NORTHWEST NEPHROLOGY CLINIC
REGISTRATION FORM
(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Phone Number: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐ Medicare	☐ Medicaid	☐ Aetna	☐ Blue Cross	☐ Cigna

☐ UHC	☐ Care Improvement	☐	☐	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to **Northwest Nephrology Clinic**. I understand that I am financially responsible for any balance. I also authorize Northwest Nephrology Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

NORTHWEST NEPHROLOGY CLINIC

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____

Date of Birth: _____

Allergy: _____ Reaction: _____

Allergy: _____ **Reaction:** _____

Current List of Medications (Please list name/dose/frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History:

	Living		Age (or age at death)	Medical History
Mother	☐ Yes	☐ No	_____	_____
Father	☐ Yes	☐ No	_____	_____
Sisters	☐ Yes	☐ No	_____	_____
Brothers	☐ Yes	☐ No	_____	_____

Personal Health History

History of tobacco use_____ How much _____packs/day No. of years _____
Year you quit _____

History of alcohol use _____ How much _____drinks/week No. of years _____
Year you quit _____

History of drug use _____

Past Surgical History (indicate date if known)

☐ None
☐ Tonsillectomy _____
☐ Adenoidectomy _____
☐ Cardiac Stents _____
☐ Defibrillator _____
☐ Appendectomy _____
☐ Hemorrhoidectomy _____
☐ Hysterectomy _____
☐ Colonoscopy _____
☐ Spinal Surgery _____
☐ Orthopedic/joints _____
☐ Other _____
☐ Cataracts _____
☐ Thyroidectomy _____
☐ Coronary Bypass _____
☐ Pacemaker _____
☐ Gall Bladder _____
☐ Bowel /Stomach Resection _____
☐ Bariatric Surgery _____
☐ Endoscopy _____
☐ Hernia _____
☐ Bladder Surgery _____
☐ Prostate Surgery _____

Patient Name: _____ **Date of Birth:** _____

Past Medical History:

Headaches	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Heart Burn/Reflux	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
☐ Coronary Disease	☐ Yes	☐ No
☐ MI/Heart Attack	☐ Yes	☐ No
☐ Congestive Heart Failure	☐ Yes	☐ No
☐ Atrial Fibrillation	☐ Yes	☐ No
☐ Angina	☐ Yes	☐ No
☐ Valve Disorder	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Gastrointestinal Bleeding	☐ Yes	☐ No
Hepatitis (A, B, C)	☐ Yes	☐ No
Chronic Wounds	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
☐ Breast	☐ Yes	☐ No
☐ Ovarian	☐ Yes	☐ No
☐ Prostate	☐ Yes	☐ No
☐ Lung	☐ Yes	☐ No
☐ Throat	☐ Yes	☐ No
☐ Kidney	☐ Yes	☐ No
UTI	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Prostate Disease	☐ Yes	☐ No
Breast Disease	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No

Patient Name: _____ **Date of Birth:** _____

Social History:

Work: □ Employed □ Unemployed □ Retired □ Disabled

Occupation: _____

Marital Status: □ Married □ Single □ Divorced □ Domestic Partner

Children (age):

_____

_____

Hobbies:

_____

_____

Sports:

_____

_____

Religious Preference: _____

NORTHWEST NEPHROLOGY CLINIC

HYPERTENSION AND NEPHROLOGY

5255 Snapfinger Park Dr Ste 110
Decatur, GA 30035
Office 770-981-2211 Fax 770-981-0208

465 Winn Way Ste 201
Decatur, GA 30030
Office 404-355-1446 Fax 404-328-0226

Andrew A Dixon, M.D. Juan L. Pimentel, M.D.,FACP Arun Kumar, M.D. Aakash Amin, M.D.

Thank you for choosing us as your healthcare provider. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

PLEASE UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE.

Understanding your bill
When you receive your bill, you will have the name of the physician whom treated you. Bills for physician services are separate from bills you will receive for any services performed outside our office. Quest Diagnostics, Solstas and LabCorp are separate entities from Northwest Nephrology Clinic.

