

NEPHROLOGY SPECIALISTS OF TULSA, INC.

OSU Physicians Office Building
802 S Jackson Ave., Suite 301
Tulsa, OK 74127
Phone: (918) 582-3154
Fax: (918) 582-3593

Dear New Patient

Welcome to our **Physician Office Building on the OSU Medical Center Campus!** Our office address is **802 S Jackson Ave, Suite 301, Tulsa, OK 74127.**

It is **VERY IMPORTANT** that you complete and return before your appointment time. You need to be at our office at least 30 minutes prior to your appointment time to complete final paperwork and return it by fax at (918) 585-3593 or return by mail before your appointment.

Please bring your insurance cards and all medications (actual bottles that the medication came in) that you are currently taking, this also needs to include all vitamins, minerals, herbals and over the counter medications.

FEES AND PAYMENTS: We make every effort to keep your medical costs to a minimum. **Please be prepared to pay for your visit on the day of service.** This is expected unless prior financial arrangements have been made. For your convenience, we accept Discover, Visa, MasterCard, cash and personal checks.

INSURANCE: Please check with your insurance prior to your visit to verify coverage, deductibles and co-pays. Our staff will be happy to answer questions regarding our physician's participation in the various insurance plans. If you have insurance coverage; please understand that this is an agreement between you and your insurance company. You are responsible for all remaining balances on your account after all insurances have been filed, paid or denied on your behalf.

Our physicians are participating in the Medicare program, this means that they will accept what Medicare approves, not what Medicare pays. **Medicare will pay 80% of approved charges and the patient is responsible for the 20% due. This is expected at the time services are rendered.**

HMO's and PPO's will be filed by our office according to the contract with the individual carrier. The patient is responsible to obtain the authorization from the PCP before the initial visit. **All co-payments are to be paid by the patient at the time of services. This is a contractual agreement that is made between you and your insurance company and, must be collected by our office.** Please notify us before seeing the doctor if you have had any insurance changes. Any patient seen without proper authorization will be expected to pay for services at the time of visit.

Returned Checks: We Charge \$35.00 for any returned checks.

Cancelled Appointment: We Charge \$25.00, for appointments not cancelled at least 24 hours in advance.

Unfortunately, we cannot guarantee wheel chairs for transport for our patients. If you know you have health issues that may prevent you from getting to our office, please bring someone with you.

Please contact our office if you have any questions prior to your visit. We look forward to meeting you!

Nephrology Specialists of Tulsa

NEPHROLOGY SPECIALISTS OF TULSA - Patient Information Form

(Please review and make corrections if needed)

1. Patient Information

Name: _____ Date of Birth: _____
 Street Address: _____ Social Security Number: _____
 City, State, Zip: _____ Sex: _____
 Preferred Language: _____ Ethnicity (circle one): Hispanic Non Hispanic
 Marital Status (circle one): Single Married Divorced Widowed Long Term Partner Separated
 Race (circle one): African American Indian/Alaskan Native Asian Caucasian Hispanic Other Pacific Islander Refuse to Report
 Pharmacy/Location: _____ Email Address: _____

2. Guarantor (RESPONSIBLE PERSON) Information

Name: _____ Date of Birth: _____
 Street Address: _____ Social Security Number: _____
 City, State, Zip: _____ Email Address: _____
 Home Phone: _____ Cell Phone: _____
 Employer: _____ Phone: _____

3. Insurance Information

PRIMARY Insurance Name: _____ ID#: _____ Group #: _____
 Policy Holder Name: _____ Policy Holder DOB: _____ Insured's relationship to pt: _____
 Exact Name on Card: _____ Effective Date: _____
 Insured's relationship to patient: _____ Policy Holder Employer: _____
 SECONDARY Insurance Name: _____ ID#: _____ Group #: _____
 Name of Insured: _____ Policy Holder DOB: _____ Insured's relationship to patient: _____
 Exact Name on Card: _____ Effective Date: _____
 Insured's relationship to patient: _____ Policy Holder Employer: _____
 If your insurance is Indian Health, please list which Nation: _____
 If your insurance is Tricare, Champus or ChampVA: Sponsor Name: _____
 Date of Birth: _____ SSN: _____

