RNA # _____

RICHMOND NEPHROLOGY ASSOCIATES

PATIENT REGISTRATION FORM

DATE: _____

REFERRING PHYSICIAN: _____

PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____

PATIENT NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____

CELL PHONE: _____

DOB: _____ **SOCIAL SECURITY NUMBER:** _____

SEX: [ ] MALE [ ] FEMALE

MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED

PATIENTS EMPLOYER: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

PC _____	**CGA** _____	**KK** _____	**AH** _____
HBP _____	**ST** _____	**EB** _____	**SB** _____
DG _____	**ABH** _____	**SP** _____	
KS _____	**JB** _____	**SK** _____	

Richmond Nephrology Associates, Inc.

MEDICATION LIST

PATIENT NAME: _____ **DOB:** _____

Name of Medication	Dosage	How Often Taken	Date Medication Started

ALLERGIES:

FOOD OR MEDICINES	REACTION

PREFERRED PHARMACY INFORMATION

NAME OF PHARMACY: _____

ADDRESS: _____

PHONE NUMBER: _____

RNA # _____

Richmond Nephrology Associates, Inc.

PATIENT HISTORY

DATE: _____

PATIENT NAME: _____

MEDICAL ILLNESSES:

ILLNESS	PRESENT	DURATION
HIGH BLOOD PRESSURE		
DIABETES MELLITUS		
KIDNEY DISEASE		
KIDNEY STONES		
HEART DISEASE		
ATHEROSCLEROSIS		
HIGH CHOLESTEROL		
HARDENING OF THE ARTERIES		
TOXEMIA		
LUNG DISEASE		
CANCER		
LUPUS		
ARTHRITIS		
GI ILLNESS (STOMACH)		
ULCERS		
ANEMIA		
STROKE		
ALLERGIES		
PROSTATE DISEASE		
NEUROLOGICAL DISEASE		
SEIZURES		
PSYCHIATRIC DISEASE		
SLEEP DISORDERS		
EYE DISEASE		

SURGICAL HISTORY:

DATE	SURGERY	SURGEON

PATIENT HISTORY Cont.

SYMPTOMS:

SYMPTOM	PRESENT	DURATION
BLOOD IN URINE		
PUS IN URINE		
FOAMY URINE		
PAINFUL URINATION		
FREQUENT URINATION		
URINATION AT NIGHT		
INCONTINENCE		
URGENT URINATION		
INCOMPLETE BLADDER EMPTYING		
SWELLING		
FLANK PAIN		
STONE IN URINE		
RASH		
ARTHRITIS		
FEVER		
SWALLOWING PROBLEMS		
HEARING PROBLEMS		

DATE OF LAST CHEST X-RAY: _____

WHERE: _____

TRANSFUSIONS IN PAST?: _____

WHEN: _____

MENSTRUAL HISTORY:

REGULAR PERIODS? [ ] YES [ ] NO

DATE OF LAST PAP SMEAR: _____

RESULTS OF PAP SMEAR: _____

TOTAL PREGNANCIES: _____

MISCARRIAGES	
COMPLICATIONS	
LIVE BIRTHS	

HAVE YOU HAD ANY GYN ILLNESS OR SURGERY? _____

_____

PATIENT HISTORY Cont.

FAMILY HISTORY:

ILLNESS	YES	NO	RELATIONSHIP
HIGH BLOOD PRESSURE			
DIABETES			
KIDNEY DISEASE			
HEART DISEASE			
TUBERCULOSIS			
CANCER			
OTHER			
STROKE			

MOTHER: LIVING? _____ AGE (OR AGE AT DEATH) _____ ILLNESSES? _____

FATHER: LIVING? _____ AGE (OR AGE AT DEATH) _____ ILLNESSES? _____

SISTERS: NUMBER: _____ AGE(s) _____ ILLNESSES? _____

BROTHERS: NUMBER: _____ AGE(s) _____ ILLNESSES? _____

CHILDREN: NUMBER: _____ AGE(s) _____ ILLNESSES? _____

ARE YOU ON A SPECIAL DIET? [ ] YES [ ] NO
If so, what kind of diet are you on? _____