Regarding Insurance
WE DO REQUIRE YOUR CO-PAYMENT, DEDUCTIBLES AND ANY CO-INSURANCES BE PAID AT THE TIME SERVICES ARE RENDERED. IF YOU ARE UNABLE TO PAY AT THE TIME SERVICES ARE RENDERED, YOU MAYBE REQUIRED TO RESCHEDULE YOUR APPOINTMENT IF OTHER ARRANGEMENTS HAVE NOT BEEN MADE WITH THE BILLING DEPARTMENT. It is your responsibility to provide us with complete and accurate insurance information. If you are a member of a managed healthcare system or an HMO (Health Maintenance Organization), such as Aetna, Blue Cross Blue Shield HMO or POS, Cigna, or Coventry, etc., a referral is required from your primary care physician before we can see you. **IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL FROM THE PHYSICIAN or PRACTICE LISTED ON YOUR INSURANCE CARD.**

Uninsured Patients
Full payment is due at the time services are rendered. We accept your personal check (we process electronically with Certegy Check Services), VISA, MC, and American Express. If your physician orders lab work for you, you will receive a separate bill from the lab for those charges. If you are unable to pay the full amount of your bill, please ask to speak to someone in our billing department in order to make payment arrangements.

Other Policies
For any checks returned unpaid, your account will be charged a 30.00 service fee. We do not balance bill for any copays. Copays are to paid at the time services are rendered.

Billing Inquiries
When you have a question regarding your bill, you may call 770-981-2211 and ask to speak with a representative in the billing department.

I have read and agree to this financial policy. I understand that failure to follow this policy may result in delay of medical services.

DATE

PATIENT SIGNATURE

HIPAA
NOTICE OF PRIVACY PRACTICES

Practice Name: Northwest Nephrology Clinic
Address: 5255 Snapfinger Park Dr, Suite 110
City, State: Decatur, GA 30035

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

For purposes of this Notice "us" "we" and "our" refers to (our healthcare facility) and "you" or "your" refers to our patients (or their legal representatives as determined by us in accordance with state informed consent law). When you receive health-care services from us, we will obtain access to your medical information (i.e. your health history). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

State law and the Health Insurance Portability & Accountability Act of 1996 (HIPAA) require us to maintain the confidentiality of all your health-care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally ("PHI or Protected Health Information). HIPAA is a federal law that gives you significant new rights to understand and control how your health information is used. HIPAA and state law provide penalties for covered entities and records owners, respectively, that misuse or improperly disclose PHI.

Starting April 14, 2003, HIPAA requires us to provide you with the Notice of our legal duties and the privacy practices we are required to follow when you first come into our office for health-care services. If you have any questions about this Notice, please ask to speak to our privacy officer, (insert name) at (insert telephone number and extension, email address, etc.).

Our doctors, clinical staff, Business Associates (outside contractors we hire), employees and other office personnel follow the policies and procedures set forth in this Notice. If your regular doctor is unavailable to assist you (i.e. illness, on-call coverage, vacation, etc.), we may provide you with the name of another health-care provider outside our practice for you to consult with by telephone. If we do so, that provider will follow the policies and procedures set forth in this notice or those established for his or her practice, so long as they substantially conform to those for our practice.

OUR RULES ON HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we must have your signature on a written, dated Consent form and/or an Authorization form (not an Acknowledgement form) before we will use and disclose your PHI for certain purposes as detailed in the rules below.

Documentation – You will be asked to sign a Consent form and/or an Authorization form when you receive this Notice of Privacy Practices. If you did not sign such a form or need a copy of the one you signed, please contact our Privacy Officer. You may take back or revoke your consent or authorization at any time (unless we already have acted based on it) by submitting our Revocation form in writing to us at our address listed above. Your revocation will take effect when we actually receive it. We cannot give it retroactive effect, so it will not affect any use or disclosure that occurred in our reliance on your Consent or Authorization prior to revocation (i.e. if after we provide services to you, you revoke your authorization or consent in order to prevent us billing or collecting for those services, your revocation will have no effect because we relied on your authorization or consent to provide services before you revoked it).

General Rule – If you do not sign our Consent form or if you revoke it, as a general rule (subject to exceptions described below under "Healthcare Treatment, Payment and Operations Rule" and "Special

Rules"), we cannot in any manner use or disclose to anyone (excluding you, but including payers and Business Associates) your PHI or any other information in your medical record. Under state law, we are unable to submit claims to payers under assignment of benefits without your signature on our Consent form. We will not condition treatment on your signing an Authorization, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign the Consent or revoke it.