4. Emergency Contact Information

Name: _____ Relationship: _____ Daytime Phone: _____

5. AUTHORIZATION

May we leave the following types of messages at your home, work, cell or emergency contact:
 Appointment Changes: Yes No Test Results: Yes No Telephone Nurse Advise: Yes No
 Prescription Info: Yes No Billing Answers: Yes No

| | | |
|-----|----|---|
| Yes | No | I hereby authorize the physician(s) of Nephrology Specialists of Tulsa, to provide medical treatment to the patient named on this form. I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand the fees are due an payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of appropriate statement. |
| Yes | No | I hereby authorize third parties to pay directly to the physician(s) any insurance benefits due for services rendered on behalf of the named patient. I also authorize the physician(s) to furnish my insurance company and/or third party payers any medical information necessary to process insurance claims. |
| Yes | No | I authorize the release of information including diagnosis, records or examination rendered to me and the claims information to the following individuals: _____ _____ There is no expiration unless or terminated by the patient or personal representative in writing to the Practice Manager. |
| Yes | No | As required by the HIPPA, I hereby acknowledge that I have reviewed and understand current copy of "Notice of Privacy Policy" and understand my rights contained in the notice. |
| Yes | No | I provide Nephrology Specialists of Tulsa my authorization and consent to use and disclose protected healthcare information for the purposes of treatment, payment and healthcare operations described in the Privacy Policy. |
| Yes | No | I hereby acknowledge that there is a \$35 charge for any returned check and a \$25 charge for appointments that are not cancelled at least 24 hours in advance. |

Primary Care Physician: _____ Referring Physician: _____
 Signature: _____ Date: _____
 Printed Name: _____ Relationship to Patient: _____

New Patient – Male

Please fill out and return to our office using the pre-paid envelope provided, before your appointment.

Name: _____ Date: _____

Date of Birth: _____ Are you: Male Female Date of last physical: _____

Are you: Married Single Widowed Divorced Referring Physician? _____

Reason for referral? _____

Medical History

Hypertension (High Blood Pressure): Yes No If yes, duration? _____

Diabetes: Yes No If yes, duration? _____ Borderline Diet Controlled Oral Medication Insulin

Urinary Tract Infection? Yes No If yes, duration? _____

Kidney Stones? Yes No If yes, last stone? _____

Other Medical Illnesses? _____

Surgical History

Please list operations, hospital, dates and Surgeon(s) Name(s): _____

Hospitalization(s) other than surgery, list reason? _____

Serious injury, broken bones etc? _____

Childhood Diseases

Measles: Yes No Mumps: Yes No Chicken Pox? Yes No

Other childhood diseases? _____

Immunizations

Hepatitis? Yes or No Pneumonia? Yes No Influenza? Yes No

Have you ever had a blood transfusion? Yes No If yes, and give approximate dates: _____

Health Habits

Do you currently smoke? Yes No Amount: _____

Have you ever smoked? Yes No Date you quit: _____

How long did (have) you smoke(d)? _____ Amount: _____

Have you ever used illegal drugs? Yes No Type: _____

How many meals do you eat a day? _____

Do you drink coffee? Yes No If yes, how many cups per day? _____

Do you drink tea? Yes No If yes, how many cups per day? _____

Do you drink caffeinated beverages? Yes No Daily amount? _____

Do you drink alcohol? Yes No Daily amount? _____

| Family History | Age | Medical History | Age at death | Cause |
|----------------|-------|-----------------|--------------|-------|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Brother(s) | _____ | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ | _____ |
| Son(s) | _____ | _____ | _____ | _____ |
| Daughter(s) | _____ | _____ | _____ | _____ |

