RENAL MEDICINE ASSOCIATES

Patient Demographic Sheet

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile _____

SSN: _____ Email: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

Preferred Pharmacy: _____

Secondary Pharmacy: _____

Insurance Information

Primary Insurance

Subscriber's Name: _____

Subscriber: Self: _____ Spouse: _____ Parent: _____ Other: _____

Subscriber's ID: _____ Subscriber's Date of Birth: _____

Secondary Insurance

Secondary Insurance Subscriber's Name: _____

Subscriber: Self: _____ Spouse: _____ Parent: _____ Other: _____

Secondary Insurance ID: _____ Subscriber's Date of Birth: _____

Responsible Party Information (if different from the patient)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____

RENAL MEDICINE ASSOCIATES
3821 Masthead St NE Albuquerque NM 87109
PH 505-998-7400 FX 505-998-7744

NOTICE OF PRIVACY PRACTICES

David Ginsberg, Privacy Official (*505-998-7418*)

Effective Date: [03/01/2017]

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact us at the phone number above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment.We use medical information about you to provide your medical care.We disclose medical information to our employees and others who are involved in providing the care you need.For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide.Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment.We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations.We may use and disclose medical information about you to operate this medical practice.For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff.Or we may use and disclose this information to get your health plan to authorize services or referrals.We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death.In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts.We may also disclose information to someone who is involved with your care or helps pay for your care.If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances.If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

5. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

6. Public Health.We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to:preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

7. Health Oversight Activities.We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure, and other proceedings, subject to the limitations imposed by law.

8. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

9. Law Enforcement.We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

10. Coroners.We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

11. Organ or Tissue Donation.We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

12. Public Safety.We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

13. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

14. Worker's Compensation.We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

15. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

16. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

17. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written

authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections.You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed.If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy.You have the right to inspect and copy your health information, with limited exceptions.To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format.We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, we will provide your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and state law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend.You have a right to request that we amend your health information that you believe is incorrect or incomplete.You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete.We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial.We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures.You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your

written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Official listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area and we will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Official listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

OCRMail@hhs.gov

The complaint form may be found at:**www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**.
You will not be penalized in any way for filing a complaint.

RENAL MEDICINE ASSOCIATES

Patient Informed Consent Form

Patient Name: _____

Last 4 of SSN: _____ DOB: _____

Address: _____

- I hereby understand that Renal Medicine Associates will file all my insurance claims, provided I inform them of the correct policy information and that I have a current referral or prior authorization from my primary care provider as required by my insurance carrier.
- I understand that I am financially responsible for all services provided.
- I request that payment be may to Renal Medicine Associates, LTD. on any billed services that are rendered to me.
- I have received a copy of the Notice of Privacy Practices. **Initial:** _____
- I give Renal Medicine Associates consent to run a Pharmacy History Report. **Initial:** _____

Appointment Confirmation

I give Renal Medicine Associates permission to confirm my appointment forty-eight hours (48) in advance of my next appointment and/or I authorize representatives of Renal Medicine Associates to leave information on my home, mobile or work phone numbers. **Initial:** _____

I give Renal Medicine Associates permission to send correspondence via email. **Initial:** _____

I give Renal Medicine Associates permission to send text messages to my mobile phone. **Initial:** _____

★ Please keep in mind that a $30 fee may apply if you do not contact our office within twenty-four hours (24) to cancel a scheduled appointment.

Authorizing Representative

1) _____ Relation: _____

2) _____ Relation: _____

Patient Signature (or Authorized Representative Signature)

_____ _____

Patient/Parent/Guardia/Authorized Representative Signature Date

RENAL MEDICINE ASSOCIATES

Authorization to Release Medical Information (To RMA)

Patient Name: _____

Last 4 of SSN: _____ DOB: _____

Address: _____

The undersigned authorizes my healthcare providers to release to Renal Medicine Associates any and all medical records or reports, including hospital records, outpatient provider notes, radiology and laboratory reports, prescription information, and all information pertaining to my examination and treatment. This authorization includes the release of all information, with the exception of information concerning:

☐ Mental Health Records

☐ Communicable Diseases (Including HIV & AIDS)

☐ Alcohol/Drug Abuse Treatment

☐ Other (Please Specify): _____

☐ No Exceptions

I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

The above information is to be released for the purpose for continued medical care, treatment or consultation, billing and claims payment, or other purposes as I may direct. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____

Patient Signature Date

_____ _____

Patient Guardian or Authorized Representative Date

RENAL MEDICINE ASSOCIATES

Patient Medication List

Patient Name: _____ DOB: _____

Are you allergic to any medications? (Please list): _____

_____

_____

_____

Please provide the names of all medications you are currently taking. This includes any over the counter (OTC) medications and supplements. Be sure to include the Medication Name, Medication Dosage/Strength (i.e. mg, mcg, mEq, etc.), and frequency of use (i.e. daily, twice daily, etc.).

If you are unsure about any medications, please bring all of your bottles in with you for your appointment.

	Medication	Dose	Frequency of Use
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			

RENAL MEDICINE ASSOCIATES

Review of Systems Form

Constitutional	☐ Fever	☐ Fatigue
	☐ Weight Gain	☐ Weakness
	☐ Weight Loss	
HEENT (Head, Eyes, Ears, Nose & Throat)	☐ Vision Impaired	☐ Sinus Problems
	☐ Hearing Loss	☐ Sore Throat
	☐ Ear Pain	☐ Headache
Respiratory	☐ Shortness of Breath	☐ Wheezing
	☐ Cough	☐ Night Sweats
Cardiovascular	☐ Chest Pain	☐ Edema
	☐ Palpitations	
Gastrointestinal	☐ Abdominal Pain	☐ Vomiting
	☐ Nausea	☐ Constipation
	☐ Diarrhea	☐ Indigestion
	☐ Heartburn	☐ Loss of Appetite
Genitourinary	☐ Urinary Urgency	☐ Urinary Frequency
	☐ Blood in Urine	☐ Foamy Urine
Musculoskeletal	☐ Back Pain	☐ Joint Pain
	☐ Neck Pain	☐ Muscle Pain
Skin	☐ Rash	☐ Itching
Neurological	☐ Numbness	☐ Tingling
Psychiatric	☐ Depression	☐ Anxiety
	☐ Insomnia	
Endocrine	☐ Excessive Thirst	☐ Excessive Urination
Hematology	☐ Bleeding Gums	☐ Bruising

Other Review of Systems Not Listed Above:

RENAL MEDICINE ASSOCIATES

Patient History Form

Instructions:
Please fill out the following sections to the best of your knowledge and as completely as possible. If none are applicable, please fill in with "N/A" or "Unknown".

Past Medical/Surgical History:

Family Medical History:

Social History: