ACE KIDNEY

Sanghamitra Sadhu, M.D.

PATIENT REGISTRATION

Directions: Please complete all sections, initial where necessary, and sign at the bottom. Write/check N/A if not applicable.

Patients' Demographics				
Last Name:	First Name:	Ml:		Date:
Sex: ☐ M ☐ F	DOB: Age:	SSN:	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	
Home Phone#:	Cell / Alternative Phone #:		Email:	
How do you prefer to be contacted? ☐ Home Phone ☐ Cell/Alternative Phone ☐ Email				
Address:	City:		State:	Zip:
Status: ☐ Employed ☐ Student ☐ Disabled ☐ Unemployed ☐ Retired	Employer Name: ☐ N/A		Work Phone:	

Patients' Care		
How did you hear about us? ☐ Family ☐ Friend ☐ Employer ☐ Doctor ☐ Other _____		
Primary Care Doctor Name:	Phone Number:	Fax Number:
Referring Doctor Name:	Phone Number:	Fax Number:
PHARMACY Name:	Location:	Phone Number:

Insurance Information		
Do you have Health Insurance: ☐ Yes (A copy will be placed in chart) ☐ No/Self Pay **(You will be asked for insurance at every visit)**		
Primary Insurance Name:	Group Number:	ID/Policy Number:
Primary Insurance Phone Number:	Relationship to Policy Holder/Name: ☐ Self	
Secondary Insurance Name:	Group Number:	ID/Policy Number:
Secondary Insurance Phone Number:	Relationship to Policy Holder/Name: ☐ Self	

EMERGENCY CONTACT INFORMATION		
1. Name:	Relationship:	Phone:
2. Name:	Relationship:	Phone:
Ace Kidney has permission to discuss my medical care with myself and the following: ☐ 1. Name: _____ ☐ 2. Name: _____ ☐ Other:_____		

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CONSENT FOR TREATMENT & INSURANCE ASSIGNMENT AGREEMENT

I authorize ACE KIDNEY LLC ***to examine me and order/perform such tests, procedures and/or treatment that are reasonable and necessary in the diagnosis and treatment of my case.*** I hereby acknowledge that I am seeking medical care on my volition without any coercion.

I furthermore authorize payment from any insurance company or any governmental agency to Ace Kidney for any medical or surgical benefits otherwise payable to me for the services provided by Ace Kidney, but not to exceed the reasonable and customary charge for these services. ***I understand that I am financially responsible for charges not paid by this assignment. I further understand that it is my responsibility to understand the coverage my insurance policy provides including any out of pocket expenses I am responsible for as well as the referral and authorization process for services.***

Signature of Patient or Patient Representative: _____ Date: _____

MEDICAL HISTORY, MEDICATIONS AND ALLERGIES

Medical History

☐ No Known Medical History

Please check the following if you are known to have these currently or in the past:

☐ Chronic Kidney Disease	☐ History of Acute Kidney Injury	☐ Protein in urine
☐ Blood in urine	☐ Flank pain	☐ Excessive thirst
☐ Increased urine output	☐ Kidney Stones	☐ Congenital Kidney Disease
☐ Diabetes Mellitus	☐ Hypertension	☐ Coronary Arterial Disease
☐ Heart Failure	☐ Heart Rhythm Abnormalities	☐ High Cholesterol
☐ Liver Disease	☐ Anemia	☐ Bleeding Disorders
☐ Leg Swelling	☐ Fatigue	☐ Decreased urine output
☐ Increased urination at night	☐ Repeated urine Infections	☐ Stroke
☐ Asthma	☐ Chronic Bronchitis	☐ Dyspnea (shortness of breath)
☐ Cancer	☐ Thyroid Disease	☐ Sleep apnea
☐ Alzheimer's Dementia	☐ Deep Vein Thrombosis	

☐ Others: _____

Medications

☐ No Medications Taken

Please list all current medications including Prescription,
Non Prescription (ex. Aspirin), and Supplements you are taking: ☐ See Attached Med List:

Medication Name	Dosage	Frequency

Allergies

☐ No Known Allergies

Please list all known allergies: _____

_____

Sanghamitra Sadhu, M.D.

