

Melvin Yudis, M.D., F.A.C.P.  
Edward R. Snipes, M.D., F.A.C.P.  
Victor E. Ghantous, M.D., F.A.C.P.  
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Inessa Parkansky, M.D.  
Juanita R. Keomt, M.D.  
Majid A. Khan, M.D.  
Winston W. Shu, M.D.

Your appointment is:

With Doctor \_\_\_\_\_  735 Fitzwatertown Road Willow Grove, PA 19090  
215-657-2012 Fax 215-657-2018

On: \_\_\_\_\_  9922 Roosevelt Boulevard Philadelphia PA 19115  
215-624-6610 Fax 215-624-3152

At: \_\_\_\_\_ AM/PM  721 Arbor Way Suite 103 Blue Bell PA 19422  
215-657-2012 Fax 215-657-2018

Welcome to our practice. We have enclosed new patient information and release forms needing completion prior to your visit with us. Please review and complete all forms and bring with you at the time of your appointment. This will help to expedite the check-in process so we can better serve our patients.

Since you are a new patient, it is important that you arrive at least 20 minutes prior to your appointment and bring with you the following:

**1. ALL MEDICAL RECORDS:**

This includes 2 years of labs, 1 year of x-ray reports (**not films**) and the last few office notes from your PCP or referring physician.

Please contact your primary doctor or any other specialist that you have seen in the last two years and obtain this information. You may bring it with you the day of your appointment or have it mailed to us. Our office will be unable to return records to you or make copies at the time of your visit. It is the patient's responsibility should additional copies of your medical records be needed.

**Please note: Your past medical history and any current laboratory and/or testing results are vital in properly evaluating your health by our physician(s). If your past medical history is unavailable, we may need to reschedule your appointment with us.**

2. **A list of your current medications** including the strength and how many times a day you are taking it.
3. If your insurance requires you to obtain a referral please call your primary doctor, in advance and obtain one. If your insurance plan also requires a referral to a specialist, it is your responsibility to request that referral from your PCP. The referral must be issued by the day of your appointment. Our NPI number to use for the referral is 1831251180. **If you are required to have a referral and do not have one on the day of your visit you will need to reschedule or pay for your office visit.**
4. Your insurance card(s) and a photo ID. We will need to make a copy of your insurance card(s) for your chart. **Additionally, please bring any co-pay or coinsurance amount which you are responsible for paying under your insurance plan. We accept cash, check, Visa, MasterCard or Discover. Exact change is greatly appreciated.**
5. If you are going to be late for your appointment, please call to let us know. **It is our office policy to reschedule patients who are 30 minutes late for their scheduled appointment.**

**We look forward to meeting you!**

**HYPERTENSION NEPHROLOGY ASSOCIATES**

**Patient Information**

To provide you with the best possible care, please complete all sections below. This will give us a full medical and family history.  
All answers will remain CONFIDENTIAL.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

City/Zip: \_\_\_\_\_ Referred by: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Language Spoken: \_\_\_\_\_ Race: *Asian Black Hispanic White Decline to report*

Ethnicity: *Latino Non-Latino Decline to report* Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Please circle: *Self Spouse Father Mother*

Secondary Ins: \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Please circle: *Self Spouse Father Mother*

Subscribers Date of Birth \_\_\_\_\_

**MEDICAL HISTORY**

**Do you have any allergies to the following (yes or no) if yes please describe type of reaction (rash, hives, difficulty breathing, etc.)**

Latex \_\_\_\_\_ Foods \_\_\_\_\_ Medication \_\_\_\_\_ Other: \_\_\_\_\_

List item allergic to and describe reaction \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had a screening colonoscopy: \_\_\_\_\_ Date \_\_\_\_\_

Have you had a pneumonia shot: \_\_\_\_\_ Date \_\_\_\_\_

**SURGERY**

Type: \_\_\_\_\_ Year: \_\_\_\_\_ Hospital: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For females:**

Last menstrual period: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of living children: \_\_\_\_\_

**Reviewed with Patient:**

\_\_\_\_\_ Date

\_\_\_\_\_ Patient Signature

\_\_\_\_\_ Physician Signature

# Hypertension-Nephrology Associates, P.C.

## Patient History Form

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

What is the main reason for your visit today? \_\_\_\_\_

\_\_\_\_\_

### Family History

Do you have any major illnesses involving the immediate family?

