Nephrology & Hypertension MEDICAL ASSOCIATES

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION — Referred By:

Name:_____ Soc Sec #:_____
First Mid Last

Address:_____
Street / PO Box City State Zip

Telephone: Home (_____) _____ Work (_____)_____Cell (_____)_____

Sex: M F Date of Birth: _____/_____/_____ E-Mail: _____
Email is required for our Patient Portal and other educational communications.

Primary Care Physician: _____
Name Phone Address

Marital Status: _____ Race:_____ Ethnicity: Hispanic_____ Non-Hispanic_____

Emergency Contact:_____
Name Phone Relationship to Patient

Spouse Info (*If Applicable*):_____
Name Date of Birth Phone Employer

EMPLOYMENT INFORMATION

Employed By_____Occupation_____

Business Address_____Business Telephone_____

Employment Status: FT_____ PT_____ Self____ Retired____ Military____ Not Employed_____ Student_____

PRIMARY INSURANCE ___Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:_____
Name HMO / PPO / OPEN ACCESS

Policy #_____Group #_____Specialist Co-Pay_____

Address_____City _____State_____Zip_____

Name of Insured_____ Insured SS #_____

Relationship to Patient_____ Date of Birth of Insured_____

Patient Preference: _____
Hospital Laboratory Pharmacy/Address

SECONDARY INSURANCE _____Not Applicable ___Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:_____
Name HMO / PPO / OPEN ACCESS

Policy #_____Group #_____Specialist Co-Pay_____

Address_____City _____State_____Zip_____

Name of Insured_____ Insured SS #_____

Relationship to Patient_____ Date of Birth of Insured_____

ASSIGNMENT AND RELEASE

Authorization to treat and release information to insurance carrier for direct payment to the provider: I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance carrier. I authorize direct payment from my insurance company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor listed above, which could include a 25% collection fee. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services. I authorize the release of medical records to Nephrology and Hypertension Medical Associates PC as necessary for continuity of care. Also, I understand that the practice will provide, at my request, a copy of the HIPAA Notice of Privacy, which is clearly posted in the lobby area.

_____ _____ _____
PATIENT'S SIGNATURE PRINT NAME DATE

_____ _____ _____
GUARANTOR'S SIGNATURE (If other than patient) PRINT NAME DATE

Return To: Nephrology & Hypertension Medical Associates - 1115 Lexington Ave - Savannah, GA 31404

HISTORY AND PHYSICAL EXAMINATION

Date_____ Patient name_____
List prior names_____ Birth date_____ Age_____
Informant if other than or in addition to patient_____

CHIEF COMPLAINT:

PRESENT ILLNESS (and status review of prior problems):

Present Medications (or medication prior to admission), current recommended diet, other therapy (dialysis, physical therapy, etc.):

Drug allergies/unexpected adverse results from drug or diagnostic agent use:

PAST MEDICAL HISTORY:

List all prior illnesses, operations, injuries and treatments (except minor, transient, completely resolved illnesses) including birth defects, inherited conditions, learning disabilities, behavorial disorders, childhood illnesses, poisonings, toxin exposures; include infections, benign or malignant tumors, endocrine diseases including diabetes, glucose intolerance and thyroid disease, allergic disorders, transfusions, persistently abnormal lab tests, and all surgical operations including "incidental" organ removal (appendix removed at time of gallbladder removal for example), and complications from anesthesia or surgery; any allergy not mentioned beforehand in this document, systemic conditions (such as high blood pressure), addictions and their treatment, and known organ malfunction (such as liver or kidney insufficiency or failure).

SOCIAL HISTORY

List current and prior occupations and current and prior hobbies:

Habits-Have you ever used any of the following:

Smoking (packs per day)_____
Alcohol (drinks per day, see right margin)-_____
Caffeine use (drinks per day)-_____
coffee, tea, caffeinated drinks
Recreational drug use-YES or NO
Analgesic use (pain medicine)-YES or NO
Laxative use-YES or NO
Oral tobacco use-YES or NO
Over The Counter medicine use-YES or NO
Other (explain)

Standard Drink
Beer-12 oz.
Alcohol-1oz.
Wine-2 oz.

History of memory losses, legal problems, or injuries while drinking alcohol or using recreational drugs.

