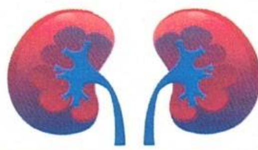


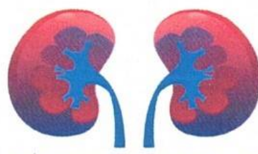
Patient Demographics			
LAST NAME	FIRST NAME	M.I	
MAILING ADDRESS	CITY	STATE	ZIP CODE
LAST 4 DIGITS OF SS# X X X – X X-	Sex Male Female	Date of Birth	
HOME PHONE	WORK PHONE	CELL PHONE	
MARITAL STATUS	EMAIL ADDRESS		
RACE ☐ Black ☐ White ☐ Asian ☐ Other	ETHNICITY ☐ Hispanic ☐ Non- Hispanic	COMMUNICATION PREFERENCE ☐ Phone ☐ Mail ☐ Email	
PRIMARY CARE PHYSICIAN	REFERING PHYSICIAN		

Emergency Contact Information		
Name	Relationship to Patient	Contact Number

Insurance Information		
Primary	ID:	Group #:
Policyholder Name:	Date of Birth:	Relationship:
Secondary	ID:	Group #:
Policyholder Name:	Date of Birth:	Relationship:

______________________________ Date ________________________

Patient Signature



KIDNEY SPECIALISTS OF GEORGIA
EXCELLENCE IN KIDNEY CARE

Notice of Private Practices: You have the right to read this Privacy Practices notice before you decide whether to sign. A copy of this Notice and/or this consent is available upon request. This Privacy Notice provides a description of Kidney Specialists of Georgia's treatment, payment activities and health care operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you consent to Kidney Specialists f Georgia use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Patient Consent: I have been given a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this form, I am giving my consent to Kidney Specialists of Georgia use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patients Name:

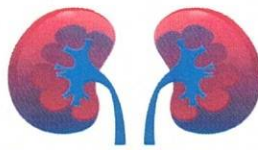
____

Patients Signature:

______________________________ Date: ____________________

Parent/ Legal Guardian Name: Relationship to Patient:

____



Notice of Privacy Practices

OUR COMMITMENT TO YOUR PRIVACY

Kidney Specialists of Georgia values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information (PHI) about you and the nursing and physician services or medical treatment provided to you. PHI is information about you including individually identifiable information that can reasonably be used to identity you and which relates to your past, present or future physical or mental health or condition; the provisioning of health care to you; or the payment for that care. We are required by certain federal and state laws to maintain the privacy of your PHI or ePHI. We are also required by the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to give you this Notice about our privacy practices, our legal duties and your rights concerning PHI. We protect your privacy by taking the following precautions:

- **Limiting who may see your PHI.**
- **Limiting how we may use or disclose your PHI.**
- **Informing you of our legal duties with respect to your PHI.**
- **Explaining our privacy policies.**
- **Adhering to the policies currently in effect.**

The terms of this notice apply to all records containing your PHI that are created by our practice. We reserve the right to revise of amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

How We May Use and Disclose Your Protected Heath Information (PHI) - may use and disclose your PHI for the purposes of treatment, payment, and health care operations, described in more detail below without obtaining written authorization from you. In addition, CVG and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to provide treatment, received payment and manage their health care operations.

For Treatment – may use and disclose your PHI while providing, coordinating, or managing your medical treatment. This includes sharing or disclosing your PHI to your other health care providers for treatment. For example, we may use your PHI when performing medical procedures. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other health care professionals who provide your health care services or are otherwise involved in your care.

For Payment – may use and disclose PHI about you so the services and items you receive may be billed to and payment may be collected from you, an insurance company, or a third-party payer. We may need to give your health plan information about the services or items you received so that your health plan will pay us or reimburse you for the services or items.

For Health Care Operations –may use and disclose PHI about you for health care operations. These uses, and disclosures are necessary to make sure you receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in providing services to you. We may also disclose information to other physicians, nurses, technicians, students, attorneys, consultants, accountants, and other health care professionals for review and learning purposes. We may remove information that identifies you from this set of PHI so that others may use it to study health care and health care delivery without learning the names of the specific individuals.

Appointment Reminders – We may use and disclose your PHI to contact you and remind you of an appointment at our office, or to inform you of treatment alternatives or other health related benefits and services that may be of interest to you.

We May Use and Disclose Your PHI in Certain Special Circumstances: As Required by Law and Law Enforcement – We may use or disclose PHI when required to do so by law. We may disclose PHI when ordered to do so in a judicial or administrative proceeding, to identify or locate a suspect, fugitive, material witness, or missing person, or for other law enforcement purposes without an authorization from you.