Kidney Disease                      Yes                      No                      Who \_\_\_\_\_

Dialysis                                Yes                      No                      Who \_\_\_\_\_

Kidney Transplant                    Yes                      No                      Who \_\_\_\_\_

Blood in urine                        Yes                      No                      Who \_\_\_\_\_

High Blood Pressure                Yes                      No                      Who \_\_\_\_\_

Diabetes                                Yes                      No                      Who \_\_\_\_\_

Other                                      Yes                      No                      Who \_\_\_\_\_

### Social History

Have you smoked at least 100 cigarettes in your entire life?     Yes     No

How often do you smoke cigarettes?

Never smoked     Current every day smoker     Current some day smoker     Former smoker

How many cigarettes per day do you/did you smoke? \_\_\_\_\_

How many years have you/did you smoke? \_\_\_\_\_

Do you use smokeless tobacco?     Yes     No

Are you at risk for secondhand smoke?     Yes     No

Describe your history of alcohol intake \_\_\_\_\_

Have you ever used illicit drugs? \_\_\_\_\_

What is or what was your occupation? \_\_\_\_\_

Are you retired? Yes No    Martial Status: Single Married Divorced Widowed

Do you live with someone? Yes No    If yes, with whom? \_\_\_\_\_

## REVIEW OF SYSTEMS

Do you have any problems related to the following systems? Circle Yes or No

### **CONSTITUTIONAL SYMPTOMS**

Fever	Y	N
Weight loss	Y	N
Chills	Y	N

### **EYES**

Blurry vision	Y	N
Double vision	Y	N
Cataracts	Y	N
Glaucoma	Y	N
Diabetic eye disease	Y	N

### **EAR/NOSE/THROAT/MOUTH**

Hearing loss	Y	N
Sore throat	Y	N
Sinusitis	Y	N
Migraines	Y	N

### **CARDIOVASCULAR**

Heart Attack	Y	N
Angina	Y	N
High blood pressure	Y	N
Chest Pains	Y	N
Irregular Heartbeat	Y	N
Congestive Heart Failure	Y	N
Problems with heart valves	Y	N
Rheumatic Fever	Y	N
Edema (swelling)	Y	N

### **RESPIRATORY**

Shortness of breath	Y	N
Chronic cough	Y	N
Wheezing	Y	N
Exposure to TB	Y	N
Emphysema	Y	N

### **GASTROINTESTINAL**

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Bloody or Dark stools	Y	N
Change in bowels	Y	N

### **INTEGUMENTARY**

New skin lesions	Y	N
Changes in hair, nails	Y	N
Breast lumps	Y	N

### **NEUROLOGICAL**

Areas of numbness	Y	N
Weakness	Y	N
Stroke	Y	N
Difficulty walking	Y	N
Loss of bowel control	Y	N

### **PSYCHIATRIC**

Depression	Y	N
Difficulty sleeping	Y	N

### **ENDOCRINE**

Thyroid condition	Y	N
Diabetes	Y	N

### **HEMATOLOGIC/LYMPHATIC**

Anemia	Y	N
Enlarged lymph nodes	Y	N
Easy bleeding/bruising	Y	N
Transfusion history	Y	N
Immune deficiency	Y	N

### **ALLERGIC/IMMUNOLOGIC**

Asthma	Y	N
Hay Fever	Y	N
Shellfish/Iodine allergy	Y	N
Intravenous contrast allergy	Y	N

### **MUSCULOSKELETAL**

History of orthopedic surgery	Y	N
Arthritis	Y	N
Chronic back pain	Y	N
Chronic neck pain	Y	N

### **GENITOURINARY**

Blood in urine	Y	N
Urinary tract infection	Y	N
Kidney Stones	Y	N
Urine leakage	Y	N

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# Hypertension-Nephrology Associates, P.C.

## MEDICATION LIST

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

List all daily medications and supplements:

	<u>Medication</u>	<u>Dose</u>	<u># of Pills</u>	<u>How many times daily</u> (Circle the number)
Example:	Medication Name	20mg	2	① 2 3 4
1.				1 2 3 4
2.				1 2 3 4
3.				1 2 3 4
4.				1 2 3 4
5.				1 2 3 4
6.				1 2 3 4
7.				1 2 3 4
8.				1 2 3 4
9.				1 2 3 4
10.				1 2 3 4
11.				1 2 3 4
12.				1 2 3 4

## PHARMACY INFORMATION

Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Mail Order Pharmacy Name \_\_\_\_\_

### MY TREATING PHYSICIANS – PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

**Hypertension Nephrology Associates, P.C.**  
**Financial Policy**

Hypertension Nephrology Associates, P.C. believes that communicating our financial policy is a good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances only, as a courtesy. Please realize that having a secondary insurance does not necessarily mean that your services are covered at 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are responsible for all copays, coinsurance, deductibles, and non-covered services/items. We are obligated to collect your copay at the time of service per your insurance company. We accept cash, check, MasterCard, Visa or Discover. Statements are sent out monthly, and we ask that payment for balances due be rendered when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service. There is a \$25.00 returned check service charge. Payment will then need to be made by cash, money order or credit card for the balance due and the service charge.

