NEVADA

NEPHROLOGY

CONSULTANTS

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2820 W. Charleston Boulevard

Suite 33

Las Vegas, NV 89102

P: (702) 880-1558

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Dear Patient

Thank you for choosing Nevada Nephrology Consultants. We are pleased for the opportunity to help you improve your kidney health. It is the policy of NNC to treat all patients and not to discriminate with regards to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.
To assist us in managing your nephrology care and to assure you a thorough understanding of your rights and responsibilities as a patient, we ask that you review and complete the enclosed forms, prior to your first appointment.

When you arrive at our office, a member of our staff will ask you for the **completed forms,** along with your **health insurance card, a photo identification card,** and if required by your insurance provider, referral documentation from your primary care physician. **At this time, your co-payment or a coinsurance remittance will be due.**

In order for us to provide for your nephrology needs, you will be required to have renal labs done no older than 30-days prior to your appointment and office notes from your referring physician.

In the event that you need to cancel or reschedule your appointment, we ask that you notify our office at least 24 hours in advance. As we have many patients that need to be seen, we ask that you be considerate of your appointment time and afford us the ability to schedule someone else should you cancel your appointment. We make every effort to provide a courtesy reminder call before your appointment, but ultimately, it is your responsibility to reschedule or cancel if you are unable to keep your appointment. As such, a **$25 "no show" fee is charged to patients who fail to comply with this request.** To cancel or change an appointment, or for directions to one of our offices, please call (702) 880-1558.

Feel free to contact us if you have any questions about our policies or any of the information contained in the enclosed forms. Our staff will be happy to assist you in any way they can.
We recognize the trust you put in us, and the responsibility we have in providing high quality medical care. We ask in return that you respect our office by abiding by our policies and always treating all staff members with respect. Inappropriate behavior in the office will not be tolerated.

We appreciate your confidence in our group and look forward to seeing you soon.

Front Desk Check-in

initials: _____

Nevada Nephrology Consultants

2820 W. Charleston Blvd, Suite 33

Las Vegas, NV 89102

Office Location: _____

Today's Date: _____

☐ New Patient

☐ Name Change

☐ Address Change

☐ Insurance Change

Patient Information

Please Complete All Sections

Name (First, MI, Last) _____ Date of Birth ___/___/____ Age:____ Sex: M / F

Mailing Address (street) _____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone (___) _____ Daytime Phone (___) _____ Mobile Phone (___) _____

SS# _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address _____

Employer _____ Phone Number (___) _____

Employer Address _____

Name of referring physician _____ Phone Number (___) _____

Name of Primary Care Physician _____ Phone Number (___) _____

Other family members that are patients _____

Parent, Spouse, or Responsible Party

Name (First, MI, Last) _____ Date of Birth _____ Age:____ Sex: M / F

Mailing Address (street) _____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone (___) _____ Mobile Phone (___) _____ SS# _____

Insurance Coverage - Primary

Name of Policy Holder (Insured) _____ Date of Birth ___/___/____

Insurance Company Name _____ Ins Phone Number (___) _____

SS# _____ Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Other _____

Address of Claim Center (street, city, state, zip) _____

Policy # _____ Group Name or Number _____

Policy Type: ☐ PPO ☐ EPO ☐ POS ☐ HMO If HMO, Name of Medical Group _____

Employer _____ Phone Number (___) _____

Employer Address _____

Insurance Coverage - Secondary

Name of Policy Holder (Insured) _____ Date of Birth ___/___/____

Insurance Company Name _____ Ins Phone Number (___) _____

SS# _____ Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Other _____

Address of Claim Center (street, city, state, zip) _____

Policy # _____ Group Name or Number _____

Policy Type: ☐ PPO ☐ EPO ☐ POS ☐ HMO If HMO, Name of Medical Group _____

Employer _____ Phone Number (___) _____

Employer Address _____

PLEASE TURN TO NEXT PAGE AND COMPLETE

Nevada Nephrology Consultants

2820 W. Charleston Blvd, Suite 33
Las Vegas, NV 89102

Patient Information
Continued

In case of emergency

Name of friend or relative not residing with you _____

Relationship to patient _____ Address _____

Day phone # ( ) _____ Evening phone # ( ) _____

Pharmacy Information

Pharmacy Name _____

Address _____

Phone Number ( ) _____ Fax Number ( ) _____

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature _____ Date __/__/____

Payment Policy

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. Any **applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any/all charges not paid for by insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is preformed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. Your signature below signifies your understanding and willingness to comply with these policies.

A $25.00 "No Show" fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment.

A fee will be charged for any returned checks.

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibili to obtain and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it , it may be necessary to reschedule your appointment.
I have read the Payment Policy and Insurance coverage described above. I understand and agree to al its provisions.