Record any recent animal exposure (pets, hunting, dressing, occupational):

Record places of recent foreign travel and when:

FAMILY HISTORY (known diseases/conditions/causes of death)

Mother
Father
Children
Siblings

Describe any characteristics or traits that run in the family:

Religion or religious objections to medical therapy:

REVIEW OF SYSTEMS

For symptoms currently ongoing or recent—within weeks or months (not part of a prior, now resolved illness) mark the category and subcategory of complaint in the circle then list the letter in the space provided and explain if desired.

1. Constitutional:

( )a. Malaise (vague ill feeling characterized by lack of energy, fatigue and weakness)
( )b. Fever measured over 99.6° orally
( )c. Feverishness (fever sensation without actual measurement over 99.6°)
( )d. Chills
( )e. Weight change
( )f. Night sweats
( )g. Loss of appetite
( )h. Other

2. Eyes:

( )a. Abnormal vision
( )b. Eye discomfort
( )c. Eye discharge
( )d. Double vision
( )e. Visual Disturbance
( )f. Unusual or painful eye sensitivity to light
( )g. Other

3. Ears, Nose, Mouth, and Throat:

( )a. Ringing or other abnormal sounds in ears
( )b. Abnormal hearing
( )c. Ear pain
( )d. Drainage of material or fluid from ears
( )e. Facial pain
( )f. Report of sinus disease
( )g. Nasal discharge: ( )blood ( )mucous ( )discolored material
( )h. Nasal obstruction
( )i. Oral problems: ( )dental ( )gum ( )tongue ( )palate
( )j. Difficulty speaking
( )k. Abnormal or changing voice
( )l. Throat pain
( )m.Choking while swallowing
( )n. Other

4. Skin and Breasts:

( )a. Rash
( )b. Itching
( )c. Change in hair texture
( )d. Change in nails
( )e. Other skin lesions (any discontinuity of normal skin such as nodules, ulcers, stretch marks, cysts, pimples, boils and others)
( )f. Breast(s) enlargement
( )g. Breast(s) lesions (any discontinuity of normal breast such as cysts, ulcers, moles, lumps)
( )h. Breast pain, soreness, or tenderness
( )i. Discharge from breast(s): ( )clear ( )milky ( )foul
( )j. Other

5. Musculoskeletal:

( )a. Muscle abnormalities
( )b. Joint pain
( )c. Joint swelling
( )d. Joint/tendon redness/tenderness
( )e. Back discomfort
( )f. Neck discomfort
( )g. Change in finger tips
( )h. Other

6. Allergic/immunologic:

( )a. Recurrent episodes of: ( )nasal obstruction ( )swollen eyes ( )"bags" under eyes
( )b. Recurrent episodes of wheezing or asthma with exposure to: ( )plants ( )perfumes ( )odors ( )dusts ( )animals
( )c. Recurrent thrush (oral candida)
( )d. Recurrent infections
( )e. Shingles at any time
( )f. History of rash or itching on exposure to: ( )jewelry ( )cosmetics ( )cloth ( )leather ( )deodorants ( )chemicals ( )medications
( )g. History of HIV or AIDS
( )h. History of **any** of the following even if distant past: Sexual relations with IV drug user, hemophiliac, known HIV+ person or homosexual or bisexual; IV drug use; transfusion prior to 1985; transfusion in third world country; homosexual behavior; open heart surgery before 1985
( )i. Other

7. Hematopoletic/Lymphatic

( )a. Unusual lumps (lymph nodes or masses of unknown origin)
( )b. Unusual bleeding
( )c. Unusual bruising
( )d. Petechiac (tiny red to brown non-blanching bruises)
( )e. Known or reported anemia
( )f. Blood transfusions
( )g. Radiation exposure
( )h. bone marrow or spleen abnormality
( )i. Reported abnormality of red or white blood cells or platelets
( )j. Other

8. Cardiovascular:

( )a. Chest dicomfort (tightness, heaviness pressure, or pain)
( )b. Shortness of breath: ( )rest ( )with exertion ( )on lying flat ( )when chest discomfort occurs ( )causing awakening at night
( )c. Swelling of tissues in feet or ankles
( )d. Sensation of nearly losing consciousness
( )e. Abnormal heart beat: ( )rapid ( )slow ( )irregular
( )f. Prior knowledge of or report of elevated blood pressure
( )g. Pain or cramping with exertion in: ( )leg ( )arms ( )jaw
( )h. Coldness or discoloration of ends of extremities
( )i. Abnormal veins
( )j. Other

