Nephrology & Hypertension Associates of New Jersey

Appointment Date: _____ Dr. _____

Patient Name: _____
Last Name **First Name** **M. Initial**

DOB: _____ Soc. Sec # _____

Sex: { } Male { } Female { } Minor { } Single { } Married { } Divorced { } Widowed { } Separated

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____
Name Contact Number

Relationship to Patient: _____

Physician Information

Referring Physician: _____ Contact #: _____

Reason for Referral: _____

Primary Physician: _____ Contact #: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance: _____

Policy Holder Name: _____ DOB: _____ Soc. Sec #_____

Address: _____ Contact #: _____

City: _____ State: _____ Zip: _____

Policy ID#: _____ Grp # _____ Effective Date: _____

Secondary Insurance: _____

Policy Holder Name: _____ DOB: _____ Soc. Sec #_____

Address: _____ Contact #: _____

City: _____ State: _____ Zip: _____

Policy ID#: _____ Grp # _____ Effective Date: _____

Nephrology & Hypertension Associates of New Jersey

Under the new HIPPA regulations that went into effect on April 14, 2003, we are only privileged to release health information to family members that you designate us to.

Please check off and provide the names and contact information for the following family members that you would like us to release your health information to.

{ } Wife: _____

{ } Husband: _____

{ } Mother: _____

{ } Father: _____

{ } Son: _____

{ } Daughter: _____

{ } Entire Family: _____

{ } Other: _____

Signature: _____

Date: _____

Please provide following information to gain access to our patient portal:

Last four of social security number: _____

E-Mail address: _____

Patient Signature: _____

Date: _____

Medication List

Patient Name: ____ **DOB:** _______________ **Date:** _______________

Allergies: ____
____
____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Medication Name: ____
Dosage: __________________ **Frequency:** ____________________________________ **Qty:** ________________
Refills: ____________ **Additional Sig:** ____
____

Nephrology & Hypertension Associates of New Jersey

Patient Name: _____DOB: _____

Primary Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____

Secondary Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____

Additional Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____

Nephrology & Hypertension Associates of New Jersey

Patient Health History

Patient Name: _____**DOB:** _____ **Date:**_____

Social History:

Do you smoke: **yes / no**

If yes, how many cigarettes/cigars per day do you smoke? _____How long? _____

Do you drink alcohol: **yes / no**

If yes, how many drinks do you consume per day? _____How long? _____

Do you use any drugs: **yes / no**

If yes, what type of drug(s)? _____ How long? _____

Immunizations:

Influenza shot: **yes / no** **Date:** _____ **Pneumonia:** **yes / no** **Date:** _____

Family/Personal History:						**Type if Known:**
Kidney Disease { } None	{ } Father	{ } Mother	{ } Sibling	{ } Child	{ } Self	
Diabetes { } None	{ } Father	{ } Mother	{ } Sibling	{ } Child	{ } Self	
Hypertension { } None	{ } Father	{ } Mother	{ } Sibling	{ } Child	{ } Self	
Heart Disease { } None	{ } Father	{ } Mother	{ } Sibling	{ } Child	{ } Self	
Cancer { } None	{ } Father	{ } Mother	{ } Sibling	{ } Child	{ } Self	
Stroke { } None	{ } Father	{ } Mother	{ } Sibling	{ } Child	{ } Self	
Mother	{ } Living	{ } Deceased	{ } Unknown	**Reason Deceased**		
Father	{ } Living	{ } Deceased	{ } Unknown			
Other:						

Have you had a Kidney Transplant: **yes / no**

Transplant Date: _____

Place of Transplant: _____

Nephrology & Hypertension Associates of New Jersey

Cultural Competency:

State of New Jersey mandates that every physician documents and barrier to care including cultural and linguistic needs in the medical record. Factors affecting care are visual or auditory factors which may impede your ability to comprehend medical discussions and language, cultural and/or religious customs which may impact the medical provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decrease health care disparities.

