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PATIENT INFORMATION

PATIENT NAME: ______________________________
Last First Middle

ADDRESS: ______________________________

ZIP CODE: __________ CITY: __________ STATE: __________

Please mark (☑) preferred daytime contact phone number.

☐ HOME PHONE: __________ ☐ WORK PHONE: __________ ☐ CELL PHONE: __________

EMAIL ADDRESS: ______________________________

DATE OF BIRTH: __________ SOCIAL SECURITY NUMBER: __________

MARITAL STATUS: __________ PREFERRED COMMUNICATION: ☐ PHONE ☐ SECURE EMAIL ☐ POSTAL MAIL

GENDER: __________ RACE: __________ ETHNICITY: __________ LANGUAGE: __________

PRIMARY CARE PHYSICIAN: __________ REFERRING DOCTOR: __________

EMPLOYER: __________ EMPLOYER PHONE #: __________

RESPONSIBLE PARTY INFORMATION *(if different from patient)*

RESPONSIBLE PARTY NAME: ______________________________
Last First Middle

☐ same as above

ADDRESS: ______________________________

ZIP CODE: __________ CITY: __________ STATE: __________

HOME PHONE: __________ WORK PHONE: __________ CELL PHONE: __________

DATE OF BIRTH: __________ SOCIAL SECURITY NUMBER: __________

INSURED PARTY INFORMATION

PRIMARY INSURANCE COMPANY: ______________________________

IDENTIFICATION NUMBER: __________ POLICY GROUP NUMBER: __________

PATIENT RELATIONSHIP TO INSURANCE SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PRIMARY INSURANCE SUBSCRIBER NAME: ______________________________

PRIMARY SUBSCRIBER'S DATE OF BIRTH: ______________________________

SECONDARY INSURANCE COMPANY: ______________________________

IDENTIFICATION NUMBER: ______________________________

PATIENT RELATIONSHIP TO INSURANCE SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE SUBSCRIBER NAME: ______________________________

SECONDARY SUBSCRIBER'S DATE OF BIRTH: ______________________________

EMERGENCY CONTACT INFORMATION

NAME: __________ RELATIONSHIP: __________

☐ HOME PHONE: __________ ☐ WORK PHONE: __________ ☐ CELL PHONE: __________

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PATIENT HISTORY

Do you have a: ☐ Living Will/Advance Directive ☐ Durable Power of Attorney

Patient's Name: ____________________ Date: ____________

Height: __________ Weight: __________ Age: __________

Describe Your Chief Complaint (Reason for your visit): ____________________

____

PAST MEDICAL HISTORY: (Please check if you are receiving treatment or have received treatment in the past for any of the following conditions)

☐ Anemia ☐ Diabetes ☐ Rheumatoid Arthritis ☐ Kidney Disease ☐ Hypertension ☐ Cancer
☐ Heart Disease ☐ Heart Failure ☐ Stroke ☐ Kidney Stones ☐ Liver Disease ☐ Lupus
☐ Other: ____________________

PAST SURGICAL HISTORY:

☐ Heart Surgery ☐ Heart Valve Surgery ☐ Abdominal Surgery
☐ Other: ____________________

Other Physicians you are currently seeing/have seen for the above conidtions: ____________________

____

FAMILY HISTORY: Please list any immediate family members who have experienced the following:

Cancer & Type:	☐ Yes	☐ No	Family Member:
Diabetes:	☐ Yes	☐ No	Family Member:
Heart Disease:	☐ Yes	☐ No	Family Member:
High Blood Pressure:	☐ Yes	☐ No	Family Member:
Stroke:	☐ Yes	☐ No	Family Member:
Kidney Disease:	☐ Yes	☐ No	Family Member:

Please list any medications you are allergic to (include reaction): ____________________

Please list all medications you are currently taking - Prescriptions/OTC/Supplements

Medication Name:	*Dosage:*	*Frequency:*	*Duration:*	*Medication Name:*	*Dosage:*	*Frequency:*	*Duration:*

Local Pharmacy: ____________________ Mail Order Pharmacy: ____________________

Please bring all bottles/containers of medicine with you on the day of your appointment.