Health-care Treatment, Payment and Operations Rule

With your signed consent, we may use or disclose your PHI in order:

- To provide you with or coordinate health-care treatment and services. For example, we may review your health history form to form a diagnosis and treatment plan, consult with other doctors about your care, delegate tasks to ancillary staff, call in prescriptions to your pharmacy, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other health-care providers, schedule lab work for you, etc.
- To bill or collect payment from you, an insurance company, a managed-care organization, a health benefits plan or another third party. For example, we may need to verify your insurance coverage, submit your PHI on claim forms in order to get reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan or provide your x-rays because your health plan requires them for payment; or
- To run our office, assess the quality of care our patients receive and provide you with customer service. For example, to improve efficiency and reduce costs associated with missed appointments, we may contact you by telephone, mail or otherwise remind you of scheduled appointments, we may leave messages with whomever answers your telephone or email to contact us (but we will not give out detailed PHI), we may call you by name from the waiting room, we may ask you to put your name on a sign-in sheet, we may tell you about or recommend health-related products and complementary or alternative treatments that may interest you, we may review your PHI to evaluate our staff's performance, or our privacy officer may review your records to assist you with complaints. If you prefer that we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, please notify us in writing at our address listed above and we will not use or disclose your PHI for these purposes.

Special Rules

Notwithstanding anything else contained in this Notice, only in accordance with applicable law, and under strictly limited circumstances, we may use or disclose your PHI without your permission, consent or authorization for the following purposes:

- When required under federal, state or local law
- When necessary in emergencies to prevent a serious threat to your health and safety or the health and safety of other persons
- When necessary for public health reasons (i.e. prevention or control of disease, injury or disability, reporting information such as adverse reactions to anesthesia, ineffective or dangerous medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence)
- For federal or state government health-care oversight activities (i.e. civil rights laws, fraud and abuse investigations, audits, investigations, inspections, licensure or permitting, government programs, etc.)
- For judicial and administrative proceedings and law enforcement purposes (i.e. in response to a warrant, subpoena or court order, by providing PHI to coroners, medical examiners and funeral directors to locate missing persons, identify deceased persons or determine cause of death)
- For workers' compensation purposes (i.e. we may disclose your PHI if you have claimed health benefits for a work-related injury or illness)

- For intelligence, counterintelligence or other national security purposes (i.e. Veterans Affairs, U.S. military command, other government authorities or foreign military authorities may require us to release PHI about you)
- For organ and tissue donation (i.e. if you are an organ donor, we may release your PHI to organizations that handle organ, eye or tissue procurement, donation and transplantation)
- For research projects approved by an Institutional Review Board or a privacy board to ensure confidentiality (i.e. if the researcher will have access to your PHI because involved in your clinical care, we will ask you to sign an authorization)
- To create a collection of information that is "de-identified" (i.e. it does not personally identify you by name, distinguishing marks or otherwise and no longer can be connected to you)
- To family members, friends and others, but only if you verbally give permission. We give you an opportunity to object and if you do not, we reasonably assume, based on our professional judgment and the surrounding circumstances, that you do not object (i.e. you bring someone with you into the operatory or exam room during treatment or into the conference area when we are discussing your PHI); we reasonably infer that it is in your best interest (i.e. to allow someone to pick up your records because they knew you were our patient and you asked them in writing with your signature to do so); or it is an emergency situation involving you or another person (i.e. your minor child or ward) and, respectively, you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you. In these emergency situations we may, based on our professional judgment and the surrounding circumstances, determine that disclosure is in the best interests of you or the other person, in which case we will disclose PHI, but only as it pertains to the care being provided and we will notify you of the disclosure as soon as possible after the care is completed.

