NHS NEPHROLOGY HYPERTENSION SPECIALISTS

*Comprehensive Kidney and Blood Pressure Care*

# NEW PATIENT INFORMATION

Welcome to Nephrology Hypertension Specialists!

In order to make your first visit with us as smooth as possible, we have put together a new patient package. It includes the following documents:

- Patient Information Form
- Patient History Forms
- Patient Medication Form
- HIPAA Acknowledgement Form
- Privacy Notice
- Information Disclosure Authorization
- Cancellation Policy
- Clean Catch Urine Specimen Procedure

To Prepare For Your Appointment:

- Please read these forms and fill them out as accurately as possible. Then sign and date where appropriate and bring the forms to the office with you.
- You will also need to bring identification (photo ID) and your insurance card.
- If your insurance requires a referral, be sure to obtain one from your primary care provider. Our National Provider Identifier (NPI) is 1669426342. You will need this number to have the referral issued.
- Have your records sent to our office. Our fax number is 215-348-7002.
- Be sure to arrive 15 minutes before your scheduled appointment time to allow for check-in.
- Bring in a clean catch urine specimen. A clean catch urine specimen procedure is included in this packet.
- We only accept cash/check for any co-pays, due at time of service.

Our office is in suite 100 of the Doylestown Hospital Pavilion, on the 1st floor, in the South Entrace.

We hope your visit is informative and takes you closer to better health.

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# PATIENT INFORMATION

Patient Name:_____
(last) (first) (middle)

Address:_____

City:_____State:_____Zip:_____

Phone (home):_____Phone (day):_____

Phone (cell):_____

Email Address:_____

Age_____Birthdate:_____Height:_____Weight:_____

Social Security #:_____

Ethnicity:_____Preferred Language:_____

Emergency Contact:_____Relationship:_____Phone: _____

Primary Physician:_____Referred By:_____

Employer:_____Employer Phone:_____

Employer Address:_____

Financially Responsible Party's Name:_____

Address:_____

Pharmacy:_____Phone: _____

"I request that payment of authorized insurance benefits be made on my behalf to Nephrology Hypertension Specialists for any services furnished me by my physician or supplier. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and/or insurance companies as needed to determine these benefits or the benefits payable for related services."

"I authorize Nephrology Hypertension Specialists to use the phone numbers and emergency contact number to relay any laboratory or medical results or appointment information, or to leave such information on an answering machine."

Patient Signature:_____Date:_____

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# PATIENT MEDICAL HISTORY

Patient Name:_____Birthdate:_____

Please list all medical conditions for which you have been diagnosed or treated.

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Please list all surgeries you have undergone, including biopsies, prostheses, and devices.

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Tobacco Use: Yes No If yes, how much?_____/day

How many years?_____

Alcohol Use: Yes No If yes, how much?_____
(Per day/week/month)

Do you follow a diet? Yes No If yes, what kind?_____

_____

Do you exercise? Yes No If yes, how often?_____

What kind of exercise?_____

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# PATIENT MEDICAL HISTORY

Patient Name:_____Birthdate:_____

Family Medical History:

| Relation | Medical Conditions |
|---|---|
| Father | |
| Mother | |
| Siblings (specify) | |
| | |
| | |
| | |
| | |
| Children (specify) | |
| | |
| | |
| | |
| | |
| Paternal grandfather | |
| Paternal grandmother | |
| Maternal grandfather | |
| Maternal grandmother | |
| Aunts/Uncles | |
| | |
| | |
| | |

Has anyone related to you ever had: (if yes, who?)

High blood pressure?_____

Heart disease?_____

Stroke?_____

Kidney disease?_____

Cancer?_____

Diabetes?_____

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# PATIENT MEDICATIONS

Patient Name:_____Birthdate:_____

Allergies:

| Medication | Reaction |
|---|---|
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Medications: (including over the counter, herbals, supplements, as needed medications)

| Medication Name | Dosage | Frequency |
|---|---|---|
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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that Nephrology Hypertension Specialists has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. Nephrology Hypertension Specialists have given me the opportunity to ask any questions about this notice, and all my questions have been answered.

_____
Patient's Name Printed

_____
Patient or Guardian Signature

_____
Date Signed

Provider Use Only
If the patient was not able to sign due to an emergency, or did not want to sign, please document if the patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _____Yes _____No

Reason signature was not obtained:_____
_____
_____
_____

_____
Staff Signature

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# NOTICE OF PRIVACY PRACTICES
Effective 4-08-2014

I. 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.

"Medical information," as used in the paragraph above, may not completely describe the type of information Nephrology-Hypertension Specialists, hereinafter referred to as NHS, may use and disclose. Information about your past, present, or future health or condition, the provision of health care or other services to you, or payment for services rendered, if such information does or could be used to identify you, is considered "Protected Health Information" ("PHI") under the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and federal regulations issued thereunder (collectively, the "HIPAA Privacy Rule"). Included in your PHI, for example, are your treatment or service records, your name and address, and your insurance or other health benefit information. This Notice describes potential uses and disclosures of your PHI, as well as your rights with respect to your PHI.

