ATLANTIC KIDNEY CARE

ATLANTIC KIDNEY CARE PC

NEW PATIENT REGISTRATION PACKET

Patient Information

Last Name _____ First Name _____ MI: _____

Date of Birth _____ Gender: M □ F □ Social Security # _____

For Minors please indicate responsible Parent/Guardian: _____

Address: _____

Street _____ City _____State/Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

Email _____

Marital Status: Single □ Married □ Widowed □ Separated □ Divorced □

Insurance Information (Present Insurance Card(s) to Receptionist)

Primary Insurance _____

Subscriber Information:

Last Name _____ First Name _____ MI: _____

Date of Birth _____ Age _____ SS# _____ Sex (M/F) _____

Address _____ City/State _____ Zip _____

Home Telephone ( ) _____ Work Telephone ( ) _____

Secondary Insurance _____ Policy/ID # _____

Subscriber Information:

Last Name _____ First Name _____ MI: _____

Date of Birth _____ Age _____ SS# _____ Sex (M/F) _____

Address _____ City/State _____ Zip _____

Home Telephone ( ) _____ Work Telephone ( ) _____

ATLANTIC KIDNEY CARE

ATLANTIC KIDNEY CARE PC

Preferred Pharmacy

Indicate your preferred Pharmacy below:

Local Pharmacy Name: _____ Phone Number: _____

Address: _____

MaIl- Order Pharmacy Name: _____

(Indicate City and Cross Streets, Zip Code, if known)

Communication Preferences

I understand that the staff and/or physicians of Atlantic Kidney Care PC may need to contact me regarding appointments, test results or other issues related to my health. Listed below are my preferences:

Preferred method for communication: □ Home □ Work □ Cell □ Email

Can we leave a message on machine or with whoever answers? (Circle Yes or No)

Home Y / N Work Y / N Cell Y / N

DO NOT CALL: □ Home □ Work □ Cell

Disclosure to Designated Family/Friends/Caregivers

I allow Atlantic Kidney Care PC to disclose medical information as needed to the following designated individual(s) involved with my health care. I understand that I am not required to list anyone. I also understand that I may change the list in writing anytime.

Print Name Date of Birth Relationship Phone Number

_____ _____

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ATLANTIC KIDNEY CARE PC

Print Name Date of Birth Relationship Phone Number

Authorization to Access Electronic Prescription Records

- ✓ I authorize ATLANTIC KIDNEY CARE PC and its affiliated providers to view my external prescription history via electronic prescribing services.
- ✓ I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years, and may include prescriptions to treat HIV, substance abuse and psychiatric conditions, if applicable.
  - ✓ I understand that my prescription history will become part of my ATLANTIC KIDNEY CARE PC

Release and Assignment of Benefits

- ✓ I directly assign all health insurance benefits, to which I am entitled, by Medicare, Medicaid, Blue Cross, or any other insurance plans, directly to the providers in ATLANTIC KIDNEY CARE PC for services rendered on my behalf.
- ✓ I understand that I am financially responsible for all charges, whether or not I am insured at the time of service, including deductibles, co-insurance, copayments and benefits services that are out of network, denied and/or not covered by my health insurance plan.
- ✓ I authorize ATLANTIC KIDNEY CARE PC or any other holder of medical or other information about me to release to Medicare, Medicaid, or Blue Cross, or any other insurance carriers or their authorized agents any information needed for this or a related claim.

Consent to Treat

- ✓ I, the undersigned, voluntarily consent to and authorize Atlantic kidney care PC through its physicians, employees, and/or agents, to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic, radiological and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of my Atlantic Kidney Care PC physician(s), including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products.
- ✓ I acknowledge that no guarantees have been made to me about the results of any examination or treatment.
- ✓ I acknowledge that I have been advised of my right to an Advance Directive. ✓ I acknowledge receipt of Atlantic Kidney Care PC Financial Agreement
- ✓ I agree to allow access to my electronic prescription records .
- ✓ I agree to the assignment of benefits as described above.
- ✓ I agree to treatment as described above.
- ✓ I have read this form, my questions have been answered, and I understand and agree to its content.

Patient/Representative's Signature: _____ Date: _____

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ATLANTIC KIDNEY CARE PC

If signed by Authorized Representative, Print Name:_____
Relationship to Patient/Authority to Sign: _____

ATLANTIC KIDENY CARE PC FINANCIAL POLICY

Patient Name _____ Date of Birth: _____

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our **FINANCIAL POLICY.**

It is important for you to understand that health insurance coverage is an agreement between

you and your insurance company.

