



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:

Secondary Insurance:

Policy #: _____

Policy #: _____

Insured DOB: _____

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: _____

Phone: 903-893-7170 Fax: 903-893-4372

2741 FM 691
Denison, TX 75020

Tel: 903-893-7170
Fax: 903-893-4372

1400 Bryan Dr
Suite 202 Durant,
OK 74701



Wirasat Hasnain, MD
Vinod Prasad, MD
David Reynolds, MD
Imran Shafique, MD
Luis D. Torres, MD
Adil S. Ahmed, 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



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: _____

Patient Signature

Date



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 Total Brothers: ____ Total Sisters: ____							



SOCIAL HISTORY

	CURRENTLY USE	TYPE	FREQUENCY & AMOUNT	IF QUIT, WHEN
ALCOHOL USE	YES NO			
SMOKING	YES NO			
ILLCIT 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.

September 15, 2023

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

September 15, 2023

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