Check if any of your blood relatives had any of the following and relationship to you:

Diabetes: _____ Malignancies/cancer: _____
Heart disease/stroke: _____ Tuberculosis: _____
Kidney disease: _____ Chemical dependency: _____
Other: _____

Occupational Information

Occupation: _____ Is work stressful? _____
Do you work: ___ Indoors ___ Outdoors ___ Heavy Lifting Hours Worked? _____

Review of Symptoms (Male): Do you now, or have you recently had any of the following?

| Have you had? | When |
|--------------------------|-------|
| _____ Chest X-Ray | _____ |
| _____ Abdominal Sonogram | _____ |
| _____ Stress Test | _____ |
| _____ Heart Biopsy | _____ |
| _____ Upper GI Series | _____ |
| _____ CT/MRI Scan | _____ |
| _____ Echocardiogram | _____ |
| _____ Barium Enema | _____ |
| _____ EKG | _____ |
| _____ Cardiac Cath | _____ |
| _____ Other Recent Tests | _____ |

General:

_____ Weight Gain
_____ Weight Loss
_____ Chills
_____ Dietary Changes
_____ Fatigue
_____ Fever
_____ Night Sweats

Cardiovascular:

_____ Fainting/Blacking Out
_____ Chest Pain
_____ Difficulty Breathing on Exertion
_____ Swelling of Extremities (edema)
_____ Irregular Heart Beat
_____ Escalated Blood Pressure

Psychiatric:

_____ Depression
_____ Inability to concentrate
_____ Suicidal Ideation
_____ Suicidal Planning
_____ Anxiety

- Skin:**
- Excessive Sweating
 - Rash
 - Skin Bumps
 - Skin Cancer
 - HEENT
 - Headache
 - Eye Pain
 - Eye Redness
 - Hearing Loss
 - Ear Discharge
 - Ear Infection
 - Earache
 - Ringing in the Ears
 - Frequent Colds
 - Seasonal Allergies
 - Bleeding Gums
 - Hoarseness
 - Sore Throat
 - Voice Changes
 - Loss of Smell
 - Retinal Disease
 - Thyroid Disease
 - False Teeth
 - Dental Problems
 - Wear Glasses/Contacts

- Gastrointestinal:**
- Abdominal Pain
 - Black, Tarry Stool
 - Bloody Stool
 - Constipation
 - Diarrhea
 - Gas
 - Heartburn
 - Jaundice
 - Nausea
 - Vomiting
 - Hemorrhoids

- Neck:**
- Neck Pain

- Respiratory:**
- Cough
 - Wheezing
 - Phlegm
 - Bronchitis
 - Pain with Breath
 - History of Pneumonia
 - Breathless with Rest
 - Breathless with Exercise

- Male Genitourinary:**
- Change in Urinary Stream
 - Frequency
 - Hesitancy
 - Flank Pain
 - Impotence
 - Incontinence
 - Painful Urination
 - Penile Lesions
 - Urinary Retention
 - Urinating at Night
 - Bladder/Kidney/Prostate Infections

- Musculoskeletal**
- Joint Pain
 - Muscle Pain
 - Muscle Weakness

- Neurological:**
- Dizziness
 - Paresthesia's
 - Seizures
 - Stroke
 - Spinning Sensation

Males

- Loss of Sexual Interest
- High Risk for HIV/Aids?
- Bumps/Swelling/Sores in groin or genital area
- Difficulty with Erection

History of Sexually Transmitted Disease? Yes No If yes, type? _____

Do you take any of the following medications?