AND

Your doctor's bill for services provided is an agreement between you and your doctor.

YOUR RESPONSIBILITY: Our Physicians participate with several insurance companies. It is your responsibility to call your insurance company to verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will expect payment from you at the time of service. We will give you a bill at the end of the visit, which you can submit to your insurance comapany and get reimbursed as per your contract with your insurance. If you do not have valid insurance information, do not provide your social security number and we cannot confirm coverage, we will consider you a self-pay and ask for full payment at time of service.

All co-payments or payments for non-covered service are the patient's responsibility and will be collected by our staff at time of service. If you have not met your deductible for the year then you will be required to pay for the services at the time of the visit.

SPECIALIST OFFICES & REFERRALS: If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization in Navinet prior to your appointment. Please allow five (5) business days for non-emergency services prior to seeing that specialist or facility. If you do not have a valid referral/authorization, you may be asked to reschedule. You are responsible for payment of your account regardless of referral status. If your insurance company requires referrals for services at a Specialist office, If you go to the Specialist office without a referral, you will be responsible for the entire bill.

I understand that it is my responsibility to know and abide by the terms of my benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. I also understand that I am responsible for full payment for services provided if I fail to supply the referral forms, when required.

Signature of Patient/Guarantor **Date**

ATLANTIC KIDNEY CARE PC

PAYMENT FOR SERVICES PERFORMED:

- Our office accepts Visa, MasterCard, Discover and American Express, as well as Cash, Debit Cards and Personal Checks for payment of services.
- Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement; we cannot bill you for these.
- All payments are expected at the time of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

RETURNED CHECK FEE IS $30

CHARGES TO ACCOUNT: You shall have the right to cancel our privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or cancel with less than 24 hours' notice will be charged a $10 fee. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

FORMS FEE: There is a charge for the completion of forms. The fee for this service is $10 per page of form and will not be paid by your insurance company. The forms will be completed within five (5) business days.

TRANSFERRING OF RECORDS: If you require a copy of your records, you must submit a written request. You are authorizing us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. Please note we cannot email the records as it is HIPPA violation.

AGREEMENT: I have read and fully understand the Financial Policy set forth by ATLANTIC KIDNEY CARE PC, and I agree to the terms of this policy. I also understand and agree that ATLANTIC KIDNEY CARE PC may amend the terms of this Financial Policy at any time without prior notification to the patient.

EFFECTIVE DATE: Once you have signed this Agreement, you agree to all of the terms and conditions contained herein, and the Agreement will be in full force and effect.

_____

Signature of Patient/Guarantor **Date**

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO ATLANTIC KIDNEY CARE PC

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician Name: _____ Phone #: _____

Referring Physician Name: _____ Phone #: _____

Other doctors: _____Specialty: _____ Phone #: _____

Other doctors: _____Specialty: _____ Phone #: _____

Reason for visit: _____

Past Medical History: (Please check all that apply)

□ Diabetes mellitus Type 2 □ High Blood Pressure □ Hypothyroidism

□ Diabetes mellitus Type 1 □ High Cholesterol □ Kidney cysts

□ Kidney stones □ Heart attack/ Coronary artery disease

□ Chronic kidney disease □ Anxiety/ Depression

□ Gout □ Cancer

□ Other_____ □ Other_____ □ _____

Past Surgical History:

Type of surgery Date: Month and year

_____

_____

_____

_____

ALLERGIES:

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO ATLANTIC KIDNEY CARE PC

Medication Reaction:

PATIENT NAME: _____

D.O.B: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

TELEPHONE: Home: _____Cell: _____

I hereby authorize _____

Phone: _____ Fax: _____

To disclose my health information to ATLANTIC KIDNEY CARE PC:

- Dr. Harneet Kaur

The information to be disclosed to and used by the above is for the following purpose: _____

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

□ EMERGENCY ROOM RECORD	□ CONSULTATIONS	□ COMPLETE RECORD
□ HISTORY & PHYSICAL EXAM	□ PROGRESS NOTES	□ ABSTRACT
□ OPERATIVE REPORT	□ LAB, X-RAYS & TESTS	□ PATHOLOGY
□ DISCHARGE SUMMARY	□ NURSES' NOTES	□ BILLING INFO.
□ CLINIC RECORDS	□ REHAB. RECORDS	□ OTHER _____

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, AND email correspondence as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Harneet Kaur of Atlantic Kidney care PC. I understand that this revocation will not apply to the extent of any actions that the practice has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or Condition: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

ATLANTIC KIDNEY CARE

ATLANTIC KIDNEY CARE PC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO ATLANTIC KIDNEY CARE PC

If I have questions about disclosure of my health information, I can contact Dr.Harneet Kaur, MD of Atlantic Kidney Care PC of at 780 Route 37 W, Suite 220, Toms River, NJ 07701 Phone: 732-734-0775.