Do you have any Impairment (i.e. visual, hearing, speech, learning, physical and language/cultural barrier)? **Y / N**

Impairment: _____

_____

Do you have any religious or culture customs that the doctor should know about? **Y / N**

Description: _____

_____

Race:

{ } Asian	**{ } Native Hawaiian**	**{ } Other Pacific Islander**
{ } Black/African American	**{ } American Indian/Alaskan Native**	**{ } White**

Ethnicity:

{ } Latino or Hispanic Identity	**{ } Non- Latino or Hispanic Identity**	**{ } Refuse/Unreported**

What Language do you speak?

{ } English	**{ } Spanish**	**{ } Arabic**
{ } French	**{ } French Creole**	**{ } Chinese**
{ } German		

Advance Directives: For all patients 18 years and older

Advance Directives is a federal and state mandates Self-Determination Act enacted in 1990. This allows you to provide specific instructions and directions regarding your own medical care wishes if you become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions.

Dou you have a "Living Will" or "Advance Directive" ? **Y / N**

Would you like to know more about a living will? **Y / N**

Patients Name (printed): _____

Patients Signature: _____

Date: _____

Nephrology & Hypertension Associates of New Jersey

Patient name: _____ **DOB**: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____

I authorize the use and disclosure of the health information for the individual named above as described below.

Treatment Dates and Locations:

Emergency Department Location/Date(s):_____
Outpatient Location/Date(s): _____
Inpatient Location/Date(s): _____

The Type of information to be used or disclosed is as follows:

{ } Face Sheet / Admission records	**{ } Discharge Summary**	**{ } Operative Reports**
{ } Emergency Department Reports	**{ } History & Physical**	**{ } Consultation**
{ } Pathology Reports	**{ } Laboratory Reports**	**{ } Psychiatric Records**
{ } X-Ray Reports	**{ } Unified Assessment Form**	**{ } Educational Reports**
{ } Breathalyzer / Drug Screen Reports	**{ } Treatment Plan**	**{ } Family Assessment**

Other: _____

This information may be disclosed to and used by the following organization:

Organization Name: Nephrology & Hypertension Associates of NJ
Address: **City:** **State:** **Zip:**
Phone: **Fax:**
Reason / Purpose for the request: Continuity of Care

I understand that the information in my health records may include information relating to the (HIV) Human Immunodeficiency Virus, (AIDS) Acquired Immune Deficiency Syndrome, psychological conditions or treatment, sexually transmitted diseases, drug/alcohol dependence status, detoxification or rehabilitation services.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my revocation to the Nephrology & Hypertension Assoc. of New Jersey. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apple to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition
_____.

I understand the authorizing this disclosure of health information is voluntary and I can refuse to sign this form if I do not wish this request to be processed. I do not need to sign to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Printed Name of Patient or Legal Representative: _____

Signature of Patient or Legal Representative: _____

Date: _____

Nephrology & Hypertension Associates of New Jersey

Notice of Privacy Practices

A. Who Will Follow This Notice?

This notice describes the privacy practices of the Nephrology & Hypertension Associates of New Jersey and that of:

- All employees, staff and other Nephrology & Hypertension Associates of New Jersey personnel.
- Any health care professional authorized to enter information into you medical record while working at any practice of Nephrology & Hyp0ertension Associates of New Jersey.
- All departments and units of the practice Nephrology & Hypertension Associates of New Jersey.
- Any member of a volunteer group we allow to help you while you are a patient with our practice, Nephrology & Hypertension Associates of New Jersey.

All Nephrology & Hypertension Associates of New Jersey entities, sites, and locations that are subject to HIPPA regulations follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for the treatment, payment or health care operations purposes described in this notice. All of the entities, sites and locations are hereafter referenced as Nephrology & Hypertension Associates for New Jersey.