DO YOU NOW OR HAVE YOU EVER SMOKED? [ ] YES [ ] NO
If yes, how many packs per day? _____ How long? _____ When did you stop? _____

DO YOU NOW OR HAVE YOU EVER DRUNK ALCOHOL? [ ] YES [ ] NO
Beer? _____ Hard Liquor? _____ If so, how much? _____ When did you stop? _____

DO YOU USE DRUGS OTHER THAN THOSE PRESCRIBED BY YOUR DOCTOR?
[ ] YES [ ] NO If yes, what drugs? _____

I certify that all the information contained in this medical health history is true to the best of my knowledge. I release Richmond Nephrology Associates, Inc., from any and all responsibilities for actions stemming from incorrect information or information not given.

SIGNATURE: _____ DATE: _____

RNA # _____

RICHMOND NEPHROLOGY ASSOCIATES

Nephrology & Hypertension

Peter Condro, Jr., M.D.
H. Brian Peppiatt, M.D.
Christopher G. Acker, M.D.
Ellen Bedichek, M.D.
Karl G. Koenig, M.D.
Daran Glenn, M.D.
Shreyank Tripathi, M.D.

Ari Hirsch, M.D.
Satish Patel, M.D.
Srikanth Kunaparaju, M.D.
Kendall Sikes Weinert, F.N.P.
Angela Harvey, F.N.P.
Sarah Brabrand, F.N.P.
Jessica Burris, F.N.P.

FINANCIAL RESPONSIBILITY

Should collection proceedings become necessary to collect an overdue account, the patient or the patient's responsible party understands that the practice has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees in the amount up to thirty-three and one-third percent (33-1/3%) of the total unpaid balance due.

_____
Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

RNA # _____

RICHMOND NEPHROLOGY ASSOCIATES

Nephrology & Hypertension

Peter Condro, Jr., M.D.
H. Brian Peppiatt, M.D.
Christopher G. Acker, M.D.
Ellen Bedichek, M.D.
Karl G. Koenig, M.D.
Daran Glenn, M.D.
Shreyank Tripathi, M.D.

Ari Hirsch, M.D.
Satish Patel, M.D.
Srikanth Kunaparaju, M.D.
Kendall Sikes Weinert, F.N.P.
Angela Harvey, F.N.P.
Sarah Brabrand, F.N.P.
Jessica Burris, F.N.P.

NOTICE OF "DEEMED CONSENT" FOR HIV, HBV, AND HCV TESTING

As a health care provider, we are required by § 32.1-45.1 of Code of Virginia (1950), as amended, to give you the following notice.

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus ("HIV," the "AIDS" virus) and for the presence of the hepatitis B and hepatitis C viruses. A Physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus ("HIV", the "AIDS" virus) and the presence of hepatitis B and hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

_____
Patient Name

_____
Patient Signature

_____
Date

RNA # _____

RICHMOND NEPHROLOGY ASSOCIATES

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 it carefully.

If you have any questions about this Notice please contact the Privacy Officer.

Jennifer Horsley
671 Hioaks Road, Suite B
Richmond, VA 23225
(804)272-5814

Effective Date: April 14, 2003 Revised: April 9, 2014

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.richmondnephrologyassociates.com.**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing directed to Jennifer Horsley, Privacy Officer at 671 Hioaks Road, Suite B, Richmond, VA 23225.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Jennifer Horsley, Privacy Officer
671 Hioaks Road, Suite B
Richmond, VA 23225
(804)272-5814

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003. Revised on April 9, 2014.

RNA # _____

RICHMOND NEPHROLOGY ASSOCIATES

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named Practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:

  _____

- ❑ Other: _____

  _____

Date: _____

Prepared by: _____

Signature: _____

RNA # _____

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____

Richmond Nephrology Associates is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Patient Portal	☐ Appointment Reminders ☐ Results of lab tests/x-rays ☐ Other _____
☐ Spouse (provide name and phone number) _____	☐ Financial ☐ Medical
☐ Parent (provide name & phone number) _____ ☐ Other (provide name, phone number, & relationship) _____	☐ Financial ☐ Medical ☐ Financial ☐ Medical
☐ Email communication via Patient Portal-Provide email address* _____ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication, if accessed through patient portal, the information is encrypted and secure.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)