Patient Signature _____ Date __/__/____

Nevada Nephrology Consultants

2820 W. Charleston Blvd, Ste 33
Las Vegas, NV 89102

HIPPA Notice of Privacy Practices

Updated: December 20, 2022

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

If you have any questions about this notice, please contact the Privacy Officer at this practice.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the Privacy Officer at this practice. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Privacy Officer at this practice.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer at this practice.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the privacy officer at this practice. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer at this practice. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the Privacy Officer at this practice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our practice Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

PROTECTED HEALTH INFORMATION AUTHORIZATION:

Please allow access of my Protected Health Information (PHI) to:

Person's name:	Relationship:
_____	_____
_____	_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Registrations pertaining to medical assignment of benefits apply. If not signed by patient, please indicate relationship (e. g. spouse)

Printed Name: _____

Signature: _____

Date: _____

NEVADA NEPHROLOGY CONSULTANTS

CONSENT TO RELEASE INFORMATION

Please transfer the medical records of:

Name: _____

DOB: _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Cell#:** _____

Release Information from:

Name: _____

Phone#: _____

Fax #: _____

Release Information to:

Nevada Nephrology Consultants
2820 W. Charleston Blvd., Suite 33
Las Vegas, NV 89102
PHONE: 702-880-1558
FAX: 702-870-6821

The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV, and AIDS information, and that I may withdraw this authorization in writing, at any time, except to the extent that action has been taken based on this authorization.

_____ _____

Authorized Signature Date

_____

Please Print Name

Office Use Only:

1st Request sent: Date: _____ By: _____

2nd Request sent: Date: _____ By: _____

3rd Request sent: Date: _____ By: _____

Nevada Nephrology Consultants

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2820 W. Charleston Blvd.
Suite 33
Las Vegas, Nevada 89102

Patient Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY / FAMILY HISTORY

Self / Family	Self / Family	Self / Family
TB	Kidney Trouble	HIV / AIDS
Heart Trouble	Asthma / Allergies	Anemia (Weak, Low, Blood)
Diabetes	Bpwe; Disorders / Colitis	Phiebitis, Varicose Veins
Liver Disease	Cancer	Gall Bladder
Multiple Sclerosis	Emphysema	Glaucoma / Cataracts
Hypertension	Stroke	Other
Epilepsy / Seizures	Thyroid Trouble	

HOSPITALIZATION HISTORY	SURGICAL HISTORY	MVA/INJURY HISTORY
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____

SOCIAL HISOTRY

Do you or have you smok(ed)?	Yes	No	How Long?_____	How much?_____
Do you drink Alcoholic Beverages?	Yes	No	How Long?_____	How much?_____
Do you take recreation/street drugs?	Yes	No	How Long?_____	How much?_____

Medication Allergies: _____
Food Allergies: _____

Current Medications: 1._____ 2._____
3._____ 4._____

REVIEW OF SYSTEMS

Please circle all that apply to you

Headaches	Shortness of Breath	Frequent Diarrhea/Constipation	Neurologic Problems
Eye Trouble	Chest Pain	Blood in Stool	Dizziness/Weakness
Hearing/Eye Trobule	Palpitations/Angina	Hemorrhoids	Anxiety/Depression
Mouth Problems	Breast Lumps	Difficulty Urinating/Frequency	Fainting
Allergies/Sinus Problems	Heart Murmur	Kidney Stones	Numbness/Tingling
Throat Problems	Decreased Appetite	STD	Insomnia
Skin Rash	Abdominal Pain	Neck Pain	Coughing Blood
Chronic Coughing	Weight Loss	Chronic Neck Pain	Frequent Indigestion
Arthitis			

Patient Name: _____ Date of Birth: _____

IMMUNIZATION HISTORY

TB Exam Date: _____ Last Flu Injection Date: _____ Pneumovax Date: _____

Hepatitis B #1: _____ #2: _____ #3: _____

Additional Information: _____

PSYCHOSOCIAL HISTORY

Marital Status: Single / Married / Divorced / Widowed

Do you have a Living Will? Yes No Do you have an Advanced Directive? Yes No

FUNCTIONAL ASSESSMENT

Able to Feed Self:	Yes	No	With Assistance	Able to Bathe Self:	Yes	No	With Assistance
Able to Ambulate:	Yes	No	With Assistance	Able to Walk Unassisted:	Yes	No	With Assistance
Able to Climb Stairs:	Yes	No	With Assistance	On a Special Diet:	Yes	No	

EQUIPMENT AIDS

Please circle all that apply to you

Walker Wheelchair Cane Prosthesis _____ Bedside Commode Other: _____

Please circle the # which best describes your medical health needs #1 being minimal and #10 being catastrophic

Severity of Need: 1 2 3 4 5 6 7 8 9 10

PLEASE IDENTIFY ANY OTHER AREAS OF CONCERN:

_____

_____

_____

_____

_____

_____

_____

Declaration: All information submitted by me in the above is true to the best of my belief and knowledge:

Patient / Guardian Signature: _____ Date: _____