treatment. My participation in treatment will indicate the above referenced benefits and risks have been fully explained. My signature consenting to treatment will also signify my clear understanding that I am always in control of what treatment is performed and that I may, at any time, refuse all or any part of the recommended treatment. I may also withdraw from treatment at any time.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient information, including medical information. I hereby authorize Hypertension and Kidney Center of St. Louis, LLC, its affiliates, and my treating physician to release by electronic means or otherwise any medical, prescription and/or billing information concerning my care, including copies of my medical records, to the following:

A. Any health professional, including but not limited to my referring physician, involved in my care for the purpose of facilitating the continuity of my medical care.

B. Any person or entity responsible for, or any person or entity acting as an agent for, the party responsible to pay for the medical services rendered to me at Hypertension and Kidney Center of St. Louis, LLC by employees of Hypertension and Kidney Center of St. Louis, LLC or any person providing services at Hypertension and Kidney Center of St. Louis, LLC or any affiliate. The parties responsible to pay may include third party payors, self-insurers, workers' compensation carriers and governmental agencies.

C. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining eligibility in government sponsored benefit programs.

D. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by Hypertension and Kidney Center of St. Louis, LLC, affiliates, and/or their physicians, provided that those studies are deemed appropriate by Hypertension and Kidney Center of St. Louis, LLC, affiliates, and/or their physicians.

E. Any continuing care, residential or long-term care facility, or home health agency for the purpose of providing services for my care.

I acknowledge that the above authorization for release of information to the above-mentioned has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

3. HEALTH INSURANCE BENEFITS

I understand that any insurance I may have is a contract between me and my insurance company. Hypertension and Kidney Center of St. Louis, LLC is not a party to this contract, in most cases. In cases where Hypertension and Kidney Center of St. Louis, LLC is a party to my insurance contract, Hypertension and Kidney Center of St. Louis, LLC will handle claims according to its agreement with the insurance company. Hypertension and Kidney Center of St. Louis, LLC will not become involved in disputes between me and my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc, other than to supply factual information as necessary. I understand I am responsible for verifying my level of benefits with my insurance company, obtaining appropriate referrals or preauthorization's from my insurance carrier or my primary care physician, and for coverage of supply & educational items, probes, or other durable medical equipment (DME) should such items be needed. I am also responsible for timely payment on my account.

4. MEDICARE/TRICARE/VA INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim filled by Hypertension and Kidney Center of St. Louis, LLC. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year.

5. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above named patient by Hypertension and Kidney Center of St. Louis, LLC the undersigned agrees, whether he/she signs as patient or guarantor, to pay Hypertension and Kidney Center of St. Louis, LLC for all services rendered. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payor, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred. Further, the undersigned acknowledges and agrees that the Guarantor shall be responsible for all collection fees, attorney fees, court costs, and other fees incurred by Hypertension and Kidney Center of St. Louis, LLC as a result of collection action for amounts due on this account.

6. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services provided by Hypertension and Kidney Center of St. Louis, LLC, I authorize direct payment to Hypertension and Kidney Center of St. Louis, LLC of all insurance benefits applicable to my care, which are now or which shall become due payable by me.

7. DISCLOSURE STATEMENT – DAVITA TOWN AND COUNTRY WEST

Pursuant to Missouri state law this disclosure is to advise you the physician of Hypertension and Kidney Center of St. Louis, LLC, Tricia Pavlopoulos, MD, has an investment interest in Davita Town and Country West and Davita Town and Country West at Home. We wish to inform you that should you be referred to the above named facility you are free to seek services elsewhere. Your ongoing care will not be conditioned on, or affected by, accepting the referral to Davita Town and Country West or Davita Town and Country West at Home.

8. NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received and been given the opportunity to review Hypertension and Kidney Center of St. Louis, LLC's Notice of Privacy Practice and am aware of my rights and the uses of my protected health information as indicated in this notice.

_____ _____

Patient Signature or Signature of Authorized to Consent/ Relationship to Patient Date

_____

Signature of Guarantor (if other than custodial Parent or legal guardian) Date

_____

Witness Date

Hypertension & Kidney Center of St. Louis

Medical History Form

Patient Name:_____ Date of Birth:_____

Today's Date:_____

Reason for Today's Visit: _____

Do you have…? (Circle Answer)

Renal History

Yes	No	Kidney disease	Yes	No	Pain/Burning with urination
Yes	No	Kidney stones	Yes	No	Trouble passing urine
Yes	No	High blood pressure	Yes	No	Urinate frequently at night?
Yes	No	Bladder or Kidney infections	Yes	No No	Urinary incontinence?
Yes	No	Blood in your urine	Yes	No	Swelling of legs
Yes	No	Protein in your urine	Yes	No	Sodium, Potassium, or Calcium problems?