Dear Patient,

Thank you for choosing Ace Kidney LLC for your specialty healthcare needs. We are pleased to welcome you to our practice. We'd like to familiarize you with our office policies to keep you informed and avoid any potential misunderstandings.

APPOINTMENTS: In the event that you cannot keep a scheduled appointment, please provide a minimum of 24 hours' notice to avoid a no show/cancellation fee of $50.00 being charged to your account. This allows us to schedule other patients in the vacant appointment slot and decrease appointment wait times.

REFERRALS: If your insurance policy requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain such referral prior to your scheduled appointment. If you do not have a valid referral, your appointment will be rescheduled.

CO-PAYMENTS AND DEDUCTIBLES: By law, we are required to collect your carrier designated copayment (co-pay). This payment is due at the time of service. Any diagnostic testing or procedures performed may require a separate co-pay, deductible, and/or coinsurance. We will collect such balance at the time of service.

SELF PAY PATIENTS:

Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

Self Pay: • New Patient 1st Visit ONLY: $225 • Follow Up Visit ONLY: $145

FMLA/DISABILITY FORM COMPLETION: Please have FMLA and/or disability paperwork completed by your PCP wherever possible.

MEDICAL RECORDS REQUESTS: We will provide you with a copy of your medical records upon request.

****A charge of $1.00 per page will be assessed for the first 25 pages and $0.25 per page thereafter****

This fee covers the cost of reproducing these records. There will be no charge if records are sent to another physician. Ace Kidney is only permitted to release our office records only.

REFILL REQUESTS: Medication refills will be sent electronically to your pharmacy. Please provide us with your pharmacy name, address, and phone number and notify us of any changes as soon as possible. Refills are generally processed at your scheduled appointment: however, please call our office during business hours if refills are needed prior to your scheduled appointment date. *Please allow a minimum of 72 business hours for processing these requests.*

ACCEPTED PAYMENT TYPES: Cash, check or card (Visa, MasterCard, American Express, and Discover) are acceptable forms of payments. A $35.00 fee will be charged to the patient's account for checks returned due to insufficient funds.

By initialing here, I am agreeing that I have read the information above. _____

MEDICARE PATIENTS ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Ace Kidney to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medical claims. I hereby authorize payment directly to Ace Kidney for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routing testing may not be covered by Medicare unless the physician provides medical necessity.

☐ Not Applicable ***Initial*** _____

PATIENT NOTIFICATION RESPONSIBILITY

If my follow-up appointment after any study, test and/or procedure is cancelled or rescheduled by myself or by Ace Kidney, I understand it is my responsibility to contact the office within 7-10 days after the study/test/procedure has been completed to verify results are negative/normal/stable and no other testing/office visit is necessary.

Initial _____

ORIGINAL ASSIGNMENTS. AUTHORIZATIONS. AND RELEASES ON FILE

I permit a copy of the above assignments, authorizations, and releases to be used in place of the original, which has been filed in the office of Ace Kidney LLC.

Initial _____

PATIENT/GUARANTOR

If proper authorization is not obtained from my Primary Care Physician (PCP), I will be liable for charges incurred for those services. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days the claim remains unpaid, I understand the balance may be due from me.

Initial _____

ADVANCED DIRECTIVES: (For compliance with the patient self-determination act)

Have you executed an advanced directive? ☐ YES ☐ NO
(Have you decided upon the degree of care you want in the event of a catastrophic medical event?)

- If **YES,** is this directive in the form of: ☐ A LIVING WILL ☐ A DURABLE POWER OF ATTORNEY ☐ HEALTH CARE SURROGATE
- If you have executed an advanced directive in any of the above formats, have you provided this office with a copy for your medical records? ☐ YES ☐ NO

PATIENT CONSENT / NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA) of 1996, I have certain privacy rights related to my protected health information (PHI). I understand this information can be used to:

1) Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in such treatment directly and indirectly.
2) Obtain payment from third party payers.
3) To conduct normal healthcare operations such as quality assurance and physician certifications.