B. We Have a Legal Duty to Safeguard Your protected Health Information (PHI)

Nephrology & Hypertension Associates of New Jersey understands that medical information about you and your health is personal and we are committed to protecting it. This notice applies to all records of your care generated by Nephrology & Hypertension Associates of New Jersey. This notice informs you on how Nephrology & Hypertension Associates may use and disclose information about you. It describes your rights and also the obligations Nephrology & Hypertension Associates of New Jersey has regarding the use and disclosure of your information. Nephrology & Hypertension Associates of New Jersey is required by law to do the following:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

C. How We May Use and Disclose Your Protected Health Information (PHI)

Nephrology & Hypertension Associates of New Jersey may use or disclose your PHI for three reasons:

- To arrange or plan your treatment (e.g., informing your doctors of your condition)
- To obtain payment for treatment (e.g., submitting your information to your insurer to process your claim)
- To support health care operations (e.g., quality assurance and medical teaching)

Nephrology & Hypertension Associates of New Jersey may use and disclose you PHI without your authorization for the following reasons:

- The disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.
- Public health activities.
- Health oversight activities.
- Lawsuits and disputes.
- Organ and tissue donation.
- Specific government functions.
- To avert a serious threat to health or safety.
- Research.
- Workers Compensation.
- Appointment reminders and health related benefits or services.
- Fundraising activities.
- Health plan disclosures.
- Change of ownership.

Uses and Disclosures that require you to have the opportunity to agree or object

- **Patient Directories:** Unless you are a patient in a behavioral health unit, we will include the following information in a patient directory while you are a patient: Name, location in the facility, your general condition and you religious affiliation. Your religious affiliation may be given to a member of the clergy. You may opt out of the patient directory.
- **Individuals involved in your care or payment for your care:** Unless you object, we may release your PHI to a family member, friend, or other person who is involved in your medical care.
- **Persons acting on behalf of you:** If you are not present or able to agree or object to the disclosure, we will use professional judgment and experience to determine whether it is in your best interest to allow another person to act on your behalf.

D. Your Rights Regarding your Protected Health Information

- **Right to inspect and get copies of your PHI:** You have the right to look at and get copies of your records that may be used to make decisions about your care. We may deny your request in certain circumstances.

(Continued on Next Page)

Nephrology & Hypertension Associates of New Jersey

Notice of Privacy Practice

- **Right to amend:** If you believe there is a mistake in your records, you have the right to request a correction.
- **Right to an accounting of disclosures:** You have the right to get a list of instances in which we have disclosed your PHI.
- **The right to request restrictions:** You have the right to ask that we limit how we use and disclose your information for treatment, payment or health care operations. We will consider your request, but we are not legally required to accept it.
- **The right to choose how we send PHI to you:** You have the right to ask that we send information to you at an alternate address or using a different means.
- **The right to a paper copy of this notice:** You have the right to a paper copy of the complete Notice of Privacy Practices.

E. Information and Complaints

If you would like additional information about Nephrology & Hypertension Associates of New Jersey privacy practices, if you think that we have violated your privacy rights, or if you disagree with a decision we made about access to your PHI, contact the Chief Privacy Officer, Nephrology & Hypertension Associates of New Jersey, 201 Laurel Oak Road, Suite B, Voorhees, NJ 08043, telephone 856-566-5478. You may also send a written complaint to the Secretary of the Department of Health and Human Services, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington D.C 20201.

F. Changes

Nephrology & Hypertension Associates of New Jersey reserves the right to change the terms of this notice and our privacy policies at any time. Before any important changes, we will promptly change this notice and post a new notice.

G. Effective Date of This Notice and Coverage

This notice went into effect on April 14, 2003 and applies to designated corporate subsidiaries of Nephrology & Hypertension Associates of New Jersey.

Patient Printed Name: _____

Patient Signature: _____

Date: _____

{ } Signed Today { } Previously Signed { } Declined to Sign { } Unable to Sign

Printed Name of Legal Representative: _____

Representative Signature: _____

Date: _____