KIDNEY DISEASE CONSULTANTS, P.C.
Olufemi O. Adeleye, M.D., FACP
Ola O. Adeleye, DNP, FNP-BC
7080 GOLDEN OAKS LOOP E, STE 101
SOUTHAVEN MS, 38671
PHONE: (662) 536-1892
FAX: (662) 536-1859

Dear _____,

Your primary doctor/hospital has set up an appointment for you to see Dr. Adeleye on

_____ at _____.

Please fill out the attached forms completely and bring them with you to your appointment. Also, please bring all insurance cards, a picture ID, and all medications you are currently taking. Failure to do so may cause a delay in your scheduled appointment time.

We look forward to seeing you at your scheduled appointment.

Thank you,

Olufemi O. Adeleye, M.D., FACP
Ola O. Adeleye, DNP, FNP-BC
And
Kidney Disease Consultants Staff

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PATIENT INFORMATION

Name:_____Date_____

Date of Birth: _____ SSN: _____ ☐ Male ☐ Female

Race: _____ Language Spoken: _____

Address: _____City:_____State:_____Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Employer: _____ Work Phone (_____) _____

Person to contact in case of emergency: _____ Phone: _____

Relationship to You: _____

Primary Doctor: _____ Phone: _____

Who referred you to our practice? _____

Phone: _____ Fax: _____

Pharmacy Name: _____ Phone: _____

Address: _____

_____

Welcome to our practice, we appreciate the opportunity to serve you. Our goal is to provide you with the best medical care possible. The information below is intended to ensure you are aware of certain treatment, financial and privacy policies. If you have any questions, please inform a member of our front desk.

Consent for Medical Treatment and Authorization to Release Medical Information

I hereby authorize examination and/or treatment by Dr. Adeleye or persons under his supervision.

I give Kidney Disease Consultants, PC. (KDC) permission to obtain and/or release medical records from/to any physician, pharmacy or healthcare facility that has assisted or will assist in my care.

Section II: Acknowledgement of Receipt of HIPAA

I acknowledge that I have received a copy of KDC Patient Agreement including the Notice of Privacy Practices for Protected Health Information. I have been given an opportunity to ask questions about this agreement and the privacy practices described therein.
I give permission for messages to be left on my answering machine/voicemail system and/or speak to a family member or other persons at my home if I am not available unless I have completed a ***Restriction Form*** which has been approved in writing by Kidney Disease Consultants, PC.

Section III: No Show Policy

A $50 service charge per visit will be applied to a patient's account if the patient is a no show and the appointment has not been cancelled within 24 hours of scheduled appointment time.

Section IV:Consent for Electronic Prescribing

I authorize the physicians and other appropriate licensed providers of KDC and other healthcare teams to submit prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history, and current medications for any health care providers.

Section V: Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by KDC. I assign and authorize payments of medical insurance benefits to KDC directly and release any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fee, court costs and collection agency costs in the event of default of payment of charges. It is my responsibility to contact my insurance plan prior to treatment at KDC.

If my insurance plan requires a referral in order to be treated by KDC providers, it is my responsibility to obtain the referral prior to being treated by KDC. If a referral is required, and I fail to obtain one, I will be financially responsible for any services rendered.

KDC will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or a plan that KDC does not participate in, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out-of-network" I am responsible for the balance.
KDC accepts cash, checks, bank debit cards such as American Express, Discover, Mastercard, and Visa. In the instance of a returned check, it is subject to a $35 processing fee.

Section VI: Uninsured and Self-Pay Patients

Do not let the lack of healthcare insurance deter you from seeking medical advice and treatment at our practice. An office visit Payment of $253.00 for new patients and $217.00 for additional visits, is due in full at the time services are rendered and any remaining costs will be billed to you accordingly. If you have financial constraints, payment arrangements can be made prior to your actual visit.

Section VII: Refunds

Overpayments will be refunded to the appropriate party, normally the insurance company or guarantor. Patients' refunds will not be processed until all active or past due accounts are paid in full. Refunds of less than $25.00 will not be issued unless specifically requested.

Name of Patient: _____ D.O.B. _____

Signature: _____ Date: _____

Revised 04/2025

KIDNEY DISEASE CONSULTANTS, PC

Consent for Email Communications

Please provide an email address if you would like to access our online lab result portal for patients.

(If you have chosen to Opt-out, please do not sign this form).

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

I understand and agree to the following:

o I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.

o I understand that all email communications in which I engage may be forwarded to other providers for purposes of providing treatment to me.

o I agree to hold Kidney Disease Consultants and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

_____ _____

Signature of patient **Date**

KIDNEY DISEASE CONSULTANTS, PC

EMAIL OPT-OUT FORM

If you do not have an email address to access the patient portal or do not want to sign up for the patient portal, please sign this form, opting out.

(If you are providing an email address, please do not sign this form)

I, _____ hereby choose to opt out of CMS EHR Meaningful Use patient electronic access.

_____ _____

Signature **Date**

Name:_____ D.O.B.:_____ Date:_____

Medicare Questionnaire (MSPQ)

Part I:

1. Are you receiving Black Lung (BL) Benefits? _____YES _____NO
2. Are the services to be paid by a government research program? _____YES _____NO
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)? _____YES_____NO
4. Was the illness/injury due to a work-related accident/condition? _____YES _____NO

Part II:

1. Was the illness/injury due to a non-work-related accident? _____YES _____NO

Part III:

1. Are you entitled to Medicare based on Age? _____YES _____NO
2. Are you entitled to Medicare based on disability? ____YES _____NO
3. Are you entitled to Medicare based on End-Stage Renal Disease? _____YES _____NO

Part IV:

1. Are you currently employed? _____YES _____NO
2. Do you have a spouse who is currently employed? _____YES _____NO
3. Do you have a group health plan (GHP) coverage based on your own current employment? _____YES _____NO
4. Do you have a group health plan (GHP) coverage based on your spouse's current employment? _____YES _____NO
5. Does your employer that sponsors or contributes to the GHP employ 100 or more employees? _____YES _____NO