9. Respiratory:

( )a. Cough
( )b. Sputum production
( )c. Coughing up blood
( )d. Noisy respiration
( )e. Wheezing (continual high pitched sound of respiration)
( )f. Obstruction of air passages while asleep
( )g. Severe snoring
( )h. Variable breathing pattern
( )i. Exposure to asbestos
( )j. Exposure to other inhaled substances: ( )gases (including fumes) ( )dusts ( )animal dander, feathers, or fibers
( )k. Exposure to tuberculosis
( )l. Other

10. Gastrointestinal

( )a. Nausea
( )b. Vomiting
( )c. Diarrhea
( )d. Constipation
( )e. Black stools
( )f. Vomiting blood
( )g. Blood in stools or per rectum
( )h. Hemorrhoids
( )i. Trouble swallowing
( )j. Unusual intestinal gas
( )k. "Heartburn" (burning in upper abdomen behind breast bone or into throat)
( )l. Unusual salivation
( )m. Abdominal discomfort
( )n. Food intolerance
( )o. Yellow color to white of eyes or skin
( )p. Abdominal swelling
( )q. Known abdominal organ enlargement
( )r. Dilated veins over abdomen
( )s. Change in bowel habits
( )t. Other

11. Genitourinary:

( )a. Burning or pain on urination
( )b. Known kidney or bladder infection
( )c. Abnormal urination pattern:
( ) slow initiation of stream
( ) decreased or slow stream
( ) frequent urination ( )decreased urine volume/day ( )increased urine volume/day ( )small volume per voiding ( )awakening from sleep to void ( )rapid onset of severe need to void
( )d. Abnormal urine appearance: ( )abnormal color ( )cloudy ( )foaming urine
( )e. Passage of abnormal material: ( )stones or gravel ( )blood clots ( )tissue ( )gas
( )f. Genital abnormalities
( )g. Genital/pelvic discomfort
( )h. Problems with sexual function
( )i. Known abnormal urinalysis
( )j. Known abnormal kidney function
( )k. Tissue fluid accumulation (edema)
( )l. Other

Males only:

( )a. Male genital functional abnormalities
( )b. Problems with penile erection
( )c. Abnormal ejaculation
( )d. Known prostate abnormalities
( )e. Known abnormal PSA
( )f. Other

Females only:

( )a. Menstrual/obstetric history
Age periods started_____
Last menstrual period_____
Age at menopause_____
Pregnancies_____ Miscarriages_____
Abortions_____
Living children delivered_____
( )b. Abnormal vaginal bleeding
( )c. Unsually painful periods
( )d. Vaginal discharge
( )e. Other

12. Neurologic:

( )a. Unusual headaches: ( )new ( )different ( )frequent ( )severe
( )b. Head injury
( )c. Loss of consciousness
( )d. Light headedness ("giddy" sensation or dizziness)
( )e. Vertigo (a false sensation of motion or whirling)
( )f. Motion sickness
( )g. Weakness or paralysis of any body part or area
( )h. Any numbness of any body part or area
( )i. Abnormal sensation (pins and needles sensation, unpleasant sensitivity or "going to sleep" sensation) of any body part
( )j. Abnormal taste or smell
( )k. Difficulty swallowing
( )l. Difficulty speaking
( )m. Anxiety
( )n. Asymmetry of body part right to left
( )o. Unexpected or unjustified falls
( )p. Abnormal balance
( )q. Abnormal tremor
( )r. Abnormal movements
( )s. Convulsions
( )t. Other

13. Psychiatric/Mental State:

( )a. Trouble sleeping
( )b. Defective memory
( )c. Mood disturbance
( )d. Loss of interest
( )e. Difficulty concentrating
( )f. Decline in sexual desire
( )g. Persistent thoughts or worries
( )h. Abnormal thoughts
( )i. Seeing things that probably aren't there
( )j. Hearing things that probably aren't there
( )k. Suicidal thoughts
( )l. Unrealistic fears
( )m. Undesirable habits
( )n. Others

14. Endocrine:

( )a. Change in skin pigment or texture
( )b. Change in thickness of facial features or hands
( )c. Change in hair distribution
( )d. Unexplained weight gain or loss
( )e. Slow wound healing
( )f. Unusual intolerance to heat
( )g. Unusual intolerance to cold
( )h. Abnormality of thyroid gland
( )i. Exopthalmus(protuberance of eye, "bug eyes")
( )j. Unusual thirst
( )k. Report of: ( )low or high potassium
( )low or high calcium
( )low or high phosphorus
( )low or high sodium
( )low or high magnesium
( )suspected or proven vitamin deficiency
( )abnormal blood sugar
( )abnormal cholesterol or triglyceride or other blood lipid
( )f. Other