When you receive healthcare services from us and we bill your insurance, it is the same as us extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursement by many insurers, including Medicare, we cannot carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency unless prior payment arrangements have been made.

Some patients may accrue large balance for services provided. We will work with these patients to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid; we will need proof of financial hardship. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contracts with the insurance plans.

Completing disability forms, FMLA forms, and other requested supplemental forms requires time away from patient care and day to day business operations. Prepayment of \$10.00 per form is required. Please understand that in order to complete forms your medical record must be reviewed, forms completed, signed by the physician and scanned into your medical records. We request that you allow 5 business days for this process.

I understand and agree to Hypertension Nephrology Associates, P.C. Financial Policy.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

**HYPERTENSION NEPHROLOGY ASSOCIATES, P.C.**

**AGREEMENT OF FINANCIAL RESPONSIBILITY  
ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION**

\_\_\_\_\_  
**PATIENT NAME (Please Print)**

\_\_\_\_\_  
**CHART NUMBER**

**1. RESPONSIBILITY FOR PAYMENT:**

I understand that I, personally, am financially responsible to Hypertension Nephrology Associates, P.C. for charges not covered by the assignment of insurance benefits.

**2. ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby assign, transfer, and set over directly to Hypertension Nephrology Associates, P.C. sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said department.

**3. MEDICARE BENEFITS:**

I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, any information needed for this, or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to Hypertension Nephrology Associates, P.C.

**4. RELEASE OF INFORMATION:**

I hereby authorize and direct Hypertension Nephrology Associates, P.C. and any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

**5. COLLECTION FEES:**

I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. I understand that these additional fees will be my personal responsibility.

\_\_\_\_\_  
**SIGNATURE OF PATIENT**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF PARENT OR GUARDIAN**

\_\_\_\_\_  
**DATE**

## **Hypertension Nephrology Associates, PC**

### **Notice of Privacy Practices**

*To our patients:* This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

#### **Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

#### **Use and disclosure of your health information in certain circumstances:**

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.
9. For treatment purposes including sharing medical data with another provider, making referrals, placing lab or prescription orders.
10. For payment purposes, for filing claims either by paper or electronically.
11. For Health care operations, for quality assurance, utilization reviews, credentialing, underwriting and auditing.

#### **Your rights regarding your health information:**

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure for your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when information is necessary to treat you.
3. You have the right to obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. We, the practice, have 30 days to respond to your request, and to charge an administrative fee of at least \$25.00 for this copy.
4. You must submit your request in writing to Hypertension Nephrology Associates, with the name of your treating physician to the practices Privacy Official, MaryBeth Lawson, or to her designee who can be reached at (215) 657-2012 if you need further information.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as it is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practices Privacy Official, MaryBeth Lawson, who can be reached at (215) 657-2012 if you need further information.
6. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the practices Privacy Official, MaryBeth Lawson, or her designee at (215) 657-2012.
7. Right to file a complaint with our practices Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the practices Privacy Official, MaryBeth Lawson who can be reached at (215) 657-2012. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.



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Winston W. Shu, M.D.

### Acknowledgment of Receipt of Privacy Notice

By signing below, I acknowledge that I have received Hypertension Nephrology Associate's Notice of Privacy Practices. The notice details how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

\_\_\_\_\_  
Signature (Patient or Authorized Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print (Patient or Authorized Representative)

#### For office use only

If the patient or the patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature

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Our Valued Future Patient:

Enclosed, with the material to be completed prior to your visit in our office, is a liability waiver form. Despite the fact that this is a common part of standard contracts, you may find this unusual to be coming from a physician's office. We agree, and would like to explain why it is there.

As you may or may not be aware, in December 2002, we narrowly avoided a crisis that could have shut down the medical care in Montgomery County. The five county Philadelphia area has been dealing with a medical malpractice crisis since 2001. It has become particularly severe in Montgomery County because of the large number of physicians in private practice who do not have the umbrella of hospital employment to buffer their malpractice costs. For ten days at the end of December 2002, the Trauma Center at Abington Hospital was closed down, and those physician practices that deal in high-risk medical care were unable to obtain malpractice insurance for the third year in a row.