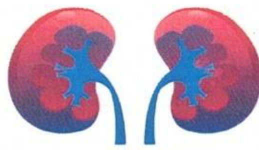
Public Health Risks – We may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect, or domestic violence, reactions to medications or product defects problems, or to execute their health oversight or public health functions.

Health Oversight Activities – We may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs, and compliance with applicable laws and regulations.

Serious Threats to Health or Safety – We may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public. We may use and disclose PHI of military personnel and veterans under certain circumstances.

Law Enforcement – We may disclose PHI for a law enforcement purpose to a law enforcement official under the following conditions:

- As required by law including laws that require the reporting of certain types of wounds or other physical injuries.
- In response to a warrant, summons, court order, subpoena, or similar legal processes.
- To identify or locate a suspect, fugitive, material witness or missing person.
- Requests for such information about an individual who is or is suspected to be a victim of a crime provided the individual agree to such disclosure. In case the individual is incapacitated or under emergency circumstances.
- In good faith that the information constitutes evidence of criminal conduct that occurred on the premises of CVG.
- During an emergency shall disclose PHI to a law enforcement officer if the individual is suspected to be a victim of crime or violence.



Workers' Compensation – We may disclose PHI to comply with workers' compensation or other similar laws. These programs provide benefits for work-related injuries or illness without regard to fault.

Research – We may use and disclose your PHI for research purposes regardless of the source of funding of the research under the following circumstances:

- With documentation related to approval of a waiver of authorization by an institutional review board or a properly constituted privacy board.
- Acceptance of necessity for the purpose of research and description of the information sought.

Deceased Patients – We may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a deceased individual, to identify the cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Disclosures to you – We may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI.

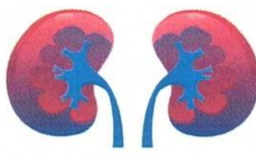
Disclosures for HIPAA Compliance Investigations. We must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the Secretary) when requested by the Secretary in order to investigate our compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Other Uses and Disclosures of PHI for Which Authorization Is Required. Other types of uses and disclosures of your PHI not described above will be made only with your written authorization. For example, your written authorization is required for psychotherapy notes (with limited exceptions), sale of your PHI, and certain marketing communications. You have the right to revoke your authorization in writing. Revocations will only apply to disclosures made after your request to revoke is received.

Regulatory Requirements. We are required by law to maintain the privacy of your PHI and to support your rights under HIPAA. You have the following rights regarding your PHI.

- Notice of Privacy Practices. We must provide individuals with notice of its legal duties and privacy practices with respect to PHI and to abide by the terms described in this Notice and of its privacy policies and to make the new terms applicable to all PHI we maintain. Before CVG makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice as required by the regulation.
- Restriction Requests. You may request that we restrict the use and disclosure of your PHI. We are not required to agree to any restrictions you request, but if we do so it will be bound by the restrictions to which it agrees, except in emergency situations. Will restrict PHI disclosures to health plan if the PHI disclosure is for payment or health care operations and the PHI pertains to a health care item or service for which you have paid out of pocket in full. However, if the information is needed to receive payment from the insurer for subsequent related services, the restriction no longer applies. • Confidential Communications. You have the right to request that communications of PHI to you from us be made by means or at particular locations. For instance, you might request that communications be made at your work address, rather than at home address. Your requests must be made in writing and sent to the responsible person. We will accommodate your

Access to PHI. You have the right to inspect or receive copies of your PHI contained in a designated record set, including patient medical records and billing records, but not including psychotherapy notes. You must submit your requests in writing to the Privacy Officer at KSGA in order to inspect and/or obtain a copy of your PHI. KSGA may charge a fee for the costs of copying, mailing, labor, or supplies associated with your request. KSGA may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. If you seek a review, a licensed health care provider chosen by us will review your request and the denial. The person conducting the review will not be the person who originally denied your request. We shall comply with the outcome of the review.