Past Medical History

Yes	No	Diabetes	Yes	No	Blood clots in your legs or lungs
Yes	No	High blood pressure	Yes	No	Sleep Apnea
Yes	No	Stroke	Yes	No	Gastrointestinal bleeding
Yes	No	Seizure disorder	Yes	No	Liver disease or hepatitis
Yes	No	Heart disease	Yes	No	Thyroid disease
Yes	No	Heart murmur	Yes	No	Cancer
Yes	No	Heart rhythm disturbance	Yes	No	HIV infection
Yes	No	Emphysema/COPD	Yes	No	Tuberculosis
Yes	No	Asthma	Yes	No	Lupus or other autoimmune disease

For Women

Yes	No	Do you have menstrual periods?
Yes	No	Have you been pregnant? If yes, # of pregnancies?
Yes	No	Did you have toxemia/preeclampsia/complications in any of your pregnancies?

Other medical history (please specify)_____

_____

Are you allergic to any medication

Medication	Reaction

Hypertension & Kidney Center of St. Louis
Medical History Form

Patient Name:_____ Date of Birth:_____

Surgeries and Hospitalizations

What surgeries or interventions (e.g. heart cath or stent) have you had? Please include dates (year is adequate):

_____

_____

_____

Hospitalizations in the past 5 years:

_____

_____

_____

Family Medical History

Member	Medical History
Father	
Mother	
Sibling(s)	
Son(s)	
Daughter(s)	
Grandparents	

Other:_____

Social History

Yes	No	Did you receive the seasonal flu shot this year?
Yes	No	Do you smoke? If yes, how many packs/day?
Yes	No	Did you previously smoke? If yes, when did you quit?
Yes	No	Do you drink alcohol? If yes, how much?
Yes	No	Have you had a blood transfusion? If so, when?
Yes	No	Do you have tattoos?

What kind of work do you do? _____

If retired, what did you do?_____

Who do you live with? (Circle all that apply)

Spouse Child/children #_____ Significant Other Parent(s) Other

Hypertension & Kidney Center of St. Louis
Medical History Form

Patient Name:_____ Date of Birth:_____

Marrital Status: (Circle that which applies)
Single Married Divorced Widowed Partnership

Do you have symptoms such as: (Circle all that apply)
Fever/Night Sweats Loss of appetite
Chills Weight loss of more than 10lbs
Fatigue or loss of energy Headaches

Remarks:_____

Eyes (Circle all that apply)
Blurred vision Loss of vision
Double vision Eye pain
Laser therapy Cataract surgery
Remarks:_____

Ear/Nose Throat/Mouth (Circle all that apply)
Sinus problems Sores in mouth Sore throat Nose bleeds
Remarks:_____

Cardiovascular (Circle all that apply)
Chest pain or discomfort Swelling of legs Calf pain when walking
Remarks:_____

Respiratory (Circle all that apply)
Shortness of breath at rest Frequent cough
Shortness of breath with walking Wheezing
Shortness of breath when you lie down
Remarks:_____

Gastrointestinal (Circle all that apply)
Abdominal (stomach) pain Diarrhea Blood in Stool
Nausea/vomiting Heartburn/indigestion
Remarks:_____

Musculoskeletal (Circle all that apply)
Joint pain Muscle pain Rheumatoid Arthritis Gout
Swollen joints Broken bones Osteoarthritis
Remarks:_____

Skin (Circle all that apply)
Skin Rash Persistent itching
Remarks:_____

Hypertension & Kidney Center of St. Louis
Medical History Form

Patient Name:_____ Date of Birth:_____

Neurological (Circle all that apply)
Trouble with memory Pain in your hands or feet Numbness or tingling in hands or feet
Remarks:_____

Endocrine (Circle all that apply)
Too hot/cold Tired/Sluggish Excessive thirst
Remarks:_____

Hematologic/Lymphatic (Circle all that apply)
Swollen glands Blood clotting problems
Remarks:_____

Immunologic (Circle all immunizations that you have received)
Influenza vaccine Hepatitis B vaccine Pneumococcal vaccine
Remarks:_____

Psychologic
In the past month, have you had little interest or pleasure in doing things? ___ Yes ___ No
In the past month, have you felt down, depressed, or hopeless? ___ Yes ___ No

Other Information
Referring Physician:_____, Phone #: _____
Primary Care Physician:_____, Phone #:_____

Are there other providers you see routinely (for example, Cardiologist, endocrinologist, etc..) that are not listed above that you feel we should obtain records from for your visit?
If so please list their name and phone number below.