The crisis in December 2002 was resolved through temporary action of the Governor. However, it was not an enduring solution, and the problem is getting worse. The Governor's taskforce and the Legislature failed to take action. Presently, several large groups at Abington Hospital have lost their present insurance and will not be able to practice in the future unless they acquire a new carrier at an enormous cost increase. There presently seems to be no viable plan in the future for relief from this problem.

This problem is a direct result of the hospital legal environment in this area, and the trial attorneys in the Philadelphia area are largely responsible for this problem. The number of frivolous lawsuits filed and the size of unjustified jury awards have escalated dramatically over the last several years. Advertisements purchased by law firms seeking plaintiffs to sue doctors are in every media – radio, television, and newspapers – even all over your telephone book covers! It is little wonder that insurance companies in Pennsylvania are refusing to write insurance policies, and those that can be obtained cost, in some cases, hundreds of thousands of dollars.

The real victim is you, the patient. Your access to quality medical care is at risk. As more and more physicians face this crisis, more will leave or retire early. The fact that Neurosurgeons, Orthopedic surgeons and Trauma surgeons are necessary to staff trauma centers, the first loss of access that you may find is the closure of the area trauma centers. What will happen then if you or a family member is in an automobile accident? This becomes a very real possibility as medical practices throughout the region have difficulty in recruiting new young doctors. When a perspective physician sees the hostility of the legal system and the low reimbursement to the managed care insurers, they give no real consideration to coming to our community to practice.

The next time it takes you weeks, or even months, to get a doctor's appointment, and you spend several hours waiting in the office only to be given a few minutes of the doctor's time before he or she moves on to the next patient, you will understand why. As the few doctors who remain try to fill the gap by seeing increasing numbers of patients, this problem will only worsen. In the case of physicians practicing high-risk medicine, you may have to travel out of the area to find one. As the Obstetricians leave or give up delivering babies, who will deliver you, your wife's or your daughter's baby?

We, therefore, ask you to sign the enclosed liability waiver. We make this request in the hope that it will help ease the liability crisis we all face, that your access to quality medical care will be preserved, and that as a result of your reading this letter, you have gained a better understanding of an important issue that involves you personally.

We have more information in the office that you may read while here and may take home with you if you desire. Included, are the names and addresses of all area State Representatives and Senators, and that of the Governor. We encourage your participation in dealing with this problem at the legislative and executive levels. Our legislators listen to you, the voter.

Finally, please be advised that it is the policy of this practice that we will not accept as a new patient anyone unwilling to sign the waiver. Please bring the signed waiver with you at the time of your appointment.

Sincerely,  
The Physicians of Hypertension-Nephrology Associates, P.C



To Our Patients:

As you know, from news reports on the radio and television, there is a crisis in medical liability coverage for doctors in Pennsylvania. The rapidly rising cost of insurance is putting it out of reach for many physicians in our area. In an attempt to control these spiraling costs, and to insure that we will be able to continue to offer our services to our patients, we ask that you sign the following agreement in anticipation of becoming one of our patients.

**In the event that the care rendered by the physicians of Hypertension-Nephrology Associates, P.C. results in a malpractice legal action:**

1. The grievance shall be subject to voluntary binding arbitration by a panel to be selected by The American Arbitration Association.
2. Arbitration shall take place in Montgomery County, the site of the primary office of Hypertension-Nephrology Associates, P.C.
3. If by agreement of the parties, or by court order, the legal action is remanded to the courts, item #2 will still pertain.
4. In preparation of the plaintiff's legal case, the plaintiff agrees:
  - a. To use only a licensed practicing board certified Nephrologist as an expert witness for the plaintiff.
  - b. To the collateral source rule which states that a recovery is limited by prohibition of recovery of an award for losses covered by any other form of insurance, award, or public program.
  - c. To periodic pay-outs of any award to the plaintiff on a reasonable scale to be decided by the arbitrators.
  - d. To pay any and all fees incurred by the defendant and/or his/her insurance carrier in defending the case in the event that the defendant prevails in this action.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PATIENT RECORD OF DISCLOSURES

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Cell Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only   |

Emergency Contact  
 Name and relationship \_\_\_\_\_  
 Phone Number \_\_\_\_\_

No Emergency Contact

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Birthdate

If necessary, Hypertension Nephrology Associates may talk with any of the following individuals about my medical condition and/or billing information: \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
 Name (please print)                      Relationship

\_\_\_\_\_  
 Name (please print)                      Relationship

\_\_\_\_\_  
 Name (please print)                      Relationship

\_\_\_\_\_  
 Name (please print)                      Relationship

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for *TPO* may be permitted without prior consent in an emergency.

### Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check this box if the disclosure is authorized  
 (2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations  
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other