If you have any questions about this notice, contact our Privacy Officer at 215-348-8020.

II. Our Pledge Regarding Medical Information:
We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care you receive at this office to provide you with quality care and to comply with legal requirements. This notice will tell you about the ways in which we use and disclose your medical information. We also describe your rights and the obligations we have regarding the use and disclosure of medical information.

III. You should read this Notice of Privacy Practices before signing the attached "Acknowledgement of Receipt of Notice of Privacy Practices."

IV. Our Duty to Safeguard Your Protected Health Information.
Under the HIPAA Privacy Rule, NHS is required to extend certain protections to your PHI, and to give you this notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum PHI to accomplish the purpose of the use or disclosure.

We are required to follow the privacy practices described in this notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new notice at the office. You may request a copy of any new notice by contacting our Privacy Officer at 215-348-8020.

V. How We May Use and Disclose Your Protected Health Information
We use and disclose PHI for a variety of reasons. For some uses and disclosures, we must have your written authorization, for others, no authorization is required. The following offers more description and examples of our potential uses/disclosures of your PHI:

A. For Treatment. We may use information about you to provide you with medical treatment. We may disclose medical information about you to office staff and others involved in your case.

B. For Payment. We may use and disclose information about you for insurance and payment services.

C. For Health Care Operations. We may use and disclose information about you for practice operations to make sure that you receive quality care and for learning purposes.

D. Appointment Reminders. We may use and disclose information to contact you about appointments.

E. Phone Messages. Call Backs. We may call and leave messages with whoever answers the phone at your house or on your answering machine unless directed otherwise.

F. Faxing. We fax only to secure lines such as physicians' offices.

G. Treatment Alternatives. We may use and disclose information to tell you about treatment options.

H. Health-Related Benefits and Services. We may tell you about health-related benefits or services.

I. Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in or helps pay for your medical care. We may disclose medical information about you to assist in a disaster relief effort.

J. Healthcare Professionals. Including physicians, nurses, and technicians—in the Doylestown Clinical Network—may access your demographic information for the purposes of providing you care.

VI. Research.

Under certain circumstances, we may use and disclose medical information about you for research purposes. We will not use or disclose information about you until a special approval process, which evaluates the use of medical information, has approved the research project. We may disclose information about you to people preparing to conduct a research project so long as the information they review does not leave the practice.

VII. As Required by Law.

We will disclose information about you when required to do so by law.

VIII. To Avert a Serious Threat to Health or Safety.

We may use and disclose information about you to prevent a serious threat to your health and safety, the public or to another person.

IX. Special Situations:

A. Organ and Tissue Donation. If you are an organ donor, we may release information to organ banks.

B. Military and Veterans. We may release information about military personnel as required.

C. Workers' Compensation. We may release information about you for workers' compensation.

D. Public Health Risks. We may disclose information about you for public health activities.

E. Health Oversight Activities. We may disclose information about you to a health oversight agency.

F. Lawsuits and Disputes. We may disclose information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

G. Law Enforcement. We may release information to a law enforcement official as required by law.

H. Coroners, Medical Examiners and Funeral Directors. We may release information to a coroner, medical examiner or funeral director as necessary.

H. National Security and Intelligence Activities and Protective Services for the President. We may release information about you to authorized federal officials for national security activities.

I. Inmates. We may release information about inmates to a correctional institution or law enforcement.

X. Other Situations:
We will NOT disclose any information about you in the following situations without your authorization.

A. Uses and disclosures of psychotherapy notes

B. Uses and disclosures of PHI for the purpose of marketing and fundraising.

C. Uses and disclosures that involve the selling of PHI.

XI. Right to an Accounting of Disclosures.
You have the right to request a list of the accounting of disclosures we made of your medical information. You must submit your request in writing to our Privacy Officer. Your request must state a time period, no longer than six years, and indicate whether you want the list on paper or electronic. Your first requested list within a year is free.

XII. Right to Request Restrictions.
You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment, or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed in an emergency. You must make your request in writing to NHS, 599 W State St, Suite 100, Doylestown, PA 18901, Attn: Privacy Officer. You must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

XIII. Right to Request Confidential Communications.
You have the right to request that we communicate with you about medical matters in a certain way or location. You must make your request in writing to Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We have the right to deny your request.

XIV. Right to a Paper copy of This Notice.
You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.nephrologyhypertension.com. To obtain a paper copy of this notice, make a request at front desk and sign a Receipt of Notice of Privacy Practices.

XV. Changes to this Notice:
We reserve the right to change this notice and make the revised notice effective for information we already have about you as well as any future information. We will post a copy of the current notice in the office. Each time you register at the office we will offer you a copy of the current notice.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information:
Other uses and disclosures of information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time. Understand that we are unable to take back any permitted disclosures, and that we are required to retain records of your care.

XVI. You have the following rights regarding medical information we maintain about you:
Right to Inspect and Copy. You have the right to inspect and copy your medical information. This includes medical and billing records, but does not include psychotherapy notes. You must submit your request in writing to our Privacy Officer. We may charge a fee for the costs of copying. We may deny your request to inspect and copy. You may request that the denial be reviewed. Another neutral health care professional, not the person who denied your request, will review your request and the denial. We will comply with the outcome of the review.

