HERSHEY KIDNEY SPECIALISTS, INC.

Kidney Diseases, Hypertension & Transplantation
Board Certified Nephrologists

Jonathan R. Diamond, M.D.
Alisa Bell, D.O.
Suneetha Vaddineni, M.D.

Barbara A. Little, C.R.N.P.

4700 Union Deposit Road, Suite 240
Harrisburg, PA 17111
(717) 526-4474
Fax (717) 526-4476
1-877-816-HKSI (4574)

Welcome to Hershey Kidney Specialists!

Your appointment has been scheduled for:

Enclosed are a few forms (medical history, medication list, authorization release) that should be completed and brought along to your appointment along with your current insurance cards. In addition, you will find a brief summary about the doctor you will be seeing and driving directions.

At the time your appointment was scheduled, your medical records were requested from the referring doctor's office. However, if the doctor's office fails to send the records your appointment may be rescheduled to ensure our doctors receive all the proper documentation. Also, if you are covered by an insurance carrier that requires a referral form or prior authorization it is your responsibility to obtain the required forms in time for your appointment.

If you have any questions concerning your upcoming appointment, please feel free to contact us at 717-526-4474. We look forward to your visit and welcome you to our practice.

Sincerely,

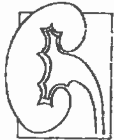
Hershey Kidney Specialists, Inc.

Other Locations

254 East High Street
Carlisle, PA 17013

38-42 Londonderry Square
Palmyra, PA 17078

240 Grandview Avenue
Camp Hill, PA 17011



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FINANCIAL POLICY

Dear Patient:

Thank you for choosing Hershey Kidney Specialists as your nephrology healthcare provider. We are dedicated to successful treatment and will provide you with the highest medical care possible.

Please understand the payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- We request that you bring your insurance cards with you to each office visit to ensure that accurate information is obtained during your registration. Regardless of your insurance, payment remains your personal responsibility whether your insurance pays or not. Your policy is a contract between you and your insurance company.
- Payment of your co-pay is expected at the time of service. We accept cash, checks, Visa, and Mastercard for your convenience.
- Your insurance and payment information is forwarded to our billing company, Healthcare Billing, Inc. All bills are generated from their office, so if you have any questions regarding your bill, please call 1-800-450-6208.

Participating Insurances

If we do participate with your insurance company, all services performed in our office and at the hospital will be submitted to your insurance carrier. All co-payments, co-insurances and deductibles are the patient's responsibility. Co-pays for office visits are due when you check out with the receptionist. Deductibles will be billed to you by Healthcare Billing. It is your responsibility to be aware of what your plan covers. If you are unsure of your coverage, we suggest that you contact Member Services at the phone number on the back of your insurance identification card.

HMO's

HMO's may require referrals for services. It is the patient's responsibility to obtain a referral prior to the date of service. If a referral is not presented at the time of service, the patient will be responsible for payment in full for that service.

Non-Participating Insurances

If we do not participate with your insurance company, the following procedure is implemented. We will bill your insurance company. If the insurance company pays us, we will then bill that amount plus the balance of our bill, if any, to the patient. If the insurance company pays the patient, we will bill that amount, plus the balance of our bill to the patient. The patient is obliged to pay the practice whether or not a patient bill is received in the mail. The "superbill" received at the time of service is the bill. Our billing company can provide you with an itemized statement that will be sufficient for submitting claims to your insurance, i.e. Major Medical, for reimbursement.

Cancellation and Missed Appointments

We ask that you kindly give us 24 hours notice if you will be canceling your appointment with us. Please help us serve you and other patients better by keeping your scheduled appointments.

Returned Checks

There will be a $20.00 processing fee for any check returned unpaid from your bank. This is in addition to any fees that your bank may charge you.

I have read and fully understand the financial policy set forth by Hershey Kidney Specialists and I agree to the terms. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient.

____ _______________
Signature of Patient   Date

Date Effective: January 1, 2005

AUTHORIZATION FORM
DISCLOSURE OF INFORMATION

I, ____, hereby authorize **Hershey Kidney Specialists, Inc.** to :

_____ use the following protected health information, and/or

_____ disclose the following protected health information to:

____

____

____

This protected health information is being used or disclosed for the following purpose(s):

____

____

____

This authorization shall be in force and effect until one year from date signed, or until the purpose for which this disclosure has been requested is fulfilled, whichever comes first. After that time, this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Hershey Kidney Specialists, 4700 Union Deposit Road, Suite 240, Harrisburg, PA 17111. I understand that a revocation is not effective to the extent that Hershey Kidney Specialists has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Hershey Kidney Specialists will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected information to be used or disclosed as permitted under federal law (or state law to the extent that the state law provides greater access rights)
- Refuse to sign this authorization

The use or disclosure requested under this authorization will result in direct or indirect remuneration to Hershey Kidney Specialists from a third party, if applicable.

______________________________________	______________________________
Signature of Patient or Personal Representative	Date
______________________________________	______________________________
Name of Patient or Personal Representative	Description of Representative's Authority

MEDICATION LIST

NAME: ______________________________ DOB: ______________

ALLERGIES (include reactions): ______________________________

❑ NKA ______________________________

DATE	MEDICATION/ DOSAGE	FREQ	PRESCRIBED BY	DISC DATE	NOTES

OTC

HERBALS/ALTERNATIVE

PHARMACY: ______________________________