Patient Signature ____________________ Date ____________

Reviewed by Physician ____________________

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SOCIAL HISTORY

Marital Status	☐Single	☐Partnered	☐Separated
	☐Married	☐Divorced	☐Widowed
Living	☐Live alone	☐Live with significant other	
	☐Live with spouse	☐Live with other:	
Employment	☐Occupation/Employer:		
	☐Retired		
Tobacco	☐NO - I do not smoke and have never smoked.		
	☐YES - I previously smoked but no longer smoke.	Quit Date?	
		Previous # of packs per day?	
		Previous # of years smoking?	
	☐YES - I am currently smoking.	Number of packs per day?	
		Number of years smoking?	
Alcohol	☐NO - I do not drink any alcohol.		
	☐YES - I previously drank alcohol but no longer drink alcohol.	Quit Date?	
		Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	
	☐YES - I drink alcohol.	Type of alcohol?	
		# of drinks per week?	
		# of years drinking?	
Drugs	☐NO - I do not use any illicit or recreational drugs.		
	☐YES - I currently use/have previously used illicit or recreational drugs. Which illicit or recreational drugs have you used? ____________________ How many years have you used illicit or recreational drugs? ____________________ Have you used IV drugs? ☐YES ☐NO		

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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.

If you have any questions about this Notice, please contact our Privacy Officer.

1. Purpose

We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at Nephrology Specialists, P.C. in order to provide you with quality care and to comply with certain legal requirements.

This Notice of Privacy Practices describes how we may use and disclose medical information about you, including demographic information, that may identify you and your related health care services to carry out your treatment and obtain payment for our services, to perform the daily health care operations of this practice and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your medical information.

We are required to abide by the terms of this Notice of Privacy Practices.

2. Written Acknowledgement

You will be asked to sign a written statement that acknowledges that you have received a copy of this notice. The acknowledgement only serves to create a record that you have received a copy of the notice.

3. Changes to this Notice

We may change the terms of our Notice, at any time. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised copy, you may call our office and request that a revised copy be sent to you in the mail or you may ask for one at the time of your next appointment.

4. How We May Use and Disclose Medical Information about You

The following categories describe the different ways that Nephrology Associates, P.C. may use and disclose your medical information and a few examples of what we mean. These examples are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures that maybe made by our office. Other uses and disclosures of your medical information that are not listed or described below will be made only with your written authorization, at any time, in writing, but it will not apply to any actions we have already taken.

For your treatment: Your medical information may be used and disclosed by us for the purpose of providing medical treatment to you or for another health care provider providing medical treatment to you. For example, a nurse obtains treament information about you and documents it in your medical record and the physician has access to that information. If you require an x-ray to be taken, the x-ray technician also has access to your medical information. In addition, your medical information may be provided to a physician to whom you have been referred or are otherwise seeing to ensure that the physician has the necessary information to diagnose or treat you.

To obtain payment for our services: Your medical information may be used and disclosed by us to obtain payment for your health care bills or to assist another health care provider in obtaining payment for their health care bills. As an example, we may submit requests for payment to your health insurance company for the medical services that you received. We may also disclose your medical information as required by your health insurance plan before it approves or pays for the health care services we recommend for you.

For our health care operations: Your medical information may be used by us to support our daily operations. These health care operation activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your medical information to medical school students that see patients at our office. We may also use the medical information we have to determine where we can make improvements in the services and care we offer.

For the health care operations of other health care providers: We may also use your medical information to assist another health care provider treating you with its quality improvement activities, evaluation of the health care professionals or for fraud and abuse detection or compliance. For example, we may disclose your medical information to another physician to assist in its efforts to make sure that it is complying with all rules related to operating a medical practice.

For appointment reminders: We may use or disclose your protected health information, as necessary,to contact you to remind you of your appointment, by telephone or by mail. Our message may include the practice name, name of the physician you are scheduled to see, date and time of the appointment, as well as the reason for the appointment. If you do not want our office to leave messages of this nature, you may request, in writing, that we not leave this type of message.

To provide you with treatment alternatives: We may use or disclose your medical information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may contact several home health agencies or physical therapy providers to discuss the services they provide when we have a patient who needs these services.

To our business associates: We will share your medical information with third party "business associates" that perform various activities (e.g., billing, dictation) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information. For example, Nephrology Specialists, P.C. may hire a billing company to submit claims to your health care insurer. Your medical information will be disclosed to this billing company, but a written agreement between our office and the billing company from using your medical information in any way other than what we allow.

Others Involved in Your Health Care: We may, to a member of your family, a relative, a close friend, or any other person you identify, disclose your medical information that directly relates to that person's involvement in your health care, unless you object. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or diclose your medical information to notify a family member or any other person that is responsible for your care of your location and general health condition. Finally, we may use or disclose your medical information to an authorized public or private entity to assist in (1) disaster relief efforts and (2) to coordinate uses and disclosures to family or other individuals involved in your health care.