Statement of Financial Policy

It is our firm belief that all patients who come to this office expect and deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies. Therefore, we are asking that you read and sign the following important information:

1. If we are a participating provider in your plan, we will be listed in your group's "provider list" or "preferred provider" directory. This is not a guarantee of payment. We will bill your insurance company directly and receive payment from them directly. Most plans require a "co-payment" per visit and/or have yearly "deductibles". Some plans require you to pay a 20% co-payment when diagnostic tests are provided. We require that co-payments and/or deductibles be paid prior to services being rendered or the appointment can either be rescheduled or patient may have an additional $25.00 added to their account.

2. If your insurance requires referral approval, necessary documentation is your responsibility. You must give your referral form and/or number to the receptionist when you check in to see the doctor. Failure to comply with the requirements of your insurance company could leave you responsible for services rendered.

3. If your insurance information is up-to-date, we will file up to two separate insurance claim forms for services you receive. It is your responsibility to tell us about changes in your insurance plan. It is important to remember that your insurance coverage is a contract between you and your insurance company. Although we file claims for you, you are still responsible for your bill, regardless of the amount your insurance company pays, except in cases of pre-negotiated insurance agreements and where legally prohibited.

4. If you do not have insurance, payment is expected at the time you receive services. Payment will be accepted in cash, by check or credit card. If check is returned for non-sufficient funds, an additional service fee of $30.00 will be added to the patient's account. If payment in full is not possible at the time of service, arrangements must be made through our billing office.

5. In the event that payment is not received after 3 payment notifications have been mailed, a 25% collection fee will be added to the account prior to being submitted to the collection agency. It is the responsibility of the patient to notify the office of any insurance, address or other demographic changes.

6. In order to assist patient requests for an immediate appointment, we require at least 48 hour advance notice should your appointment need to be cancelled or rescheduled. If you do not provide us notice at least 48 hour advance notice a $25 charge may be added to your account.

We hope this Statement of Financial Policy helps you understand the importance of prompt payment of your bill. Please feel free to call our billing office at (912)354-4813 if you have any questions.

****

I have read the above information and understand that I am responsible for notification for notification of my insurance plan mandates.

Patient / Guarantor's Signature Date

Patient's Name Patient's Date of Birth

PATIENT CONSENT TO THE USE & DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I,_____, understand that as part of my healthcare, NEPHROLOGY AND HYPERTENSION MEDICAL ASSOCIATES originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that the information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payor can verify the services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Nephrology and Hypertension Medical Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Nephrology and Hypertension Medical Associates reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Nephrology and Hypertension Medical Associates change their notice, they will send a copy of any revised notice to the address that I have provided (whether US Mail or I agree, email).

I wish to have the following restrictions to the use or disclosure of my health insurance:

_____

_____

I understand that as part of this organizations treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I hereby acknowledge that (participating organization) will share my medical information, as permitted under federal law (H.I.P.A.A.) and Georgia and South Carolina state law, with my healthcare providers through a health information exchange. I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY:

☐ Consent received by _____on _____

☐ Consent refused by patient and treatment refused as permitted.

☐ Consent added to the patient's medical record on_____

READ ONLY – Do not complete

Nephrology & Hypertension MEDICAL ASSOCIATES

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner: *(check all that apply)*

- ▢ **Work Telephone**
  - ▢ OK to leave detailed message
  - ▢ Leave message with call back number only
- ▢ **Home Telephone**
  - ▢ OK to leave detailed message
  - ▢ Leave message with call back number only
- ▢ **Written Communication**
  - ▢ OK to mail to home address
  - ▢ OK to mail to work/office
  - ▢ OK to fax to this telephone number_____

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Nephrology & Hypertension Medical Associates will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

Please print:

1._____ 3._____

4._____

2._____ 5._____

Patient Signature:_____Date:_____

Please print name:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice of Privacy Practices for Nephrology & Hypertension Medical Associates detailing how my information may be used and disclosed as permitted under federal and state law.

Patient/Guardian Signed_____ Date:_____

Relation to patient:_____

For Office Use Only:

If patient or guardian refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign here:

*Presented by:*_____*(employee name and title)*

Date:_____Time:_____

PATIENT'S RIGHTS AND RESPONSIBILITIES

CONFIDENTIALITY

It is the policy of Nephrology & Hypertension Medical Associates, P.C., to treat all patient information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please direct them to one of our staff members.

