Welcome To Our Practice

We are honored to be your physician, and are committed to providing you with the best care we can. Our hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. We will share our medical expertise with you, and we hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being. Few of us, have a completely healthy lifestyle, but each day we can take a step closer to a healthier life.

Here are some important steps you can take toward better health:

- Don't smoke cigarettes or use other tobacco products.
- Drink alcohol in moderation, if at all, and never drive when you've been drinking.
- Eat a diet low in fat and high in vegetables and fruits.
- Exercise at least three times a week.
- Learn about ways to deal with stress and tension.

We look forward to working with you as your Kidney doctor. Please contact us whenever you'd like to talk about anything you think may be affecting your health. It's our hope that we can have a relationship where the lines of communication are open and communication goes both ways. Let's work together to help you live the satisfying life that you deserve.

For your first visit –please do not forget to:

- ✓ Bring your medication bottles or a complete list of all your medications
- ✓ Bring your over the counter pills (or a list) including vitamins and herbal preparations.
- ✓ Contact the referring Doctors office to have them send us your Lab reports and office notes.

For additional information regarding our practice and directions to our offices at www.3024kidney.com.

We look forward to meeting with you.

Sincerely,
Team at Nephrology Consultants, P.A.

Nephrology P.A. CONSULTANTS
3024KIDNEY.com

Patient Registration

DEMOGRAPHIC INFORMATION

Today's Date	First Name		Last Name	MI	Gender
Street Address			City, State		Zip Code
Date of Birth	Age	Social Security #	Occupation		Marital Status

Home Phone #	Cell Phone #	Work Phone #
Email Address		
Driver's License OR Identification ID card No:	State/Place of Issue:	Expires on

EMERGENCY CONTACT

Name:	Relation to Patient

Home Phone #	Cell Phone #	Work Phone #

PHARMACY

Name:	Main Phone #	Location #

INSURANCE INFORMATION

COPY OF INSURANCE CARD & PHOTO ID
If your insurance coverage is under another person's name, please note their name and date of birth:

Name of Policy Holder	**Date of Birth**

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I give permission to Nephrology Consultants, P.A. and its employees, agents, and medical providers to release medical information to insurance carriers, health organizations, governmental agencies (including Center for Medicaid and Medicare Services - CMS), and other entities charges with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me, be directed to Nephrology Consultants, PA or appropriate provider. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of charges for the medical services provided. I understand that my medical information may be electronically submitted to any or all treating physicians, hospitals, and or health care entities. I take responsibility of providing Nephrology Consultants with true, complete and accurate information regarding my medications, health condition(s), ongoing treatments and recommendations of other providers. Also, I promise to follow their recommendations including medications, tests and follow-up visits.

Signature: _____ **Date:** _____

Relation to Patient: _____

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Patient Referral & Pre-Appointment Questionnaire

Name: _____ Date: _____

REFERRING PHYSICIAN INFORMATION

Physician/Providers **Name**: _____
Physician/Providers **Address**: _____
Physician/Providers **Phone #**: _____
Physician/Providers **Fax #** (if known): _____

PRIMARY PHYSICAN INFORMATION

□ Same as above?
Physician/Providers **Name**: _____
Physician/Providers **Address**: _____
Physician/Providers **Phone #**: _____
Physician/Providers **Fax #** (if known): _____
Hospital Last Admitted in (please mark one):
□ Christiana □ Wilmington □ St Francis □ Union □ Kent General

PRE-APPOINTMENT QUESTIONNAIRE

To help us get the most out of today's visit, please answer the following questions.

1. **What is your main purpose in coming to our office today?** (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be?)
   _____
   _____
   _____
2. **Do you have any other concerns?** □ Yes (list below) □ No
   _____
   _____
3. **Has anything new come up in your family history?** □ Yes (list below) □ No
   (For example, have any of your blood relatives recently developed a new illness?)
   _____
4. **Have you developed any new drug allergies?** □ Yes (list below) □ No
   _____
5. **What do you do for exercise?** How long?_____ How often?_____
6. **How much tobacco do you smoke or chew per day?** _____ **Note:** It is recommended that you stop using tobacco. We can enroll you in a tobacco-cessation class.
7. **How much alcohol do you consume per week?** _____
8. **How much caffeine do you consume per day?** (ie., coffee, tea, chocolate, soda)
9. **What method of birth control do you use?**
   □ Not Applicable □ The Pill □ Vasectomy □ Tubal Ligation □ Other (specify): _____

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History Form

Age & Cause of Death if Deceased	Relative		Relative		Relative
____ Alcoholism		____ Glaucoma		____ Migraine	
____ Anemia		____ Hay Fever/Allergies		____ Osteoporosis	
____ Arthritis		____ Heart Disease		____ Seizures/Epilepsy	
____ Asthma		____ High Cholesterol		____ Stroke	
____ Bleeding disorder		____ Hypertension		____ Thyroid Disease	
____ Cancer		____ Kidney Disease			
____ Diabetes		____ Mental Illness			

