Abdul Wali Nuristani, MD

Nephrology & Internal Medicine

2288 Auburn Blvd, Suite # 105
Sacramento, CA 95821
Phone: 916-500-4706 Fax: 916-200-4999

Welcome to our office. To make your visit as pleasant as possible, please take a few moments to read about our office policies.

Due to health care reform, insurance requirements vary with each insurance company and each patient. Prior to your visit, we suggest that you contact your insurance company to find out their requirements and/or services they supply you. This is the patient's responsibility and we hope it will eliminate any misunderstanding. *This appointment is a consultation, not a preventative examination; any deductible, co-insurance, and co-payment will be applied to the service, per your insurance benefits.* We do not accept any third-party billing, such as motor vehicle accidents, worker's compensation cases, or liens

All co-payments, co-insurances and deductibles are due at the time of service. We accept cash; check Visa, MasterCard and Discover. This amount is not always noted on your insurance card. It is your responsibility to know your co-payment amount. If you are a cash patient, payment is due at the time of service. If you have any questions regarding your insurance, please contact the member service department listed on your insurance card.

If you need to cancel or reschedule an appointment, please call 48 hours in advance. If you miss 2 consecutive appointments without contacting the office, you may be discharged from the practice.

Please complete the attached paperwork answering all the questions of the 4-page Health History Questionnaire, and bring to your scheduled appointment, along with your insurance cards, photo ID.

We will call and confirm your appointments 48 hours in advance.
If we leave a message, please call within 24 hours to confirm your appointment, to avoid a cancellation.

Please be on time for your appointment.
If you are more than five minutes, late your appointment will be rescheduled.

IF YOU NEED DIRECTIONS, PLEASE CALL THE OFFICE AT 916-500-4706.
We look forward to meeting you. Please call our office if you have any questions. Thank You.

Appointment is scheduled for_____; arrival time is _____ am / pm.

NOTICE OF PRIVACY PRACTICES

Abdul Wali Nuristani, M.D.
2288 Auburn Blvd, Suite # 105
Sacramento, CA 95821

MEDICAL

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by more health care providers. An example of this would include a physical exam.

Payment means such activities as obtain reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment

Health care operations include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are; however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at an alternative location.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practice with respect to protected health information.

The notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practice currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

NOTICE OF PRIVACY PRACTICES, Contd.

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For more information about HIPAA, or to file a complaint:

Dr. Abdul Wali Nuristani, M.D.

2288 Auburn Blvd, Suite # 105
Sacramento, CA 95821
916-500-4706

US Department of Health and Human Services

Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
202-619-0257 or 877-696-6775

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PATIENT FINANCIAL POLICY

Our practice is committed to providing you with the best possible medical care. Please review the following information regarding patient responsibility for the payment of services provided.

Before your appointments, please review your insurance information regarding its policies on, copayments, coinsurances and deductibles, which may be required. Office appointments are to be paid for at the time services are provided. This includes copayment, coinsurances and deductibles, and any outstanding balances. If our practice participates with your insurance plan, we will bill your insurance company for services provided.

Please bring your insurance card with you and present your card for verification at each appointment. Please note that any questions or complaints regarding your insurance coverage should be directed to your insurance company. If your insurance company happens to deny or does not respond to a claim that our practice has submitted for services to you, you may be liable for the expenses. If our practice does not participate with your insurance company or you do not have medical insurance, you will be required to pay the full cost of the office visit and any procedures or tests performed.

Payment for services can be made by cash, check, or credit/debit card including, Discover, MasterCard and Visa. **Patient or responsible party will be charges $25 for any returned check.**

CANCELLATION POLICY

If you cancel or reschedule your visit without one business days advance notice, or do not show for your appointment the fee is $50.

I have read and understand the terms and conditions in this financial policy and agree to abide by them.

Patient Name: _____

Patient Signature: _____

Date: _____

COMPLETE BOTH SIDES

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Patient Registration Information

PATIENT INFORMATION ☐ Male ☐ Female Email _____

Last Name_____ First Name_____ Middle Initial _____

Address _____City_____ State ____ Zip _____

Home phone_____ Cell phone_____ Work phone_____

Date of Birth_____ Martial Status _____ Social Security _____

Employer name and address_____

Spouse's name _____ Spouse's employer_____

Spouse's work number_____ Spouse's Social Security _____

Emergency Contact_____ Relationship to Patient _____

Address_____

Home phone_____ Cell phone_____ Work phone_____

BILLING AND/OR FINANCIAL RESPONSIBLE PARTY INFORMATION (if different from above)