As required by law: We may use or disclose your medical information to the extent that the use or fisclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

For communicable disease exposure: We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

To your employer: We may disclose your medical information concerning a work related injury or illness

to your employer if you are covered under your employer's policy in order to conduct an evaluation relating to medical surveillance of the work place or to evaluate whether you have a work-related injury, in accordance with the law.

For abuse or neglect: We may disclose your medical information to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your medical information if we believe that you have been a victim of abuse, neglect or domestic violenece as may be required or permitted by Virginia and/or federal law.

For health oversight: We may disclose your medical information to a health oversight agency for activities authorized by law. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs (such as Medicare or Medicaid), other government regulatory programs and civil rights laws.

In legal proceedings: We may disclose your medical information in the course of any judicial or administrative proceeding, in response to an order of a court or adminstrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena or other lawful request.

For law enforcement: We may also disclose your medical information, so long as all legal requirements are met, for law enforcement purposes. Examples of these law enforcement purposes include (1) information requests for identification and location purposes, (2) pertaining to victims of a crime, (3) suspicion that death has occured as a result of criminal conduct, (4) in the event that a crime occurs on the premises of Nephrology Specialists, P.C., and (5) in a medical emergency where it is likely that a crime has occured.

To coroners, to funeral directors, and for organ donation: We may disclose your medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to a funeral director to carry out its duties. We may disclose such information in reasonable anticipation of death. Your medical information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

For research: We may disclose your medical information to researchers when their research has been established as required by federal and state law.

Due to criminal activity: Consistent with applicable federal and state laws, we may disclose your medical information if we believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For military activity and national security: When the appropriate conditions apply, we may use or disclose medical information for individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your medical information to authorizd federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

For workers' compensation: Your medical information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Regarding inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

For required uses and disclosures: Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act and its regulations.

5. Your Rights

Following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your medical information. You may inspect and obtain a copy of your medical information that we maintain. You must make this request in writing. You will be charged a reasonable fee for this service. The information may contain medical and billing records, and any other records that we use for making decisions about you. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled related to a civil, criminal, or administrative action; and medical information that is subject to law that prohibits access to medical information in certain circumstances. We may deny your request to inspect your medical information. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have any questions about access to your medical record.

You have the right to request a restriction of your medical informaion. This means you may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or health care operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to your request. If we aggree to the requested restriction, we may not use or disclose your medical information in violation of that restricton unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss all restrictions in writing to our Privacy Officer.

You have the right to request that we accommodate you in communicating confidential medical information. We will accommodate reasonable requests, but we may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request. Please make this request in writing to our Privacy Officer.

You have the right to ask us to amend your medical information. You may request an amendment of your medical information as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a disagreement with us and we may respond in writing to you. Please contact our Privacy Officer if you have questions about amending your medical record.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your medical information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made pursuant to your authorization (permission), made directly to you, family members or friends involved in your care, or for appointment notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us. If you would like a paper copy of this notice, please request one from our Privacy Officer or request one when you are in our offices.

6. Complaints

You may complain to us if you believe your privacy rights have been violated by us. To file a complaint, please contact our Privacy Officer who will be happy to assist you. We will not retaliate against you for filing a complaint. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services.

7. Privacy Context

If you have any questions about this Notice or require additional information, please contact our Privacy Officer, who is available during normal business hours to discuss your privacy questions, concerns or complaints.

8. Effective Date

This notice was published and becomes effective on April 14, 2003.

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CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, FINANCIAL POLICIES

- **Consent for treatment**
  I authorize Nephrology Specialists, P.C. (NSPC) to render medical treatment to me and/or my dependents.

- **Assignments of Benefits/Release of medical information**
  I authorize that payment for Medicare or other applicable private insurance benefits be paid directly to NSPC for services provided under their care. I also authorize NSPC to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered. I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician.

- **Exposure**
  In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or my body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.

- **Financial Responsibility**
  I understand and agree that I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay, at the time of servce, any required co-payments, co-insurance and decuctibles, as well as charges for services not covered by my insurance. I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance. I undestand that there is a $30 charge for returned checks. I understand that past due accounts will be referred to a collection agency and I agree to be responsbile for all collection charges, associated legal fees, in addition to the full unpaid balance on my account.

- **Referrals/Authorizations**
  I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do no have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. In these instances, payment in full is required at the time of service.