Minimum Necessary Rule

Our staff will not use or access your PHI unless it is necessary to do their jobs (i.e. doctors uninvolved in your care will not access your PHI; ancillary clinical staff caring for you will not access your billing information; billing staff will not access your PHI except as needed to complete the claim form for the latest visit; janitorial staff will not access your PHI). Also, we disclose to others outside our staff only as much of your PHI as is necessary to accomplish the recipient's lawful purposes. For example, we may use and disclose the entire contents of your medical record:

- To you (and your legal representatives as stated above) and anyone else you list on a Consent or Authorization to receive a copy of your records
- To health-care providers for treatment purposes (i.e. making diagnosis and treatment decisions or agreeing with prior recommendations in the medical record)
- To the U.S. Department of Health and Human Services (i.e. in connection with a HIPAA complaint)
- To others as required under federal or state law
- To our privacy officer and others as necessary to resolve your complaint or accomplish your request under HIPAA (i.e. clerks who copy records need access to your entire medical record)

In accordance with the law, we presume that requests for disclosure of PHI from another Covered Entity (as defined in HIPAA) are for the minimum necessary amount of PHI to accomplish the requestor's purpose. Our Privacy Officer will individually review unusual or non-recurring requests for PHI to determine the minimum necessary amount of PHI and disclose only that. For non-routine requests or disclosures, the Plan's Privacy Officer will make a minimum necessary determination based on, but not limited to, the following factors:

- The amount of information being disclosed
- The number of individuals or entities to whom the information is being disclosed
- The importance of the use or disclosure
- The likelihood of further disclosure

NORTHWEST NEPHROLOGY CLINIC

HYPERTENSION AND NEPHROLOGY

5255 Snapfinger Park Dr Ste 110
Decatur, GA 30035
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Andrew A Dixon, M.D. Juan L. Pimentel, M.D.,FACP

465 Winn Way Ste 201
Decatur, GA 30030
Office 404-355-1446 Fax 404-328-0226
Arun Kumar, M.D. Aakash Amin, M.D.

HIPAA PATIENT ACKNOWLEDGEMENT
ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
You may refuse to sign this acknowledgement, but, in refusing, we will not be allowed to process your insurance claims

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Northwest Nephrology Clinic. A copy of this signed, dated acknowledgement shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTHCARE INFORMATION.
(This includes spouse, children, grandchildren, sister, brother, and any care takers who can have access to this your records)

Name:_____ Relationship:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- o Cell phone Confirmation
- o Home phone Confirmation
- o Work phone Confirmation
- o Email Confirmation
- o U.S. Mail/Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE** BE CONVEYED VIA:

- o Message on cell phone
- o Message on home phone
- o Message on work phone
- o Email message
- o U.S. Mail/Postcard
- o **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS OR NEW HEALTHCARE INFO** VIA:

- o Phone Message
- o Email
- o U.S. Mail/Postcard
- o **Any of the above**

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Informed Consent to use Patient Portal

Northwest Nephrology Clinic, P.C. is offering a secure, HIPAA compliant communication tool as a courtesy to our patients. It is an optional service, and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly a possible. This form is intended to inform you of the facts and risks surrounding the use of the patient portal. By signing below, you confirm that you have read, understand and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Northwest Nephrology Clinic, P.C. or any of their staff liable for network infractions beyond their control.

Privacy and Security

The Patient Portal has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons form being able to access and read your health information or your communication to us. To help insure that the tunnel remains secure, we need to have your current email address and be informed if it ever changes. Keep your portal user ID and password secured so you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to the portal site and change it.

Your email address is confidential and protected information and with our best effort, we will protect this information as we do your medical and other personal information. We will never purposefully share this information with any third party. All access to our internal network and electronic medical records (EMR) is password protected. Our staff are instructed to log off their workstations when not physically present. Additionally, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity.

Similar to phone communications, messages may be read and addressed by different NNC staff. When your provider is ill or on vacation, your emails will be addressed by a covering physician.

Patient Name _____ Date of Birth _____

Patient Signature _____

Confidential email, please print clearly:

_____(your portal login will go to this email address)

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Formulary Benefits Data Consent

Formulary Benefits Data is maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

This consent will enable Northwest Nephrology Clinic and it's clinical staff to:

- **Determine the pharmacy benefits and drug copays for a patient's health plan**
- **Check whether a prescribed medication is covered (in formulary) under a patient's plan**
- **Display therapeutic alternatives with preference rank (if availale) within a drug class for non-formulary medications.**
- **Determine if a patient's plan allow electronic prescribing to Mail order pharmacies and if so, e-prescribe to these pharmacies.**
- **Download a historical list of all medications prescribed for a patient by any provider.**

By signing below, *I hereby give permission for the health care providers at Northwest Nephrology Clinic and its clinical staff to access my pharmacy benefits data, electronically, which includes information about other prescriptions prescribed by other providers using RxHub.*

_____ _____

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

_____

Patient Signature