Kidney Care
Associates, LLP

Last Name: _____ First Name: _____DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Male: _____ Female: _____

Home #: _____ Cell #: _____ Alt #: _____

SS #: _____ Marital Status (Circle one) Married, Single, Divorced, Widow, Legally Separated

Email Address: _____

Spouse Name: _____ Date of Birth: _____ SS# _____

**Primary Care Physician**: _____

**Pharmacy Name:** _____ Phone #: _____

**Referring Physician:** _____ Phone #: _____

Employer Name: _____ Work #: _____

Emergency Contact: _____ Phone #: _____

Relationship to the patient: _____

Power Of Attorney: _____ Phone #: _____

Primary Insurance:

_____

Policy #: _____

Insured DOB: _____

Secondary Insurance:

_____

Policy #: _____

Insured DOB: _____

**PLEASE READ AND SIGN**: I hereby consent to treatment by Kidney Care Associates physicians and understand that I am financially responsible for any charges that insurance deems my responsibility. If there is any laps in coverage I am responsible for all charges as self-pay. I hereby authorize Kidney Care Associates to release all information necessary to secure the payment of my benefits. I further agree that a copy of this agreement shall be as valid as the original.

Printed Name: _____

Signature: _____ Date: _____

600 E. Taylor St., Suite 103, Sherman, TX 75090 Phone: 903-893-7170 Fax: 903-893-4372

600 E. Taylor St.,
Suite 103
Sherman, TX 75090
Tel: 903-893-7170
Fax: 903-893-4372

1400 Bryan Dr
Suite 202
Durant, OK 74701

Kidney Care
Associates, LLP

Wirasat Hasnain, MD
Vinod Prasad, MD
David Reynolds, MD
Imran Shafique, MD
Luis D. Torres, MD
Megan Little, NP

**Consent To Use and Disclosure of Protected Health Information**

**Use and Disclosure of Your Protected Health Information**
Your protected health information will be used by **Kidney Care Associates, LLP** or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the patients**.**

**Notice of Privacy Practices**
You should review the Notice of Privacy Practice for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

**Requesting a Restriction on the Use or Disclosure of Your Information**
You may request a restriction on the use or disclosure of your protected health information.

**Kidney Care Associates, LLP** may or may not agree to restrict the use or disclosure of you protected information.

If **Kidney Care Associates, LLP** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Revocation of Consent**
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to this date on which your revocation of consent is received will not be affected.

**Reservation of Right to Change Privacy Practices**
**Kidney Care Associates. LLP** reserves the right to modify the privacy practices outline in the notices.

**Signature**
**I have reviewed this consent form and given my permission to Kidney Care Associates, LLP to use and disclose my health information in accordance with it.**

_____ _____
**Signature of Patient** **Signature of Patient Representative**

_____ _____
**Name of Patient (Print)** **Relationship to Patient**

_____
**Date**

Kidney Care Associates, LLP

# HIPAA Disclosure Form

Patient Name: _____ Date: _____

Listed Address: _____

Phone No: _____

Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? Yes No

May we leave messages? Yes No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

_____ _____

Patient Signature Date

# Medications

Do you have any drug allergies? Yes or No
List of Allergies: _____

**Please list all medications (including over the counter ones):**

| Date | Medication | Dosage | How many times a day? (1x, 2x,3x) |
|---|---|---|---|
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_____ _____
Signature Date

Kidney Care
Associates, LLP

## SURGERIES

| | Yes or No | Date: | | Yes or No | Date: |
|---|---|---|---|---|---|
| **Gall Bladder** | | | **Stomach** | | |
| **Kidney** | | | **Prostate** | | |
| **Colon** | | | **Heart** | | |
| **Hernia** | | | **Thyroid** | | |
| **Any other Surgeries** | | | | | |

## FAMILY HISTORY

Please make a **CHECK** in all the boxes that apply:

| | KIDNEY DISEASE | DIABETES | HIGH BLOOD PRESSURE | DIALYSIS | HEART DISEASE | CANCER | LUNG DISEASE |
|---|---|---|---|---|---|---|---|
| FATHER | | | | | | | |
| MOTHER | | | | | | | |
| PATERNAL GRANDFATHER | | | | | | | |
| PATERNAL GRANDMOTHER | | | | | | | |
| MATERNAL GRANDFATHER | | | | | | | |
| MARTERNAL GRANDMOTHER | | | | | | | |
| SIBLINGS<br>Total Brothers: ___<br>Total Sisters: ___ | | | | | | | |

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Kidney Care
Associates, LLP

## SOCIAL HISTORY

| | CURRENTLY USE | TYPE | FREQUENCY & AMOUNT | IF QUIT, WHEN |
|---|---|---|---|---|
| ALCOHOL USE | YES NO | | | |
| SMOKING | YES NO | | | |
| ILLICIT DRUG USE | YES NO | | | |

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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 gain access to this information.**

## Please review carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health conditions and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

**Your Rights Under the Privacy Rule**
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

**You have the right to authorize other use and disclosure** - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to request an alternative means of confidential communication** – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing of how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI** - This means you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

**You have the right to request a restriction of your PHI** - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to your protected health information** - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability** - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

**How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment** - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices** - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office.

**Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations** - We may use or disclose, as needed, your PHI to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

**Health Information Organization** - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

**To Others Involved in Your Healthcare -** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or

death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures** - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and
Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

**Privacy Complaints**
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at: **903-893-7170** or The Secretary of the Department of Health and Human Services:

**Marisa Smith, Regional Manager**
**Office for Civil Rights - Region VI**
**U.S. Department of Health and Human Services**
**1301 Young Street, Suite 1169**
**Dallas, TX 75202**

Effective Date Publication Date 10/18/2022

# REVIEW OF SYSTEMS

**General**

| | | |
|---|---|---|
| Recent weight loss | _____Yes | _____No |
| Fever/Chills | _____Yes | _____No |
| Feeling Tired | _____Yes | _____No |
| Recent weight gain | _____Yes | _____No |
| Weakness | _____Yes | _____ No |

**HEAD, EARS, EYES, NOSE and THROAT**

| | | |
|---|---|---|
| Hoarseness | _____Yes | _____No |
| Oral ulcers | _____Yes | _____No |
| Sore throat | _____Yes | _____No |
| Bad breath or bad taste | _____Yes | _____No |
| Headaches | _____Yes | _____No |
| Blurred or double vision | _____Yes | _____No |
| Sinus problems | _____Yes | _____No |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Chest pain or angina | _____Yes | _____No |
| Palpitation | _____Yes | _____No |
| Swelling of feet, ankles and hands | _____Yes | _____No |
| Hypertension | _____Yes | _____No |
| Shortness of breath | _____Yes | _____No |

**RESPIRATORY**

| | | |
|---|---|---|
| Chronic cough | _____Yes | _____No |
| Shortness of breath | _____Yes | _____No |
| Wheezing | _____Yes | _____No |
| Coughing of blood | _____Yes | _____No |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Difficulty swallowing | _____Yes | _____No |
| Poor Appetite | _____Yes | _____No |
| Nausea | _____Yes | _____No |
| Frequent diarrhea | _____Yes | _____No |
| Painful bowel movements | _____Yes | _____No |
| Blood in stool | _____Yes | _____No |
| Constipation | _____Yes | _____No |
| Abdominal pain | _____Yes | _____No |
| Black/tarry stool | _____Yes | _____No |
| Vomiting | _____Yes | _____No |

**GENITOURINARY**

| | | |
|---|---|---|
| Frequent urination 7+ | _____Yes | _____No |
| Burning or painful urination | _____Yes | _____No |
| Blood in urine | _____Yes | _____No |
| Nocturia 2 + times at night | _____Yes | _____No |
| Frothy/Foamy urine | _____Yes | _____No |
| Urinary incontinence | _____Yes | _____No |

**MUCULOSKELETAL**

| | | |
|---|---|---|
| Joint pain multiple | _____Yes | _____No |
| Joint stiffness | _____Yes | _____No |
| Back pain | _____Yes | _____No |
| Muscle aches | _____Yes | _____No |
| Muscle cramps | _____Yes | _____No |

**PSYCHIATRIC**

| | | |
|---|---|---|
| Anxiety | _____Yes | _____No |
| Depression | _____Yes | _____No |

**SKIN**

| | | |
|---|---|---|
| Rashes | _____Yes | _____No |
| Skin Lesions | _____Yes | _____No |
| Wounds | _____Yes | _____No |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Tingling | _____Yes | _____No |
| Seizures | _____Yes | _____No |
| Numbness | _____Yes | _____No |
| Headaches | _____Yes | _____No |
| Balance Problem | _____Yes | _____No |
| Dizziness | _____Yes | _____No |

**ENDOCRINE**

| | | |
|---|---|---|
| Hair changes | _____Yes | _____No |
| Heat/Cold intolerance | _____Yes | _____No |
| Excessive urination | _____Yes | _____No |
| Changes in appetite | _____Yes | _____No |

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| Easy bruising | _____Yes | _____No |
| Anemia | _____Yes | _____No |
| Phlebitis | _____Yes | _____No |
| Transfusions | _____Yes | _____No |
| Easy Bleeding | _____Yes | _____No |
| Prolonged bleeding | _____Yes | _____No |