Right to Amend. If you feel that your information is incorrect or incomplete, you may ask us to amend the information. You may request an amendment as long as the office has this information. Your request must include the reason, be made in writing and submitted to our Privacy Officer. We may deny your request if you ask us to amend information not created by us, unless the person that created the information is no longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

XVII. Right to Opt-Out
As a member of the HealthShare Exchange of Southeastern Pennsylvania, Inc., (HSX), we may use or disclose your Personal Health Information to this Health Information Organization (HIO) and also to the HIO of the Commonwealth, The Pennsylvania Patient and Provider Network (P3N). Other health care providers, such as physicians, hospitals, and other health care facilities, may have access to this information for treatment, payment and other purposes, to the extent permitted by law. You have the right to “opt-out” or decline to participate in the Health Information Exchange (HIE). If you choose to opt-out of the HIE, we will not use or disclose any of your information in connection with HSX or P3N.

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# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize Nephrology Hypertension Specialists to release my patient information (laboratory results/diagnoses and appointment information) to:

____ All of my family members

____ Spouse (print name) _____

____ Mother (print name) _____

____ Father (print name) _____

____ Children (print names) _____

____ Other Family Members _____

_____

_____

_____

____ Other (print name) _____

____ NO ONE

_____

Patient's Name Printed

_____

Patient or Guardian Signature

_____

Date Signed

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## ADVANCE NOTICE OF CANCELLATIONS

Nephrology Hypertension Specialists requires a 24-hour notice of cancellation. Failure to notify the office 24 hours in advance of an upcoming appointment will result in a $50.00 charge.

This allows Nephrology Hypertension Specialists to better meet our patients' needs by being able to accommodate them as quickly as possible, as we will be able to fill all cancelled appointments.

_____

Patient's Name Printed

_____

Patient or Guardian Signature

_____

Date Signed

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# CLEAN CATCH URINE SPECIMEN INSTRUCTIONS

A clean-catch urine sample is a sample of urine collected in a special way. It is meant to allow examination and testing of urine that has not been contaminated by bacteria, blood, or skin cells from outside the urinary tract.

You will need a container to catch the urine and bring to the office with you at the time of your appointment.

For Women:

1. Wash your hands with soap and water.
2. Remove the lid from the container. Do not touch the inside of the lid or the inside of the cup. Place the lid flat side down on the counter.
3. Wash your genital area from front to back. Use wet cotton balls or gauze. Do not use soap.
4. Separate your genital folds (also called lips or labia) with your hand. Wipe gently inside the folds with more wet cotton balls or gauze.
5. Start urinating into the toilet. After the first part of the urine has gone into the toilet, put the container under the stream of urine. Catch 1 or 2 tablespoons of the urine. Then remove the container. You can finish urinating into the toilet.
6. Put the lid on the container and wash your hands.

For Men:

1. Wash your hands with soap and water.
2. Remove the lid from the container. Do not touch the inside of the lid or the inside of the cup. Place the lid flat side down on the counter.
3. Before you start urinating, gently wipe the tip of the penis around the opening with wet cotton balls or gauze. Do not use soap. If you have not been circumcised and still have your foreskin, gently pull the foreskin back before you wash the tip of the penis. Keep holding it back until you are finished getting the urine sample.
4. Holding the urine container in one hand, start to urinate into the toilet.
5. After the first part of the urine has gone into the toilet, put the container under the stream of urine. After you have caught 1 or 2 tablespoons of the urine, remove the container and finish urinating into the toilet.
6. Put the lid on the container and wash your hands.

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# Doylestown Clinical Network (DCN)

The DCN is a database created by all the physicians in the Doylestown community who have some category of membership on the Medical Staff of Doylestown Hospital. This database consists of patient medical records from participating practices in the Doylestown community. The only physicians allowed to access your records are those who are currently treating you. The DCN is designed to enhance the quality of care provided to you and reduce the risk that you will be prescribed inappropriate or excess medications.

When registered as a patient of Nephrology-Hypertension Specialists, and by signing this form, you are automatically included in the DCN. Nephrology-Hypertension Specialists will include all of your clinical information including medical history, diagnosis, allergies, medications, results, plan of care, etc., in the DCN so it will be available to any physician member of the DCN who is treating you. All of your medical information will be put into the network, including anything related to drug/alcohol treatment, sexually transmitted diseases, HIV status, and psychiatric care and treatment. This information is available to participating referring physicians and clinicians at any time they are providing you with care and/or in the event of an emergency visit.

If you do not want other physicians to have access to all of this information, and choose not to participate in the DCN, ask our registration staff for the opt-out form. Once you have completed and signed the form, your information will not be shared on the DCN. You may opt-out of the DCN at any time by simply telling any of our staff members of your decision.

I hereby understand and agree with the sharing of my clinical data for the purpose of my treatment and care on the Doylestown Clinical Network (DCN).

_____

Patient Signature

_____

Parent/Guardian Signature

_____

Print Patient Name

_____

Date