Nephrology & Hypertension Medical Associates, P.C. makes every effort to provide our patients with an environment which is safe, private, and respectful of our patient's needs. If you have a complaint about our services, facilities, or staff, we want to hear from you. We will do everything we can to see that your experience with us is pleasant and professional in every way.

ISSUES OF CARE

Nephrology & Hypertension Medical Associates, P.C. is committed to your participation in care decisions. As a patient, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare directions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please ask for further information.

PATIENT RIGHTS

1. The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.
2. The patient has the right to make decisions regarding the health care that is recommended by his or her health provider. Accordingly, patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs, regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.

4. The patient has the right to confidentiality. The health provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance and direction, and sufficient opportunity to make alternative arrangements.

PATIENT RESPONSIBILITIES

1. Good communication is essential to a successful health provider-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their health providers.

2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.

3. Patients have a responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described.

4. Once patients and health providers agree upon the goals of care, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

5. Patients should have an active interest in the effects of their conduct on others and refrain from behavior that places the health and safety of others at risk.

_____ _____

Patient Name Date

_____ _____

Date of Birth Patient Account Number

NOTICE OF PRIVACY PRACTICES

1115 Lexington Avenue
Savannah, GA 31404
Phone: 912/354-4813

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.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of yourmedical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. o We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. o We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choosesomeone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information found at the top of this page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information,you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choiceto tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your informationunless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
Inthecaseoffundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

NOTE: We do not create or maintain a hospital directory or psychotherapy notes at this practice.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hss.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective 2/1/2015

Privacy Officer:
1115 Lexington Avenue
Savannah, GA 31404
Phone 912/354-4813

Appendix A to Part 92— Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement:

Discrimination is Against the Law

Nephrology and Hypertension Medical Associates PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Nephrology and Hypertension Medical Associates PC do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Nephrology and Hypertension Medical Associates PC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Mida Vause, RN (Clinical Manager) or Trish Rotureau (Operations Manager)

If you believe that Nephrology and Hypertension Medical Associates PC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mida Vause, RN (Clinical Manager) or Trish Rotureau (Operations Manager):

1115 Lexington Avenue,
Savannah, GA 31401
912/354-4813
Fax 912/354-7569
mvause@thekidneydocs.com or trotureau@thekidneydocs.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice Informing Individuals About
Nondiscrimination and Accessibility Requirements

It is important to our practice that all our patients receive access to quality healthcare.

In accordance with Section 1557 of the Patient Protection and Affordable Care Act, the law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

Nephrology and Hypertension Medical Associates PC comply with applicable Federal civil rights laws. We also provide various free aids and services to people with disabilities or language services to people whose primary language is not English.

To read the full "Notice of Nondiscrimination and Accessibility" document and learn more about services available to you, please select the appropriate links below.

ENGLISH (English)
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-912-354-4813

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-912-354-4813

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-912-354-4813

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-912-354-4813

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-912-354-4813

ગુજરાતી (Gujarati)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-912-354-4813

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-912-354-4813

አማርኛ (Amharic)
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-912-354-4813

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-912-354-4813

Kreyòl Ayisyen (French Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-912-354-4813

Р у с с к и й (Russian)
В Н И М А Н И Е: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-912-354-4813

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (1-912-354-4813رقم
والبكم الصم هاتف

Português (Portuguese)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-912-354-4813

ی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-912-354-4813 تماس بگیرید.

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-912-354-4813

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-912-354-4813
まで、お電話にてご連絡ください。

Ukrainian (Ukrainian)
УВАГА: Якщо ти володієш англійською мовою, мова послуги допомоги, послуги безкоштовно, доступні для вас. Називають 1-912-354-4813

មនខ្មែរកម្ពុជា (Mon-Khmer, Cambodian)
យកចិត្តទុកដាក់: ប្រសិនបើអ្នកនិយាយជាភាសាអង់គ្លេស, សេវាជំនួយភាសាដោយឥតគិតថ្លៃ, ដែលអាចប្រើបានទៅអ្នក។ ហៅទូរស័ព្ទទៅ 1-912-354-4813

tagalog (Tagalog / Filipino)
Pansin: Kung nagsasalita ka ng Ingles, wika serbisyo ng tulong, nang walang bayad, ay magagamit sa iyo. tumawag 1-912-354-4813