

# The Kidney Clinic, LLC



2386 Clower Street | Suite C-105 | Snellville, GA 30078  
 1501 Milstead Road | Suite 150 | Conyers, GA 30012  
 10132 Carlin Drive | Covington, GA 30014  
 3370 Sugarloaf Pkwy | Suite A1 | Lawrenceville, GA 30044  
 4805 Lawrenceville Hwy | Suite 320 | Lilburn GA 30047

Mazen Abdalla, MD, FACP  
 Divakar Jammalamadaka, MD  
 Sherria Jasper, NP-C  
 ☎ (678) 344-0334 📠 (678) 344-0343

## Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Suffix: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender: \_\_\_\_\_ M \_\_\_\_\_ F Marital Status: \_\_\_\_\_ S \_\_\_\_\_ D \_\_\_\_\_ M \_\_\_\_\_ W

Address: \_\_\_\_\_ City: \_\_\_\_\_

State/Zip: \_\_\_\_\_, \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Preferred Contact: \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_ Work Is Patient a Referral? \_\_\_\_\_ Y \_\_\_\_\_ N

Referring Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Insurance

Primary Insurance: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Relationship to Policy Holder: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

Secondary Insurance: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

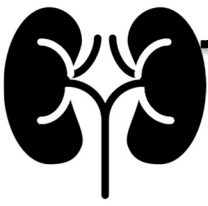
Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Relationship to Policy Holder: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

*I hereby authorize my insurance company benefits to be paid directly to the physician. I realize I am responsible to pay for any non-covered services. I hereby authorize the release of pertinent medical information to the insurance company.*

\_\_\_\_\_  
 Patient or Legal Representative's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date



2386 Clower Street | Suite C-105 | Snellville, GA 30078  
1501 Milstead Road | Suite 150 | Conyers, GA 30012  
10132 Carlin Drive | Covington, GA 30014  
3370 Sugarloaf Pkwy | Suite A1 | Lawrenceville, GA 30044  
4805 Lawrenceville Hwy | Suite 320 | Lilburn GA 30047

Mazen Abdalla, MD, FACP  
Divakar Jammalamadaka, MD  
Sherria Jasper, NP-C

☎ (678) 344-0334 📠 (678) 344-0343



**RELEASE OF MEDICAL RECORDS**

I, the undersigned, hereby authorize the medical office of THE KIDNEY CLINIC including the staff and agents, to release any and all medical information about me, including but not limited to my medical records, that is necessary to process any claims for insurance or reimbursement and to communicate with other medical personnel and medical facilities to coordinate my care.

I, the undersigned, also authorize THE KIDNEY CLINIC to obtain my medical records from all other treating physicians, hospitals and other facilities. I also authorize the release of my Protected Health Information from all other treating physicians, hospitals and other facilities to THE KIDNEY CLINIC.

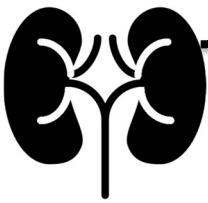
This authorization shall remain in effect until I specifically notify THE KIDNEY CLINIC in writing that I am revoking this authorization.

Please Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please Sign Name: \_\_\_\_\_

Date: \_\_\_\_\_



2386 Clower Street | Suite C-105 | Snellville, GA 30078  
1501 Milstead Road | Suite 150 | Conyers, GA 30012  
10132 Carlin Drive | Covington, GA 30014  
3370 Sugarloaf Pkwy | Suite A1 | Lawrenceville, GA 30044  
4805 Lawrenceville Hwy | Suite 320 | Lilburn GA 30047

Mazen Abdalla, MD, FACP  
Divakar Jammalamadaka, MD  
Sherria Jasper, NP-C

☎ (678) 344-0334 📠 (678) 344-0343

**Insurance Authorization / Consent For Treatment**

I, the undersigned, hereby authorize the medical offices of The Kidney Clinic including but not limited to Physicians, staff and agents, to release any and all medical information about me, including but not limited to my medical records, that is necessary to communicate with and to process any claims for insurance or reimbursement.

Payment for services provided is due at the time services are rendered. We will submit a claim for you to any third party or insurance carrier with whom we contract. Any fees not payable by the third party or insurance carrier, and any non-covered services, are the patient's responsibility.

I hereby also authorize and assign payment of any and all medical benefits to The Kidney Clinic for services rendered and authorize my insurance company on files' benefits to be paid directly to the physician.

I hereby give consent for medical treatment by the physicians and the staff of The Kidney Clinic.

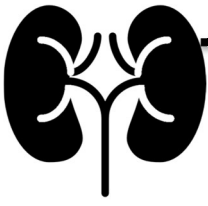
This authorization shall remain in effect until I specifically notify The Kidney Clinic in writing that I am revoking this authorization.

Please Print Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

Please Sign Name: \_\_\_\_\_

Date: \_\_\_\_\_



# The Kidney Clinic, LLC



2386 Clower Street | Suite C-105 | Snellville, GA 30078  
1501 Milstead Road | Suite 150 | Conyers, GA 30012  
10132 Carlin Drive | Covington, GA 30014  
3370 Sugarloaf Pkwy | Suite A1 | Lawrenceville, GA 30044  
4805 Lawrenceville Hwy | Suite 320 | Lilburn GA 30047

Mazen Abdalla, MD, FACP  
Divakar Jammalamadaka, MD  
Sherria Jasper, NP-C

☎ (678) 344-0334 📠 (678) 344-0343

## HIPAA PRIVACY NOTICE CONSENT FORM

I understand and have been provided with a copy of The Kidney Clinic’s “Notice of Privacy Practices”.

The Kidney Clinic reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form I acknowledge that I have been afforded the opportunity to consider The Kidney Clinics Notice of Privacy Practices prior to signing this consent and making healthcare decisions.

I authorize The Kidney Clinic to release medical and financial information, including any or all reports, records, bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare or insurance provider.

The Kidney Clinic maintains patient medical records on electronic media which may be accessible to any physician or healthcare provider participating in my current or future care.

Medical records are disclosed according to applicable GA State and Federal laws, and the provisions of this consent.

### HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

Can we leave test results on your answering machine?  No  Yes Ph# \_\_\_\_\_

You may disclose my medical information to the following family members/friends:

\_\_\_\_\_ Patient ONLY      \*\*OR\*\*

\_\_\_\_\_ Please Print Name      \_\_\_\_\_ Relationship      \_\_\_\_\_ Phone Number

\_\_\_\_\_ Please Print Name      \_\_\_\_\_ Relationship      \_\_\_\_\_ Phone Number

\_\_\_\_\_ Please Print Name      \_\_\_\_\_ Relationship      \_\_\_\_\_ Phone Number

I acknowledge that I have received a copy of The Kidney Clinic’s “Notice of Privacy Practices”.

\_\_\_\_\_ Signature of patient or Legal Guardian

\_\_\_\_\_ Date