_____
_____
_____

Which pharmacy do you use to fill most of your prescriptions?
Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone #: _____

Signature:_____Date: _____

Hypertension & Kidney Center of St. Louis, LLC
314.924.3924

3009 North Ballas Road, Suite 142
Medical Office Building A
Saint Louis, MO 63131

Missouri Baptist Outpatient Center
3844 South Lindbergh Blvd, Suite 125
Sunset Hills, Missouri 63127

MEDICATION LOG

Patient Name: _____ DOB: _____

Home Phone: _____ Alternate Phone: _____

Pharmacy: _____ Pharmacy Phone: _____

List All Allergies: _____

MEDICATION	DOSE	FREQUENCY

MEDICAL RECORDS REQUEST & RELEASE

Hypertension and Kidney Center of St. Louis, LLC

3009 North Ballas Road, Suite 142
Medical Office Building A
Saint Louis, MO 63131

Missouri Baptist Outpatient Center 3844 South
Lindbergh Blvd, Suite 125
Sunset Hills, Missouri 63127

Tel 314.924.3924 Fax 314-548-2255

Date: _____

Patient Name: _____ D.O.B. _____

To: _____
Name of Provider or Medical Provider

_____
Address

_____
Address

I, _____, hereby authorize and request the following information related to my treatment and examination:

Initial Office Note
Three (3) Most Recent Office Notes
Three (3) Most Recent Imaging Studies
Three (3) Most Recent Labs

be sent to:

Hypertension and Kidney Center of St. Louis, LLC
PO Box 411607
Saint Louis, MO 63141
Fax: 314-548-2255

Patient's Signature: _____

Patient's Address: _____

_____

Patient's Phone Number: _____

Hypertension and Kidney Center of St. Louis, LLC
Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Gina Wooden,Privacy Officer
PO Box 411607
Saint Louis, MO 63141
(314) 924-3924

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on September 23, 2013.

Hypertension and Kidney Center of St. Louis, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- < Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

I hereby grant unrestricted access to my personal medical information:

Person & Relationship	Witness Initials & Date
_____	_____
_____	_____
_____	_____

PRACTICE USE ONLY

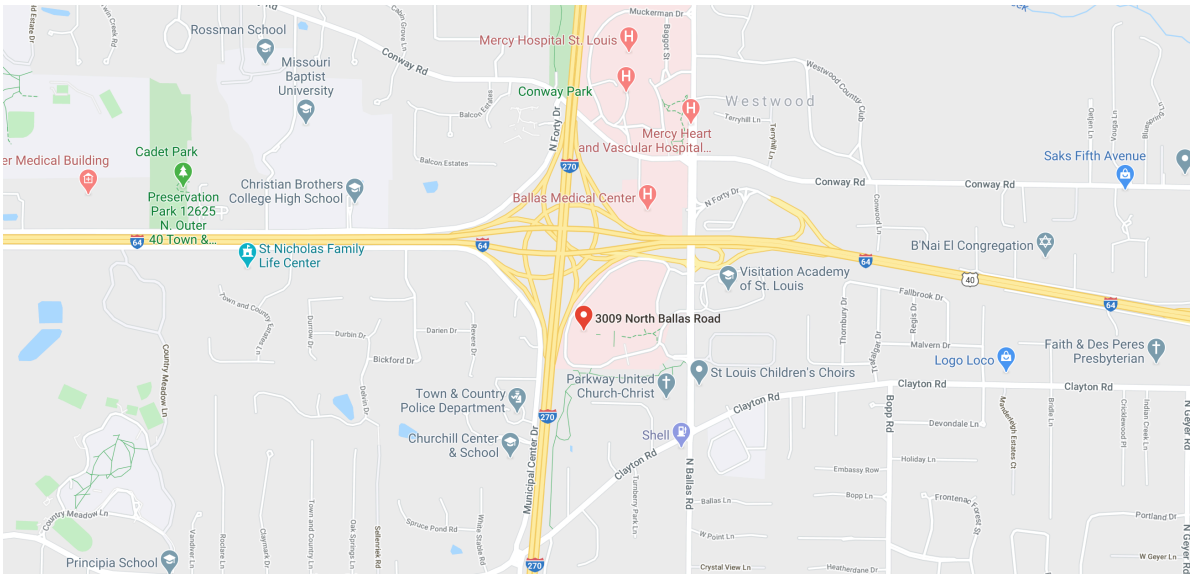
I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

HKC Hypertension & Kidney Center of St. Louis

We have two convenient locations

3009 North Ballas Road, Suite 142
Medical Office Building A
Saint Louis, MO 63131



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