PATIENT SIGNATURE: _____ DATE: _____

LEGAL REPRESENTATIVE: Name: _____ RELATION: _____ DATE: _____

Atlantic Kidney care PC

NOTICE OF PRIVACY PRACTICES PAGE 1

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 THIS NOTICE CAREFULLY.

- We are required by law to protect the privacy of your health information often referred to as protected health information or "PHI" which may include individually identifiable information that relates to your past/present/future physical or mental health condition and provision of health care and/or past/present/future payment for health care.
- We are required to provide you with a copy of this notice describing the privacy practices and legal duties and to explain how, when, and why Atlantic Kidney Care PC may use or disclose your protected health information.
- Atlantic Kidney Care PC recognizes and respects your right to confidentiality, and we maintain numerous safeguards to protect your privacy. We are required by law to abide by the terms of this notice currently in effect. We reserve the right to change this notice from time to time and to make the Notice effective for all PHI we maintain. You can always obtain a copy of our most current notice by contacting the Privacy Officer.
- If you have questions or would like additional information about this Notice, please contact the Privacy Officer Dr. Harneet Kaur, Atlantic kidney Care PC at 780 Route #& w, suite 220, Toms river, NJ 08755 Phone: 732-734-0775

II. **HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

The following categories describe different ways that we may use or disclose medical information about you. For each category, we have provided useful examples:

❒ **Treatment** means the provision, coordination, or management of your health care, including consultations between doctors, nurses, and other providers, regarding your care and referrals for care from one provider to another. For example, your primary care doctor may disclose your protected health information to a Cardiologist if he is concerned that you have a heart problem. We also may, for example, allow one specialist within our practice who treats you to see the electronic medical reports from other specialists within the Group who have treated you, or we may, for example, allow all the physicians in the Group who examine you to see certain entries in your electronic medical records such as vital signs, allergies, and medications, so that Atlantic Kidney Care PC may provide more coordinated care to you, and avoid adverse treatment interactions.

❒ **Payment** means the activities we carry out to bill and collect for the treatment and services provided to you. For example, we may provide information to your insurance company about your medical condition to determine your current eligibility and benefits. We may also provide PHI to outside billing companies and others that process health care claims.

❒ **Health Care Operations** means the support functions that help operate Atlantic Kidney Care PC such as quality improvement studies, case management, responding to patient concerns, and other important activities. For example, we may use your PHI to evaluate the performance of the staff that cared for you or to determine if additional services are needed.

III. OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO ATLANTIC KIDNEY CARE PC

In addition to using and disclosing your protected health information for treatment, payment, and health care operations, we may also use your information in the following ways:

❑ **Appointment Reminders and Health-Related Benefits or Services**. We may use PHI to contact you for a medical appointment or to provide information about treatment alternatives or other health care services that may benefit you.

❑ **Disclosures to Family, Friends, and Others**. We may disclose your PHI to family, friends, and others identified by you as involved in your care or the payment of your care. We may use or disclose PHI about you to notify others of your general condition. We may also allow friends and family to act or you and pick-up prescriptions, x-rays, etc. when we determine it is in your best interest to do so. If you are available, we will give you the opportunity to object to these disclosures.

NOTICE OF PRIVACY PRACTICES PAGE 2

❑ **To Avoid Harm**. As permitted by law and ethical conduct, we may use or disclose protected health information if we, in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual.

❑ **Fundraising & Marketing Activities**. We may contact you as part of our fundraising and marketing activities as permitted by law.

❑ **Research Purposes**. In certain circumstances, we may use and disclose PHI to conduct medical research. Certain research projects require an authorization which will be made available to you prior to using your PHI.

❑ **Law Suits & Disputes**. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information in response to a subpoena, discovery request, or other process by others involved in the dispute. We will only disclose information with assurance that efforts were made to inform you about the request or to obtain an order protecting the information requested.