Last Name_____ First Name_____ Middle Initial _____

Relationship to patient_____

Address _____City_____ State ____ Zip _____

Home phone_____ Work/cell phone_____ Social Security_____

Employer name and address_____

INSURANCE INFORMATION

Primary Insurance Company_____

Insurance address_____ City_____ State_____ Zip_____

Name of insured_____ Date of birth_____

Insurance ID number_____ Group number_____

Secondary Insurance Company_____

Insurance address_____ City_____ State_____ Zip_____

Name of insured_____ Date of birth_____

Insurance ID number_____ Group number_____

I have read and understand the office policies:

Patient Signature: _____Date _____

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Co-payment and/or or co-insurance is due at the time of service. At each visit, please be prepared to provide your insurance cards and any co-payment you may have. For cash patients, payment is due at the time of service. We accept all forms of payment. You are ultimately responsible for the payment of your bill regardless of your insurance coverage. If payment has not been received from your insurance company within 60 days, we will expect payment from you.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize Dr. Nuristani a health care provider to release all information necessary to secure the payment of benefits from my insurance carrier. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature_____ Date_____

LIFETIME BENEFICIARY CLAIM AUTHORIZATION

Name_____ Medicare Number_____

I request that payment of authorized Medicare benefits is made on behalf of Abdul Wali Nuristani, M.D. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HFCA-1500 claim form is completed, by signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is only responsible for the deductible. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Beneficiary Signature_____ Date_____

ATTENTION: MEDICARE PATIENTS

In order to prevent any delays, denials, or confusion that you may encounter with your secondary insurance billing, Medicare offers the ability to automatically bill most secondary insurance.

This will require a simple telephone call from ***you*** personally authorizing Medicare to bill your secondary insurance. Please call Medicare at 1-800-633-4227 to request this service.

COMPLETE BOTH SIDES

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PATIENT AUTHORIZATION FORM

Please complete this form if you would like us to be able to disclose the lab results or other health information to a specific family member or other individual. If you do not want any information disclosed to anyone other than yourself, please complete the appropriate area below.

Patient Name_____

I hereby authorize **Abdul Wali Nuristani, M.D**. to discuss my care and treatment with the following person(s).

_____	_____
Name	Name
_____	_____
Relationship to patient	Relationship to patient
_____	_____
Telephone number	Telephone number

I, _____ designate that _____ will be the spokesperson for my family, and have my permission to keep the family informed of my condition.

Patient's signature_____ Date_____

Please check a box - This authorization shall remain in effect from the original date signed above to my ☐ lifetime, OR ☐ until (enter an end date) _____.

OR

I hereby authorize Abdul Wali Nuristani, M.D. to discuss my care and treatment with no one other than myself.

Patient's signature_____ Date_____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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

Conduct, plan, and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and physician certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures of my health information. I understand 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 at the address above to obtain a current copy of the *Notice of Privacy Practices.*
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____

OFFICIAL USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgement, but was unable to do so as documents below:

Date: _____ Initials: _____ Reason: _____

Abdul Wali Nuristani, M.D.

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	M F	**DOB:**
Marital status:	Single Partnered Married Separated Divorced Widowed	
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	Yes	No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	Sedentary (No exercise)					
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				Yes	No
	If yes, are you on a physician prescribed medical diet?				Yes	No
	# of meals you eat in an average day?					
	Rank salt intake	Hi	Med	Low		
	Rank fat intake	Hi	Med	Low		
Caffeine	☐ None	Coffee	Tea	Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				Yes	No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				Yes	No
	Have you considered stopping?				Yes	No
	Have you ever experienced blackouts?				Yes	No
	Are you prone to "binge" drinking?				Yes	No
	Do you drive after drinking?				Yes	No
Tobacco	Do you use tobacco?				Yes	No
	Cigarettes – pks./day		Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit				

Drugs	Do you currently use recreational or street drugs?	Yes	No
	Have you ever given yourself street drugs with a needle?	Yes	No
Sex	Are you sexually active?	Yes	No
	If yes, are you trying for a pregnancy?	Yes	No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	Yes	No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	Yes	No
Personal Safety	Do you live alone?	Yes	No
	Do you have frequent falls?	Yes	No
	Do you have vision or hearing loss?	Yes	No
	Do you have an Advance Directive and/or Living Will?	Yes	No
	Would you like information on the preparation of these?	Yes	No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	Yes	No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	M F	
Mother				M F	
Sibling	M F			M F	
	M F			M F	
	M F		Grandmother *Maternal*		
	M F		Grandfather *Maternal*		
	M F		Grandmother *Paternal*		
	M F		Grandfather *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	

THE FOLLOWING 3 QUESTIONS ARE VOLUNTARY:

1. RACE: **0** American Indian and Alaskan Native **0** Asian **0** Black or African American **0** Black Hispanic or Latino
0 Native Hawaiian and Other Pacific Islander **0** White **0** White Hispanic or Latino

2. Ethnicity: **0** Hispanic or Latino **0** Not Hispanic or Latino

3. Language Preference: **0** English **0** Spanish **0** Chinese **0** German **0** French **0** Italian **0** Other _____