- **Patient Photo Identification**
  I authorize the taking of my photograph and/or scanning of my photo ID for the sole use of the physicians and staff at NSPC. NSPC will use this photograph to assist in patient identification and as part uof the medical record. As such, the use and privacy of the poto retains full protection under NSPC's HIPAA policy. It will not be used for marketing or anyother purpose not stated above without my expressed, written permission.

- **Privacy and Disclosure**
  Our **N**otice of **P**rivacy **P**ractices (**NPP**) provides information about how we may use and disclose your personal health information. By signing below, I acknlowedge that I have reviewed and understand the statements above and I agree to abide by them. I also acknowledge that I have received a copy of the NSPC Notice of Privacy Practices.

  ☐ Patient refuses to sign **Privacy and Disclosure** portion of form. Reason:

I have reviewed and I understand the statements above and I agree to abide by them.

Patient/Guarantor Signature	**Printed Name**	**Date**

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ____

Date of Birth: ______________________

Address: ____

I authorize release of my medical records (including office notes, labs, pathology reports, radiology reports) to Nephrology Specialists, P.C.

Provider:

- ☐ **Dr. Gerald Keightly**
- ☐ **Dr. Trudy Rickman**
- ☐ **Dr. Beth McNeer**
- ☐ **Dr. Walid Abou Assi**
- ☐ **Dr. Bhavesh M. Patel**
- ☐ **Dr. Deep V. Patel**

☐ **5320 Patterson Avenue, Suite 200, Richmond, VA 23226 - PHONE: 804-285-3389 FAX: 804-285-3389**

☐ **8400 North Run Medical Drive, Suite 200, Mechanicsville, VA 23116 - PHONE: 804-559-6980 FAX: 804-559-6982**

☐ **7605 Forest Avenue, Suite 109, Richmond, VA 23229 - PHONE: 804-285-6390 FAX: 804-285-6393**

This authorization will expire on: ______________________ (if no date is indicated, authorization will expire six months from the date release is signed.)

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance ipon this authorization. My writen revocation must be submitted to the Privacy Officer at:
NEPHPROLOGY SPECIALISTS, P.C., 1603 Santa Rosa Road, Suite 102, Richmond, Virginia 23229.

I ☐ **DO** ☐ **DO NOT** want information about **MENTAL HEALTH** released.

I ☐ **DO** ☐ **DO NOT** want information about **HIV TESTS** released.

I ☐ **DO** ☐ **DO NOT** want information about **ALCOHOL/SUBSTANCE ABUSE** released.

Patient's/Legal Guardian's Signature: ____

Date: ______________________

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PERMISSION TO DISCLOSE PRIVATE HEALTH INFORMATION (PHI)

Patient Name: ________________________ Date of Birth: ________________

By my signature, I authorize Nephrology Specialists, PC to (please check all that apply):

- ☐ Leave voice messages on my answering machine regarding my appointments, personal medical conditions and health issues.
- ☐ Permit the individuals listed below to pick up medications on my behalf. Proof of identifications must be provided by the individual picking up the medications.
- ☐ Speak with the individuals listed below regarding my personal medical condition/test results/health issues:

Name	Relationship to Patient
________________________	________________
________________________	________________
________________________	________________

In order to obtain information by telephone, the party speaking with the practice must share the patient identifier with the NSPC staff. The patient identifier is: ________________

I understand this form is legally binding and that I may revoke the authorizations contained within at any time by submitting another Permission to Disclose Private Health Information (PHI) form or terminating such authoriza-

Signature of Patient or Legal Guardian: ________________________ Date: ________________

Printed Name of Patient or Legal Guardian: ________________________

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FORMULARY BENEFITS DATA CONSENT FORM

Formulary benefits data is maintained for health insurance providers by organizations known as **Pharmacy Benefit Managers (PBM)**. PBMs are third-party administrators of prescription drug programs whose primary responsibility is processing and paying prescription drug claims. They also develop and maintain formularies (lists of drugs covered by a particular medication benefit plan).

We may need to access you PBM history to determine what medications have been prescribed to you in the past and which drugs are covered under your prescription drug plan.

By signing below, I give permission for Nephrology Specialists, PC to access my pharmacy benefits data via SureScripts. This consent will allow NSPC to:

- Determine pharmacy benefits and drugs copays.
- Check formularies to see if a medication is covered under your plan.
- Find therapeutic alternatives with preference rank within drug class for non-formulary medications.
- Determine if your health plan allows electronic prescribing, and, if so, send your medications electronically to your pharmacy.
- Download a list of all medications prescribed for you by other providers.

Patient Name (printed) **Date of birth**

Patient/Guardian Signature **Date**