❑ **Required by Law Enforcement**. We may release health information about you, if asked to do so by law enforcement in response to a court order, subpoena, warrant, summons, or similar process. We also may disclose information to identify or locate a suspect, fugitive, material witness, or missing person. In addition, we may disclose information about a crime victim or about a death we believe may be the result of criminal conduct. In emergency situations, we may disclose PHI to report a crime, to help locate the victims of the crime, or the identity/description/location of the person who committed the crime.

❑ **Incidental Disclosures.** We may make incidental uses and disclosures of your protected health information. Incidental uses and disclosures may result from otherwise permitted uses and disclosures and cannot be reasonably prevented. Having your name called aloud by a staff member in the waiting room is an example of an incidental disclosure.

❑ **Disaster Relief.** When permitted by law, we may coordinate our uses and disclosures of protected health information with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure to the Red Cross or a similar organization.

IV. SPECIAL SITUATIONS

❑ **Organ and tissue donation**. If you are an organ donor, we may disclose PHI to organ procurement organization.

❑ **Military personnel**. If you are a member of the armed forces, we may release PHI about you as required by military authorities. We may also release health information about foreign military personnel to appropriate foreign military authorities.

❑ **Worker's compensation**. We may disclose health information about your work-related illness or injury to comply with worker's compensation laws.

❑ **Public health activities**. We routinely disclose information about you for public health activities to: Prevent or control disease, injury or disability: Report births and deaths; Report child abuse or neglect; Persons under the jurisdiction of the Food & Drug Administration for activities related to product safety and quality and to report reactions to medications or products; Notify people who may have been exposed to a disease or are at risk of contracting or spreading a disease; Notify government agencies if we believe an adult has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if the patient agrees or when required by law.

❑ **Health Oversight Activities**. We may disclose information to government agencies that oversee our activities. These activities are necessary to monitor the health care system and benefit programs, and to comply with regulations and the law.

National Security. We may disclose PHI to authorized officials for national security purposes such as protecting the President of the United States or other persons, or conducting intelligence operations.

❑ **Inmates**. If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correction facility or law enforcement officials. This would be necessary for the institution to provide you with health care; to protect your health and safety and the health and safety of others; or for the safety and security of the correctional institution.

❑ **Other Uses of Your 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 permission in a written authorization. You have the right to revoke the authorization at any time; provided the revocation is in writing except if we have already taken action in reliance of your authorization.

V. YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Request Limits on Uses and Disclosures of your PHI. You have the right to request restrictions to how we use and disclose your PHI. Your request must be in writing, and sent to the Privacy Officer. We will review your request but we are not required to agree to your request. If we agree to your request, we will document the restrictions and abide by them, except in emergency situations, as necessary. You may not limit the uses and disclosures that we are legally required or allowed to make.

Right to Request Confidential Communications. You have the right to request to receive confidential communications of protected health information by alternative means or at alternative locations. For example, sending information to your work address rather than to your home address, or asking that we contact you by mail rather than telephone. To request confidential communications, you must specify your instructions in writing on a form provided on request. You must specify where and how you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Obtain Copies of your Protected Health Information. In most cases, you have the right to inspect and obtain copies of protected health information used to make decisions about your care, subject to applicable law. To inspect or copy your medical record, you must make a request in writing to the Privacy Officer. If you request copies of your health information, we may charge a fee for copying, postage, and other supplies associated with your request.

Right to Amend your Protected Health Information. If you believe that the protected health information we have about you is incorrect or incomplete, you may request that we amend the information. To request an amendment, you must make your request in

writing to the Privacy Officer, and specify a reason that supports you request. We may deny your request for an amendment subject to applicable law.

The Right to Obtain a List of Disclosures We Have Made. You have the right to request an "accounting of disclosures" of your protected health information. Your request must be made in writing and include a time period no longer than six years, not including dates before April 14, 2003.

There are several exceptions to the disclosures we must account for. Examples include disclosures for treatment, payment, and health care operations; those made to you; those made as a result of an authorization by you; those made for national security or intelligence purposes, and those that occurred before April 14, 2003.

Requests for an accounting of disclosures must be made in writing to the Privacy Officer. The first accounting you request within a 12-month period is free. For additional accountings, we may charge you for the cost of providing it. We will notify you of the cost before processing your request so you may withdraw or modify your request before costs are incurred.

VI. COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with us, please contact the Privacy Officer,
Dr. Harneet Kaur, Atlantic Kidney Care PC, 780 Route 37 W, suite 220, Toms river, NJ 08755, Phone: 732-734-0775,.

We will not take action against you for filing a complaint.