CONSULTANTS IN NEPHROLOGY AND HYPERTENSION, PROFESSIONAL L.L.C.

OSCAR G. DOMINGUEZ, MD YISFALEM W. ALAMDEW, MD BEHRAM K. MOHMAND, MD

9397 Crown Crest Boulevard Alpine Building Suite 401 Parker, CO 80138 | PHONE: 303 • 697 • 1636 FAX: 303 • 805 • 9948

PATIENT INFORMATION – Please Print Legibly

Full Legal Name:_____ Date of Birth (mm/dd/yyyy):_____
(Should match name on Govt. issued ID/Insurance card)

Marital Status (check one): □ Single □ Married □ Other

Gender: □ Male □ Female Language preference: □ English □ Other (Please specify):_____

Address:_____
(Street) (City) (State & Zip)

Home Phone:_____ Cell Phone:_____ Email Address:_____

Work Phone:_____ _ Occupation_____ Employer Name:_____

Contact Preference: □ Home Phone □ Cell Phone □ Work Phone

Emergency Contact:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Care Physician:_____ Phone:_____

Referring Physician (if other than Primary Care Physician):_____

INSURANCE INFORMATION

Primary Insurance_____

Secondary Insurance_____

Tertiary Insurance_____

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PATIENT COMMUNICATION SHEET

The HIPAA privacy rule gives individuals the right to request a restriction on the uses and disclosure of protected health information (PHI). The individual is also provided the right to request confidential communications or that the communication of PHI be made to alternative means, such as sending correspondences to the individual's office instead of the individual's home. The following information will help us communicate with you effectively.

Patient's Name:_____ Date of Birth (mm/dd/yyyy):_____

I give Consultants in Nephrology and Hypertension permission to contact me or others I designate in the following manner (check all that apply):

□ Home Phone #_____
□ Okay to leave a message requesting a call back.

□ Cell phone #_____
□ Okay to leave a message requesting a call back,

□ Work phone #_____
□ Okay to leave a message requesting a call back.

□ Other persons authorized to receive PHI:

Name:_____

Relationship:_____

I understand that I may revoke this authorization in writing or by completion of a revocation form available from the practice. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I understand that once the practice discloses health information, the person or organization that received it may disclose it and privacy laws may no longer protect it.

_____ _____
Patient or legally authorized person's signature *Date*

_____ _____
Printed name *Relationship to patient*

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PATIENT INFORMATION
CONSULTANTS IN NEPHROLOGY AND HYPERTENSION, PROFESSIOANL LLC

By signing this form, you are acknowledging that Consultants in Nephrology and Hypertension, Professional LLC can use and disclose your protected health information, with certain limits and protections, for the purposes of treatment, payment, and health care operations activities. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review the Notice of Privacy Practices before you sign this acknowledgement, and we encourage you read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at 303-697-1636. You have a right to request that we restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by any restrictions to which we agree.

You are responsible for any and all charges, which your insurance carrier may not pay. You agree to pay any/all co-pay amounts due at the time services are rendered.

You authorize payment of medical benefits to be paid directly to Consultants and Nephrology and Hypertension, Professional LLC as indicated by the signature on file/accept assignment on the claim form.

Signature is certification that you have read and understand the above and that the information you have provided in true and correct.

_____ _____

Patient/Legal Guardian Date