



Patient Information Sheet

Name: _____ Date of Birth: _____ Sex: Male Female
 Address: _____ Social Security # : _____
 _____ Emergency Contact: _____
 _____ Phone: _____ Hm Wk Other
 City, State, Zip: _____ Marital Status: Married Single Divorced Widow
 Phone: _____ Hm Wk Other **Referring Physician:** _____
 Phone: _____ Hm Wk Other **Primary Physician:** _____
 Responsible Party: _____ Address: _____ Phone: _____

Patient Employment

Employed Retired Unemployed Other
 Employer: _____ Contacts: _____
 Employer Phone: _____

Insurance

Primary Insurance Company: _____ Insured ID: _____ Policy Group: _____
 Guarantor: Check if Same as Patient: _____ Relationship to Patient: _____ Social Security # : _____
 Employer: _____ Date of Birth: _____
 Secondary Insurance Company: _____ Insured ID: _____ Policy Group: _____
 Guarantor: Check if Same as Patient: _____ Relationship to Patient: _____ Social Security # : _____
 Employer: _____ Date of Birth: _____

I hereby authorize payment of insurance benefits to be paid directly to Capital Nephrology Associates, PA for any services furnished to me. I authorize Capital Nephrology Associates, PA to release to the Health Care Financing Administration and its agents, Medicaid, Champus, Medicare or any commercial insurance carrier any information needed to determine the benefits or the benefits payable for related services not covered by insurance or prepayment programs. I hereby authorize the release of my medical records to other physicians and insurance companies deemed necessary.

Signature _____ **Date** _____

Authorization to Release Medical Information

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I understand that a photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time. I hereby authorize any physician, whether past or present, following my care to disclose medical information, by mail or fax to:

Capital Nephrology Associates, PA
 1015 E 32nd St., Ste. 414
 Austin, TX 78705

Signature _____ **Date** _____

IF YOUR INSURANCE REQUIRES AN AUTHORIZATION PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE. OTHERWISE YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.



Capital Nephrology Associates, PA
Office Policy- Please Read Carefully

Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks, MasterCard Visa, Discover, and American Express.

We are providers for several PPO and HMO insurance plans and will be happy to file our claim for you. Co-payments are due prior to seeing the physician at the time of service. You are responsible for obtaining any necessary referral or authorization from your primary care physician. You are responsible for any non-covered charges. If your insurance does not make payment within 45 days, you may be asked to call them for the status of the claim.

Frequently, insurance companies may require additional information from the patient before processing a claim. If you receive such information in the mail, please fill out the form and mail it back to your insurance company as quick as possible. Failure to do so will make you responsible for the entire bill regardless of our contract status. We will expect payment of the deductible and coinsurance amounts at the time of service, or proof that your deductible has been met. We allow 60 days for processing of your insurance claims. At the end of that time, if your insurance has not paid, the entire balance becomes your responsibility.

Medicare: Capital Nephrology Associates, PA will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your 20 percent and, if not met, your yearly deductible at the time of your visit.

Medicaid: Capital Nephrology Associates, PA will file claims to Medicaid on your behalf. You must present a current copy of your Medicaid eligibility letter at each visit.

Assignment of Benefits

I request payment of the medical benefits, otherwise payable to me, be made to Capital Nephrology Associates, PA for services provided by them. I understand that I am financially responsible to Capital Nephrology Associates, PA for charges not covered by this Assignment of Benefits.

Consent For Treatment

I hereby authorize evaluation and treatment by the physicians of Capital Nephrology Associates, PA. I understand that the signature and date on this form will not expire without written notice or in the case that a minor reaches an adult, and that a photocopy of this form is considered valid as the original.

Please sign below that you have read this office policy and agree to it. If there is a problem, please speak to the Office Manager before seeing the doctor.

Patient's Signature or Legal Guardian

Date



Capital Nephrology Associates, PA

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact Mark Nail, Privacy Officer of Capital Nephrology Associates, PA.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, when we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only **reasonable** requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to Mark Nail, Privacy Officer.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the **lower** of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the Privacy Officer. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set (Patient Chart)?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the Privacy Officer. Your first accounting of disclosures (within a 12 month period) will be free.

For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request **before** any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Mark Nail
1015 East 32nd Street, Suite 414
Austin, Texas 78705
Ph: (512) 833-8213

This notice is effective on the following date: April 14, 2003.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Capital Nephrology Associates, PA Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority



**Capital Nephrology Associates, PA
Acknowledgement of Review of
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be use and disclosed. I understand that I am entitled to receive a copy of this document.

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority

Signature of Patient or Personal Representative

Date

