METROPOLITAN NEPHROLOGY ASSOCIATES

STEPHEN G. GOLDBERGER, M.D. • ANDREW D. HOWARD, M.D., F.A.C.P.

SAMIR F. SHABSHAB, M.D. • MANOJ S. REDDY, M.D. • ADAM M. PEARLMAN, M.D.

MARC F. BRAZIE, M.D. • NANCY KIM ZUBER, PA-C

BOARD CERTIFIED

7801 OLD BRANCH AVENUE
SUITE 202
CLINTON, MD 20735
(301) 868-9414

2616 SHERWOOD HALL LANE
SUITE 209
ALEXANDRIA, VA 22306
(703) 360-3100

THE FOLLOWING IS A NEW PATIENT REGISTRATION PACKET.

YOU WILL NEED TO PRINT IT, COMPLETE IT AND RETURN IT TO THE

OFFICE IN WHICH YOU WILL BE SEEN FOR YOUR APPOINTMENT. WE WOULD

APPRECIATE IF YOU RETURN THIS PACKET ONE WEEK PRIOR TO YOUR APPOINTMENT

DATE. BELOW IS THE MAILING AND FAX INFORMATION FOR OUR TWO OFFICES:

MARYLAD OFFICE	VIRGINIA OFFICE
Metropolitan Nephrology Associates 7801 Old Branch Avenue Suite 202 Clinton, MD 20735 Fax: (301) 868-9055	Metropolitan Nephrology Associates 2616 Sherwood Hall Lane Suite 209 Alexandria, VA 22306 Fax: (703) 360-6117

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our Duties

We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms at any changes made will be effective for all medical information we have about you as well as information we receive in the future. A copy of a revised notice will be available at our office, or from our Privacy officer in our Virginia office by calling 703-360-3100 or Maryland office by calling 301-868-9414 or by writing to one of the corresponding addresses above. You may also address questions regarding our privacy practices, your rights or request for additional information.

Information Collected About You

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care", such as referring physicians, other doctors, your health plan, and family members or close friends.

How We May Use and Disclose Information About You

We may use and disclose personal and identifiable health information about you in different ways. All of the ways in which we may use and disclose information will fall within one of the following categories but not every use or disclosure in a category will be listed.

Permitted Uses

We may use and disclose your medical information for specific reasons:

- **Treatment:** We will use health information about you to treat you, order tests and furnish services and supplies to you. For example, we will use your medical history, such as any presence or absence of heart disease, to assess your heath and order appropriate diagnostic services. We may contact you before your visit to remind you of your appointment.
- **Payment:** We will use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give your payer information about your current medical condition so that it will pay us for the services we have furnished you. We may also need to inform your payer of the tests that you are going to receive in order to obtain prior approval or to determine whether the service is covered.
- **Health Care Operations:** We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for accreditation organizations, auditors or other consultants to review our practice, evaluate our operations, and tell us how to improve our services.

Disclosures without Authorization

We may use and disclose medical information about you, without specific authorization:

- **Disclosures Required By Law:** We may be required by federal, state or local law to disclose your medical information.
- **Public Health Activities:** We my disclose your medical information to report communicable diseases, defective medical devices to the FDA or work-related health issues.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may be required to disclose your medical information if we feel that you have been abused or neglected.
- **Health Oversight Activities:** We may be required to disclose your medical information to Medicare or a related agency if they select your case for a medical review. We may also be required to report to government agencies responsible for licensing physicians and other health care providers.
- **Coroner or Medical Examiner:** We may release personal health information to a coroner or medical examiner to identify a deceased person or determine the cause of death.
- **Tissue or Organ Donations:** We may have to disclose your medical information to organ procurement organizations,

transplant centers, and eye tissue banks.
- **Judicial and Administrative Proceedings:** We may have to disclose your medical information if we receive a subpoena from a judge or administrative tribunal.
- **Law Enforcement:** We may have to disclose you medical information in conjunction with a criminal investigation by a federal, state or local law enforcement agency.
- **Serious Threats to Health or Safety:** We may be required to disclose your medical information if, in our opinion, doing so will help avert a serious threat to the public.
- **Research:** We may use or disclose certain personal health information for research purposes where an Institutional Review Board determines that your privacy interests will be adequately protected. We may also use and disclose your protected health information to prepare or analyze a research protocol and or other research purposes.
- **Military Personnel:** We may disclose your medical information to the appropriate command authorities.
- **National Security/Intelligence Activities:** We may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.
- **Worker's Compensation:** We may disclose your medical information to comply with laws regarding worker's compensation.