Personal Medical History			
____ Allergies	____ Chronic Pain	____ Heart Attack/MI	____ Sexual Dysfunction
____ Anemia	____ COPD	____ Heart Palpitations	____ Shortness of Breath
____ Anxiety	____ Diabetes	____ Heart Murmur	____ Stroke/TIA
____ Arrhythmia	____ Dizziness/Fainting	____ High Blood Pressure	____ Ulcers
____ Arthritis	____ Epilepsy	____ Liver Disease	____ Chest Pain/Tightness
____ Asthma	____ Fatigue	____ Menstrual Dysfunction	____ High Cholesterol
____ STD	____ GI Disorder	____ Renal Disease	____ Depression
____ Claudication	____ Abdominal Pain	____ Rheumatic Fever	____ Joint Pain
____ CHF	____ Headache/Migraine	____ Scarlet Fever	____ Wheezing

Other Medical History			
____ Numbness in Hands/Feet	____ Difficulty Hearing	____ Coughing up Blood	____ Diarrhea
____ Leg Pain/Cramps When Walking	____ Excessive Thirst	____ Night Sweats	____ Constipation
____ Painful Sores/Ulcers on Legs/Feet	____ Double Vision	____ Skin Rash	____ Mood Swings
____ Swelling in Legs/Feet/Ankles	____ Frequent Urination	____ Trouble Sleeping	____ Fever
____ Bloody Bowel Movements	____ Black Bowel Movements	____ Weight Loss	
____ Painful Urination	____ Chills	____ Nose Bleeds	
____ Difficulty Swallowing	____ Cough	____ Vomiting	

Social History							
Occupation						Exercise	
Seat Belts	Y	N	Marital Status			Diet	
Tobacco Use	Y	N	Alcohol Use	Y	N	Street Drugs	Y N
Packs/Day			How Often?			How Often?	
How many years?			Amount			Amount	
			Type			Type	

Procedures/Surgeries	Date

Name: _____ Date: _____

Date of Birth: ____/____/_____

Patient Consent for Use and Disclosure of Protected Health Information

The individual whose signature appears below hereby attests to the following statements:
With my consent, NEPHROLOGY CONSULTANTS, P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Please refer to NEPHROLOGY CONSULTANTS, P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.)

With my consent, NEPHROLOGY CONSULTANTS, P.A. may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care:

Name	Relationship	Home #:	Work #:	Cell #:

Please indicate name, contact numbers, and relationship of individuals to whom NEPHROLOGY CONSULTANTS, P.A. may release PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent. NEPHROLOGY CONSULTANTS, P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO HOME
With my consent, NEPHROLOGY CONSULTANTS, P.A. may call my home or other designated location and leave message on my voice mail or with a person in reference to any item that may assist NEPHROLOGY CONSULTANTS, P.A. in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

CONSENT FOR MAIL
With my consent, NEPHROLOGY CONSULTANTS, P.A. may mail to my home or other designated location any item that may assist NEPHROLOGY CONSULTANTS, P.A. in carrying out TPO such as appointment reminder cards and patient statement as long as they are marked CONFIDENTIAL.

CONSENT FOR E-MAIL
With my consent, NEPHROLOGY CONSULTANTS, P.A. may e-mail to my designated e-mail address any message in reference to any item that may assist in my care.

NEPHROLOGY CONSULTANTS, P.A. may contact me for TPO use, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

I have the right to request that NEPHROLOGY CONSULTANTS, P.A. restricts how it uses or discloses my PHI to carry out the TPO, However, NEPHROLOGY CONSULTANTS, P.A. is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to NEPHROLOGY CONSULTANTS, P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that NEPHROLOGY CONSULTANTS, P.A. has already made disclosure in reliance upon my prior consent. If I do not sign this consent, NEPHROLOGY CONSULTANTS, P.A. may decline to provide services to me.

NEPHROLOGY CONSULTANTS, P.A. Reserves the right to modify the Privacy Practices outlined in this notice.
I have received a copy of the Notice of Privacy Practices for NEPHROLOGY CONSULTANTS, P.A.

Signed by:

_____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Patient's Name | Date

_____
Printed Name of Patient or Legal Guardian

(PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION)

care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may 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 web site, www.umclinic.net/HIPAAprivacy. To obtain a paper copy of this notice, please write to: Practice Administrator.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

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. If you wish to file a complaint with our office, contact our Privacy and Security Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

QUESTIONS

If you have any questions about this notice, please contact our Privacy and Security Officer at:

Nephrology Consultants, P.A.
Attn: Constance Damestoir
Address: 2600 Limestone Rd. Suite #7, Wilmington, DE 19810
Phone: 302-355-2383

Thank you for taking time to review our Notice of Privacy Practices.

North Wilmington Office
3521 Silverside Road
Wilmington, DE 19810

West Wilmington Office
2500 West 4th Street, Suite 6
Wilmington, DE 19805

Wilmington Office
2006 Limestone Road, Suite 7,
Wilmington, DE 19810

Newark/Bear Office
101 Becks Woods Drive, Suite 102
Bear, DE 19701

Middletown Office
222 Carter Drive
Middletown, DE 19709

Smyrna Office
315 North Carter Road
Smyrna, DE 19977

Dover Office
111 Wolf Creek Blvd., Suite 2
Dover, DE 19901

Call **(302) 4KIDNEY** or
(302) 355-2383

visit our website at:
www.3024KIDNEY.com

Nephrology P.A.
CONSULTANTS
3024KIDNEY.com

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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 THIS NOTICE CAREFULLY.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to 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 or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Practice Administrator. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Medical Director.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Practice Administrator.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Practice Administrator. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health-