- **PHI Amendment.** You may request that we amend your PHI if you believe there is a mistake in your PHI or that important information is missing. To request an amendment to your PHI, your request must be made in writing. In addition, you must provide a reason that supports your request. We will generally decide regarding your request for amendment no later than 60 days after receipt of your request. However, if we are unable to act on the request within this time, we may extend the time for 30 more days but shall provide you with a written notice of the reason for the delay and the approximate time for completion. If we deny your requested amendment, we will provide you with a written denial. Approved amendments made to your PHI will also be sent to those who need to know. We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing and explain your right to file a written statement of disagreement.
- **Accounting of Disclosures**. You may request, in writing, an accounting of disclosures. Any accounting of disclosures will not include those we made under these conditions: for payment or health care operations, to you or individuals involved in your care, with your authorization, for national security purposes or to correctional institution personnel. To request an accounting of such disclosures, your request must be submitted in writing. Your request must also state a time, which may not be longer than six (6) years. Your request should also specify the format in which you prefer to receive the accounting, i.e. paper or electronic. We may charge you for the costs of providing the accounting. We will notify you of the costs involved, and you many choose to withdraw or modify your request at that time before any costs are incurred.
- **Breach Notification.** In the case of a breach of unsecured PHI, we will contact you as required by law.
- **Right to a Paper Copy of This Notice**. You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically.
- **Right to File a Complaint**. If you believe your privacy rights have been violated, or if you are dissatisfied with our privacy practices or procedures, you may file a complaint with the U.S. Secretary of the Department of Health and Human Services or with our practice. To file a complaint with our practice, contact the Privacy Officer at KSGA. All complaints must be submitted in writing. KSGA assures you that filing a complaint will not in any way impact the services we provide to you, nor will there be any retaliatory acts against you.



PATIENT NAME	DATE OF BIRTH

Consent for Treatment

- Permission is hereby given for any medical/surgical procedures or office testing, laboratory test administration of medication, physical and assessments, or exam as may be deemed necessary by the physician or other healthcare professionals as medically necessary
- I understand I have the right to see a physician if I so choose.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN　　　　DATE

Consent to Release Medical information to a Spouse, Family Member or Significant Other:
Tell us with whom we may discuss your protected health information:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

☐ I do not authorize any information to be released to anyone other than myself.

I give permission for you to leave medical/ appointment information for me via the following sources:

HOME PHONE	CELL PHONE
EMAIL	OTHER PHONE

Financial Responsibility:

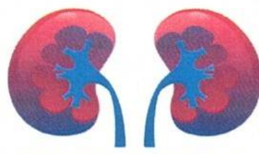
I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office.

I hereby authorize any insurance benefits to be paid Kidney Specialists of Georgia and recognize my responsibility to pay for all noncovered services.

I also authorize the release of any information necessary to process an insurance claim.

I hereby authorize Kidney Specialists of Georgia, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Kidney Specialists of Georgia or payment for the services I received at Kidney Specialists of Georgia including but not limited to, debt collection purposes

Signature of Patient or Legal Guardian　　　　Date



KIDNEY SPECIALISTS OF GEORGIA

EXCELLENCE IN KIDNEY CARE

Medical Records Release

Patient Name:____ Birthdate:_____________________

For the purpose of continuation of medical care, I hereby request to have my medical information as described below, including but limited to office progress notes ,reports from labs and other described below, including but not limited to office progress notes, reports from labs and other studies, summaries of treatment, consultation, and verbal/ telephone/ e-mail contact, released to:

Kidney Specialists of Georgia

575 Professional Drive, Suite 290

Lawrenceville, GA 30046

Phone: 770-417-8170 Fax: 770-417-8169

The type and amount of information to be used or disclosed is as follows:

Most Recent history and physical

Most Recent discharge summary

Laboratory results

X-Ray and imaging reports

Consultation Report

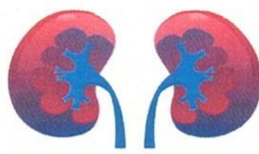
Entire Records

Other:

____

____ ___________________________

Signature of Patient Date



Patient Health History

Name: ______________________________ Date: _____________________

Which of the following illnesses have you or any your blood relatives had?

	I HAVE HAD	MY BLOOD RELATIVE HAS HAD
Chicken Pox		
Measles		
Mumps		
Rubella (German Measles)		
Rheumatic Fever		
Tuberculosis		
Thyroid Disease		
Asthma		
Diabetes		
Epilepsy/ Convulsions		
Rheumatism/ Arthritis		
Heart Disease		
Lung Disease		
Hepatitis/ Jaundice		
Kidney Infection/ Stone		
Bladder Infection/ Stone		
Sexually Transmitted Disease		
Tumor/ Cancer		
Anemia		
Stroke		
Alcoholism		
Pneumonia		
Gall Bladder Disease		
Hypertension/ high Blood Pressure		
HIV/ AIDS		
Skin Disease		
Hay Fever		
Depression		
Sickle Cell Anemia		

PLEASE LIST ALL ALERGIES:

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KIDNEY SPECIALISTS OF GEORGIA

EXCELLENCE IN KIDNEY CARE

Patient: ______________________________ Date of Birth: ________________

Medication	SIG