HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

New Patient Information

Date of Consultation		Name of Doctor	
Referred by		Case type	

Details of injury or illness, including date, location and other details

Details of any treatment or first aid already administered

Patient registration details

Name		SS Number			
Address					
City		State		ZIP	
Mobile Phone		Home phone		Work Phone	
Email					

Notes & Comments

Instructions

☐	Pre-visit instructions and directions provided
☐	Applicable records and reports acquired
☐	Appointment date and time confirmed
☐	Insurance pre-authorization completed (if required)

Insurance Details

Insured's name						D O B	
Relationship						Since (Date)	
Employer						Phone	
Address						Supervisor	
City		State		Zip		Note	
Primary Insurance Company						Phone	
Address						Insured's ID	
City		State		Zip		Group #	
Contact		Title		Phone		Claim #	
Notes							
Secondary Insurance						Phone	
Address						Insured's ID	
City		State		Zip		Group #	
Contact		Title		Phone		Claim #	
Notes							

HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

Date:		Name:		DOB:	

CURRENT MEDICATION AND VITAMINS

MEDICATION	DOSAGE	FREQUENCY	PURPOSE	PHYSICIAN

ALLERGIES

MEDICATIONS/ FOODS

NAME	REACTION

Print Name: _____ **Relationship to Patient:** _____

Signature: _____ **DOB:** _____ **Date** _____

HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

Medical History/ Medical Doctor Information

Date:		Name:		DOB:	

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal problems	
☐	☐	Heart disease	
☐	☐	Kidney disease	
☐	☐	Learning disorders	
☐	☐	Menstrual problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle cell disease	
☐	☐	Sleep disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid disease	
☐	☐	Serious injury	
☐	☐	Other	

SURGICAL PROCEDURES

Date	Procedure	Physician	hospital	notes

DOCTOR INFORMATION

PCP:		**Phone #**		**Fax #**	
Other Dr:		**Phone #**		**Fax #**	
Other Dr:		**Phone #**		**Fax #**	
Other Dr:		**Phone #**		**Fax #**	

PHARMACY INFORMATION

Pharmacy:		**Phone #**			**Fax #**		
Address:		**City**		**State:**		**Zip:**	

Print Name: _____ **Relationship to Patient:** _____

Signature: _____ **DOB:** _____ **Date** _____

HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

Authorization to Transfer Medical Records

Date _____

PATIENT INFORMATION

Name _____

Address _____

City, State, Zip _____

Email _____ Phone _____

AUTHORIZED RECIPIENT

Name _____

Address _____

City, State, Zip _____

Email _____ Phone _____

I, the undersigned, hereby authorize _____

to release and transmit my medical information to the party named above.

SPECIFIC AUTHORIZATION: I hereby acknowledge that this release includes ALL medical information, including that protected by state or federal law such as substance abuse treatment, mental health treatment, and treatment and test results for sexually transmitted diseases including HIV/AIDS.

Patient signature: _____

Date: _____

HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

HIPAA Disclosure Form

Hospital: _____ Doctor: _____

Patient Name: _____ Date: _____

Listed Address: _____

Preferred Correspondence Address: _____

Listed Phone No. _____ Preferred Phone No. _____

Listed Email Address: _____

Preferred Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? ❑ Yes ❑ No

May we identify ourselves over the phone? ❑ Yes ❑ No May we leave messages? ❑ Yes ❑ No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Print Name: _____ **Relationship to Patient:** _____

Signature: _____ **DOB:** _____ **Date** _____

HEARTLAND PHYSICIANS ASSOCIATES NEPHROLOGY

DR. ROOHI KHAN

CONFIDENTIAL INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks to months.

I understand that all information obtained at Heartland Physicians Associates Nephrology is confidential and no information will be shared without my consent.

I further understand that there are specific and limited expectations to this confidentiality which include the following:

- When there is a risk of imminent danger to myself or to another person, the clinician is bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and inform proper authorities.
- When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

Medications may have unwanted side effects. I understand that I need to continue medical care with my primary care physician (PCP) and notify the providers at Heartland Physicians Associates Nephrology.

PLEASE NOTE: If I cancel my appointment within 24 hours or miss my appointment, I will be charged a $30 fee. If I have more than 3 consecutive cancellations, then I will receive a termination of contract letter. If, at a later time if my circumstances change and I am able to commit to my treatment, then I am welcome back to start my treatment again. Upon termination of treatment, the provider will assist me in finding another provider for continuity of care. At Heartland Physicians Associates we utilize a comprehensive treatment plan. This means that we may consult your current health care providers in order to provide a thorough treatment plan. At times, it is necessary to make referrals to other providers.

If I have any questions regarding this consent form or about the services offered by the providers of Heartland Physicians Associates Nephrology, I will contact office staff. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Heartland Physicians Associates Nephrology, and I understand I can stop treatment at any time.

AUTHORIZED SIGNATURE: _____

DATE: _____

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

HEARTLAND PHYSICIANS ASSOCIATES NEPHROLOGY

DR. ROOHI KHAN

CONSENT FOR OFFICE POLICIES AND PATIENT PORTAL POLICIES AND PROCEDURES

I hereby give consent for Heartland Physicians Associates Nephrology and their business associates (such as, but not limited to medical billing company, EHR vendor, collection agency, automated appointment reminder vendor and electronic prescription vendor) to use and disclose protected health information about me to carry out treatment, payment, and health care operations. You can ask for a copy of the Notice of Privacy Practices provided by Heartland Physicians Associates Nephrology which describes such uses and disclosure in detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heartland Physicians Associates Nephrology reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to privacy officer at 501 Pine Forest Dr, Ste 501, Shenandoah, Tx. You can also pick up a copy in our office.

With this consent, Heartland Physicians Associates Nephrology may communicate to me in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as, but not limited to appointment reminders, billing statements, insurance issues and any message pertaining to my clinical care including lab results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message, text message, email, postal delivery and or by Patient Portal. By signing this form, I am consenting to allow Heartland Physicians Associates to use and disclose my PHI to carry out to TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Heartland Physicians Associates may decline to provide treatment to me. I understand and agree with all the preceding information unless otherwise indicated in writing.

I agree and accept the terms of all these documents.

PATIENT NAME: _____

SIGNATURE _____ DATE : _____

HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

_ I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.

_ Co-payments are due at time of service.

_ If my plan requires a referral, I must obtain it prior to my visit.

_ If my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

_ If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

_ I hereby authorize and direct payment of my medical benefits to Heartland Physicians Associates Nephrology on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

_ I hereby authorize Heartland Physicians Associates Nephrology to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

_ I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Heartland Physicians Associates Nephrology.

_ I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Date: **Print Name of Patient** **Signature of Patient:**

Authorized Representative or Responsible Party:

Authorized Representative or Responsible Party Relationship to Patient:

HEARTLAND PHYSICIANS' ASSOCIATES NEPHROLOGY

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Date: _____

Print Name of Patient _____

Signature of Patient: _____

Authorized Representative or Responsible Party: _____

Authorized Representative or Responsible Party Relationship to Patient: _____

HIPAA POLICY
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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.
The right to amend your protected health information.
The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775