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

Yisfalem W. Alamdew, MD | Oscar G. Domiguez, MD | Balwinder S. Kang, MD | Behram K. Mohmand, MD

9397 Crown Crest Blvd Suite 401 Parker, CO 80138 | Phone 303-697-1636 Fax 303-805-9948

PATIENT DEMOGRAPHICS

____

Full Legal Name **Date of Birth (mm/dd/yyyy)**

Gender: □ Male □ Female **Marital Status:** □ Single □ Married □ Other **Preferred Language:** □ English □ Other ________________

____

Address **Street** **City** **State** **Zip**

____

Home Phone **Cell Phone** **Email Address**

Preferred Contact □ Home Phone □ Cell Phone □ Work Phone

____

Occupation **Employer Name** **Work Phone**

____

Emergency Contact **Relationship to Patient** **Phone Number**

____

Primary Care Physician **Office Name** **Phone Number**

____

Referring Physician (if not PCP) **Office Name** **Phone Number**

INSURANCE INFORMATION

____

Primary Insurance

____

Secondary Insurance

____

Tertiary Insurance

____

Date of Birth of Policy Holder (if not patient)

PHARMACY INFORMATION

____

Preferred Local Pharmacy **Address** **Phone Number**

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Preferred Mail Pharmacy **Address** **Phone Number**

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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.

I ________________________, give Consultants in Nephrology and Hypertension, PLLC permission to contact me or others I designate in the following manner;

□ Email ____

□ Home Phone Number _______________________________

□ Okay to leave a message requesting a call back.

□ Cell Phone Number _________________________________

□ Okay to leave a message requesting a call back.

□ Work Phone Number _______________________________

□ Okay to leave a message requesting a call back.

□ Written Communication

□ Okay to mail to my home address.

OTHER PERSON AUTHORIZED TO RECIEVE PHI

____

Name of Person Authorized to Receive PHI | Relationship to Patient

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 | Printed Name | Relationship to Patient | Date

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CONSENT TO TREAT

I ____________________, give permission for Consultants in Nephrology and Hypertension, PLLC to provide me with medical treatment. I understand my physician may utilize other designated office personnel to assist with my plan of care.

I understand:

- I have the right to discuss all medical treatments with my clinician.
- I have the right to refuse any procedure or treatment.
- I understand the practice of medicine is not an exact science and that medical treatment may not improve or may aggravate or worsen my condition. No guarantees have been made to me in the relations to the results of my examination or treatment by Consultants in Nephrology and Hypertension, PLLC.
- I understand that it is my responsibility to follow instructions and make arrangements for follow-up care.

Telemedicine Consent

- Telemedicine involves the use of electronic communications to enable health care providers to provide patient care through the means of live two-way audio and/or video. The purpose of this statement is to obtain your consent to participate in a Telemedicine consultation for various medical conditions/illnesses. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:Patient medical records, Medical images, Live two-way audio and/or video and Output data from medical devices and sound and video files.
- You may withhold or withdraw consent to the Telemedicine consultation at any time without affecting your right to future care, treatment, or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.

By signing this Consent and participating in telemedicine, you understand that:

- The laws that protect the confidentiality of my medical information also apply to telehealth. I understand that I have a right to access my medical information and copies of medical records of my telehealth visits in accordance with applicable state and/or federal law.
- There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the staff at Consultants in Nephrology and Hypertension, PLLC that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- Telehealth does not provide me with emergency services. I understand that if I am experiencing an emergency situation, I should call 911 or proceed to the nearest hospital emergency room for help.
- I should use a password-protected, secure internet connection, not public or unsecured WiFi and I understand that I am responsible for (1) providing the necessary phone, computer, telecommunication equipment and/or internet access for my telehealth sessions, (2) the information security on my device, and (3) arranging a location with sufficient privacy that is free from distractions or intrusions for my telehealth session.

Consent to Bill, Assignment of Benefits, Payment

- I allow Consultants in Nephrology and Hypertension, PLLC and other designated personnel to file for insurance benefits to pay for the care I receive.

- I hereby assign all medical benefits, to include major medical benefits to which I am entitled to Consultants in Nephrology and Hypertension, PLLC. I hereby authorize and direct my insurance carrier(s), including Medicaid, Medicare, private insurance, and any other health/medical plan, to issue payment directly to Consultants in Nephrology and Hypertension, PLLC for medical services rendered. I understand that I am responsible for any amount not covered by your insurance.

I understand:

- Consultants in Nephrology and Hypertension, PLLC will have to send my medical record information to my insurance company for purposes of payment.
- Some and perhaps all of the services provided may be non-covered services or may not be considered medically necessary under Medicare, Medicaid, or by other medical insurance companies. I am responsible for any and all charges, which my insurance carrier may not pay. I agree to pay any/all co-pay, co-insurance, or deductible amounts due at the time services are rendered.
- I 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.
- If I do not have insurance I must make my payment in full prior to the time of service.

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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 acknowledgment, 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.

Signature is certification that you have read and understand the above. ***You also understand that by refusing to sign this consent or revoking this consent, Consultants in Nephrology and Hypertension, PLLC may not be able to provide services to me.***

____

Patient or Legally Authorized Person's Signature | Printed Name | Relationship to Patient | Date

NOTICE OF PRIVACY PRACTICE

Acknowledgment of Receipt of Privacy Practice

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices. Our privacy practice is available on our website https://parkernephrology.com/ or can be provided in printed format at your request.

____

Patient or Legally Authorized Person's Signature | Printed Name | Date

Refusal of Receipt of Notice of Privacy Practices
For Practice Use Only
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
[ ] Individual refused to sign
[ ] Communications barriers prohibited obtaining the acknowledgment
[ ] An emergency situation prevented us from obtaining acknowledgment
[ ] Other (Please Specify) ____

**If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.*

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ALLERGY LIST – *Please list all known drug allergies*

Allergy	Reaction

MEDICATION LIST – *Please list all current medications, including supplements*

Medication	Dose	Directions