Ibuprofen, Advil, Motrin, Naproxen, Aleve, Ketoprofen or Aspirin? Yes No

If yes, how often and how much? _____

List all medications (including dose and how often you take it): _____

Are you allergic to any medications? Yes No If so, please list: _____

Are there any other medical problems that are an area concern to you? _____

Nephrology Specialists of Tulsa

Notice of Health Information Privacy Practices

WE ARE USING INFORMATION TECHNOLOGY TO HELP YOU. As NEPHROLOGY SPECIALISTS OF TULSA keeps pace with advancements in health care, we have a growing need to safely and efficiently use computers to electronically share your health information with the team of health professionals who provide care to you. Currently, when we need to share your health information with other health providers the process is difficult and usually means numerous phone calls, mailings and faxes. And, when we need to gather information from one of your other providers it can take hours or even weeks and sometimes the information is not available at all. Technology can help us do better.

MEET OUR NEW PARTNER - MYHEALTH ACCESS NETWORK.

MyHealth Access Network (MyHealth) is a non-profit coalition of Oklahoma health providers, including doctors, hospitals, labs, pharmacies, emergency services, and other health industry professionals, who are using technology to link medical providers, exchange timely information and improve the delivery of local health care. MyHealth allows us to deliver the right information to the right doctor, at the right time, to help care for you.



FREQUENTLY ASKED QUESTIONS Although MyHealth is designed to be used by health care professionals, it provides many important benefits and choices for you. We've attempted to answer the most common questions here: To learn more about MyHealth, visit www.myhealthaccess.net.

WHO CAN ACCESS MY INFORMATION? Only the health industry professionals involved in your care (and their approved staff members) that belong to the MyHealth network can access your information, and only as their jobs require it.

WHAT ARE SOME EXAMPLES OF HOW MyHealth HELPS ME? Time is important when addressing your health needs. Some examples of when and how your personal health information is used to help you include:

- ☐ When you see a medical specialist, your doctor and the specialist need to share your information to help coordinate effective care. The quicker this happens, the quicker you receive the care you need.
- ☐ In a medical emergency such as a car accident, ambulance and emergency room doctors can have access to important health info. that might save your life or that of a loved one; like a medication list, drug and food allergies, presence of a pacemaker, etc.

If you manage care for yourself, a child, parent, etc., then you know the challenges of keeping up with medication lists, procedures, allergies, and vaccinations. MyHealth can help make these available in the doctor's office.

HOW DOES MY INFORMATION STAY SECURE? We take your privacy very seriously, and information shared through MyHealth is protected with the highest forms of security, including encryption and secured connections. We know that patients must trust their information is safe. MyHealth complies with all State and Federal laws (like HIPAA) to protect your information.

DO I NEED TO SIGN UP FOR THIS SERVICE? No. Because (Name of ORGANIZATION) is a participating MyHealth partner you are included in the network. You may opt out if you wish (see how below).

CAN I CHOOSE NOT TO PARTICIPATE IN MYHEALTH? Yes, you can choose to not participate in, or 'opt out' of MyHealth at any time. Choosing to opt out generally means that your doctors will not be able to use the MyHealth network to electronically access your health information. You can opt out of MyHealth by:

1. Obtaining an *Opt Out of MyHealth Form* from our front desk clerk, or by downloading the form www.myhealthaccess.net/opt-out
2. Complete the form (please wait to sign it in front of our desk clerk)
3. Bring the form to our front desk clerk and sign it with our clerk as a witness. We will send it to MyHealth for you. OR you may sign your form with a Notary Public as a witness and mail it to the address provided on the form.

You can always return to MyHealth by completing the *Return to MyHealth Form* which is also available from our front desk clerk, or online at www.myhealthaccess.net/opt-in

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If we have a valid authorization on file.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we may also disclose if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding.
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Dept. of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from [Insert company name] at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION - If you have questions or need further assistance regarding this Notice, you may contact Nephrology Specialists of Tulsa's Privacy Office by writing to: April Wells; 6465 S Yale Ave, Ste 401; Tulsa, OK 74136.

EFFECTIVE DATE - This Notice is effective November 22, 2013.