NEPHROLOGY SPECIALISTS OF TULSA, INC.

Warren Professional Building
6465 South Yale, Suite 401
Tulsa, OK 74136
Phone: (918) 582-3154
Fax: (918) 582-3593

Dear Patient

Welcome to our Warren Professional Building Office on the Saint Francis Hospital Campus! Our office address is 6465 S. Yale Ave, Suite 401, Tulsa, OK 74136.

It is VERY IMPORTANT that you complete your forms and fax to (918) 582-3593 or mail them before your appointment time. You need to be at our office at least 30 minutes prior to your appointment time to complete final paperwork..

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 provide 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

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

Neck:

_____ Neck Pain

Respiratory:

_____ Cough
_____ Wheezing
_____ Phlegm
_____ Bronchitis
_____ Pain with Breath
_____ History of Pneumonia
_____ Breathless with Rest
_____ Breathless with Exercise

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.