I have been informed of Ace Kidney LLC's Notice of Privacy Practices which provides a more complete description of how my PHI may be used or disclosed. I understand that I have the right to review this Notice before signing this form. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice.

- ✓ I understand that while this consent is voluntary, Ace Kidney can refuse to treat me should I refuse to sign it. I further understand that I have the right to request how my PHI is used or disclosed to carry out treatment, payment or health care operations. I also understand that the organization is not required to agree to my restrictions, but if they do agree, then they are bound to abide by such restrictions.
- ✓ I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already made releases relying on my prior consent.

Attestation: By signing this form, I consent to the Ace Kidney LLC's use and disclosure of my protected health information to carry out treatment and health care operations and/or determine a claim for payment as described in their Notice. By signing below, I also agree to all information stated herein and understand my rights and responsibilities as a patient of the Ace Kidney LLC.

Printed Name of Patient or Patient Representative: _____ Date: _____

Signature of Patient or Patient Representative: _____ Relationship to Patient: _____

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Ace Kidney Authorization of Medical Records Form

I ___________________________________ hereby authorize **Ace Kidney LLC** to obtain/release my
(Print Patient Name)

Protected Health information from/to the following person(s) and/or organization(s):

Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	**Purpose of Records Request:** ☐ Release to Ace Kidney ☐ Obtain from Ace Kidney
Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	**Purpose of Records Request:** ☐ Release to Ace Kidney ☐ Obtain from Ace Kidney
Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	**Purpose of Records Request:** ☐ Release to Ace Kidney ☐ Obtain from Ace Kidney
Doctor/Health Provider or Plan Name:	Phone Number:	Fax Number:	**Purpose of Records Request:** ☐ Release to Ace Kidney ☐ Obtain from Ace Kidney

I authorize the following information to be obtained/release: ☐ All Records ☐ Other: ____

____

The information disclosed may include matters regarding mental health, developmental disability, alcohol and drug abuse, child abuse and neglect, sexual assault, adult disabilities, and infectious disease including HIV. Refusal of information will result in such confidential records not being released. If you do not wish for such information to be released, state information to be excluded: _______________________________________.

This authorization is valid for records from ______________ to ______________ / ☐ current care.

(Specify dates, if less than one year)

_____ *I understand that I have a right to revoke this authorization at any time.* My revocation must be in writing in a letter provided to the Office Manager of **Ace Kidney LLC**. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **Ace Kidney** may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

_____ *I agree that a copy of this release or fax of this release shall be as valid as the original release.* If I authorize Ace Kidney to fax information, I realize there are inherent risks in faxing Protected Health information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider.

I understand that I will get a copy of this form after I sign upon request.

______________________________	______________	______________________
Printed Name of Patient or Patient Representative	Patient Date of Birth	Patient Last Four of SSN
		☐ Self
______________________________	______________	______________________
Signature of Patient or Patient Representative	Todays Date	Relationship to Patient

For Patients' Record Only

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can access this information**. Please review it carefully.**

Your Rights

You have the right to:

- Obtain a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Obtain a list of those with whom we've shared your information
- Obtain a copy of this privacy notice
- Designate someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have several options in regards to the manner in which we use and share information, such as:

- Communicate with family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may utilize and disseminate your information as needed for the following purposes:

- To provide medical treatment
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Your Rights (IN DETAIL)

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

Obtain an electronic or paper copy of your medical record

- You can ask to see or obtain an electronic or paper copy of your medical record and other health information. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you believe to be incorrect or incomplete. Ask us how to do this.
- We may decline your request, which would be responded to in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to an address other than the one listed as your primary place of residence in your medical record.
- We will comply with all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may decline if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with your request unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the instances we've shared your health information for up to six years prior to the date you ask, to include who and why we released said information.
- We will include all the disclosures except for those in regards to treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices (IN DETAIL)

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but will immediately cease doing so upon your request.

Our Uses and Disclosures (IN DETAIL)

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

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

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

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing disease
- Helping with product recalls
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting adverse reactions to medications

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.