Business Associates
We sometimes work with outside individuals and businesses that help us operate our business. We may disclose your health information to these business associates so that they can perform the tasks we hire them to do. Our business associates must guarantee us they will respect the confidentiality of your personal and identifiable health information.

Individuals Involved in Your Care or Payment for Your Care
We may disclose information to individuals involved in your care or in the payment for your care, but we will obtain you agreement before doing so. This includes people and organizations that are part of your "circle of care", such as your spouse, other doctors or an aide involved in your care. Although we must be able to speak with your other doctors and health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family.

Authorization for Other Uses and Disclosures
We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based on your original permission.

Patient's Rights
You have certain rights with respect to your medical information.

Requesting Restrictions
You have the right to ask in writing for restrictions on the ways in which we use or disclose your medical information beyond those imposed by law. We will consider your request but are not required to accept it.

Confidential Communications
You have the right to request in writing that you receive communications containing your protected health information from us by alternative means or location. For example, you may ask that we only contact you at home or by mail. We will consider your request but are not required to accept it.

Inspect and Copy
You may request access to inspect and copy your medical information in our records, including medical and billing records. Your request must be in writing. We will act on your request within 30 days after we get it. If we must deny your request we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.

Amendment
You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the medical information that you would be permitted to inspect or copy, or if we did not create the information.

Accounting of Disclosures
You may request a list of uses or disclosures of your protected health information for reasons other than your treatment, payment for services furnished to you, our health care operations, or disclosures you authorized that we have made over the previous six (6) years. You may not request an accounting for dates of service prior to April 14, 2003. Your first request within a 12-month period is free, but we charge for additional lists within the same 12-month period.

Paper Copy of This Notice
You are entitled to receive a paper copy of our Notice of Privacy Practices by using the contact information supplied on the first page.

File a Complaint
If you believe that we have violated your privacy rights, you may file a complaint directly with us using the contact information on the first page. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for complaining.

Effective Date: April 14, 2003

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Acknowledgement of Privacy Practice Notice

Metropolitan Nephrology Associates will use and disclose your personal health information to treat you, to receive payment for care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand our policies in regards to protect health information. The terms of the notice may change with time and we will post the current notice at our facility and have copies available for distribution. By signing this, you acknowledge that you have received, read and understand the **NOTICE OF PRIVACY PRACTICES.**

_____

Patient Signature Date

_____

Printed Patient Name

In Addition to your health care providers, list any individuals you would like to authorize Metropolitan Nephrology Associates to release any medical information regarding your health care.

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

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APPOINTMENTS

At Metropolitan Nephrology Associates we strive to make your visit to our offices as pleasant as possible. We recognize that seeing a physician is often quite stressful, especially for the first visit. We are also aware that your time and our time are very important. We NEVER overbook, meaning that no one else is scheduled for the time slot of your appointment and this reflects our faith that you will be at your appointment on time. This system has worked for us with few exceptions and we request your cooperation for it to continue to work. If you are unable to keep your scheduled appointment please give our office 24 hours notice to avoid a charge of $25. If you arrive 15 minutes late for you scheduled appointment you will need to reschedule.

Many insurance companies will only pay for your visit with a paper referral issued by your primary care doctor. We must have this referral at the time of service.

Thank You.

_____ _____

Signature Date

PATIENT INFORMATION

DATE: _____

Demographics/Contacts

Last Name: _____ First Name: _____ MI: ____

Sex: ☐ Male ☐ Female DOB: _____/_____/_____ SSN: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State & Zip: _____

Employer: _____ Phone: _____

Referring/Primary Doctor: _____ Phone: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Spouse Name: _____

Emergency Contact Name: _____ Phone: _____

Person Responsible for Payment: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ Phone: _____

Insurance Information

Primary: _____ ID # _____ Group #_____

Subscriber Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ City: _____ State & Zip: _____

Relation to Patient: _____ Phone: _____ Employer: _____

Secondary: _____ ID # _____ Group #_____

Subscriber Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ City: _____ State & Zip: _____

Relation to Patient: _____ Phone: _____ Employer: _____

Other: _____ ID # _____ Group #_____

Subscriber Name: _____ DOB: _____/_____/_____ SSN: _____

Address: _____ City: _____ State & Zip: _____

Relation to Patient: _____ Phone: _____ Employer: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize METROPOLITAN NEPHROLOGY ASSOCIATES, P.C. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

MEDICATION LIST

Patient Name: _____

Date of Birth: _____

Are you allergic to any medications? If yes, please list medication name and reaction.

_____

_____

_____

Medications you are currently taking (prescription and over the counter):

Medication	mg	Times per day

_____

Patient Signature Today's Date