Nephrology Associates of Central Florida, P.A.

Diseases of the Kidney and Hypertension

PATIENT INFORMATION

PATIENT NAME			BIRTHDATE	SEX

ADDRESS	CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER	MARITAL STATUS
					☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

HOME PHONE	CELL PHONE	REFERRING PHYSICIAN	EMPLOYER	ADDRESS

EMPLOYER PHONE #	ARE YOU RETIRED	DATE OF RETIREMENT	ARE YOU DISABLED	DATE OF DISABILITY	DO YOU HAVE INSURANCE
	☐ YES ☐ NO		☐ YES ☐ NO		☐ YES ☐ NO

SPOUSE/GUARDIAN	EMPLOYER	EMPLOYER PHONE #

NEAREST RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	ADDRESS	PHONE

EMERGENCY CONTACT	ADDRESS	PHONE

RACE	LANGUAGE	ETHNICITY	EMAIL
☐ WHITE ☐ HISPANIC ☐ BLACK/AFRICAN ☐ ASIAN ☐ OTHER	☐ ENGLISH ☐ SPANISH ☐ INDIAN ☐ OTHER	☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER	

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	ADDRESS	PHONE

EFFECTIVE DATE	PATIENT'S INS. ID #	GROUP NAME	GROUP NUMBER

NAME OF SUBSCRIBER	SOCIAL SECURITY NUMBER OF SUBSCRIBER	BIRTHDATE OF SUBSCRIBER	RELATIONSHIP OF SUBSCRIBER TO PATIENT

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY	ADDRESS	PHONE

EFFECTIVE DATE	PATIENT'S INS. ID #	GROUP NAME	GROUP NUMBER

NAME OF SUBSCRIBER	SOCIAL SECURITY NUMBER OF SUBSCRIBER	BIRTHDATE OF SUBSCRIBER	RELATIONSHIP OF SUBSCRIBER TO PATIENT

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to **Nephrology Associates** to provide whatever treatment they deem necessary to the patient named above. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to obtain authorization for future treatment and with regard to processing claims.

I certify the information I furnish is true and correct and that I know it is a crime to fill out this form with facts that I know are false or to leave out facts that I know are important.

I assign payment directly to the physicians, nurse practitioners, or physician assistants at **Nephrology Associates** which may be due to me from the Medicare program or other health insurance company. I understand I am financially responsible to **Nephrology Associates** for any non-covered insurance services.

Patient or Responsible Party:_____ Date: _____

All necessary lab work will be billed separately by an independent laboratory. Please notify nurse of special laboratory requirements.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Payment is requested at time of service for self pay patients. A bookkeeper can assist you if arrangements must be made. We will be glad to assist with insurance forms. Your policy and coverage is a contract between you and your insurance company. You are responsible for all payments.

Signature _____ Date _____

Witness _____ Date _____

NEPHROLOGY ASSOCIATES

Name _____ Today's Date _____

Height _____ Weight _____ Occupation _____

Allergies to drugs, medicines, dyes *(list by type)* _____

_____

Have you had any surgeries? *(check those)*

❒ Appendix
❒ Tubal Ligation or Vasectomy
❒ Hysterectomy
❒ Gall Bladder
❒ Tonsillectomy
❒ Back

Other _____

Other Hospital Admissions?

Date	Problem	Hospital
1.		
2.		
3.		

Referring Physician: _____

Check If You Have Ever Had:	**Yes**	**No**
TB (Tuberculosis)		
Rheumatic Fever		
VD, Gonorrhea or Syphilis		
Anemia or Low Blood		
Cancer or Tumor		
Leukemia		
Heart Attack		
High Blood Pressure		
Stroke		
Heart Murmur		
Asthma		
Emphysema		
Allergies, Hay Fever or Sinus		
Sugar Diabetes		
Ulcer		
Jaundice or Hepatitis		
Hernia (Rupture)		
Goiter or Thyroid Problems		
Seizures, Convulsions or Fits		
Nervous Condition		
Arthritis		
Gout		
Blood Clot in Leg		
Kidney Disease (other than infections)		
Kidney Stones		
Fractured or Broken Bones		
Injuries requiring over 5 days off work		
Knee Problems		
Impairment of Arm or Leg		
Difficulty Working		
Pain or Difficulty Swallowing		
Vision Impairment		
Hearing Impairment		
Chest Pain		
Angina		
Rectal Bleeding		
High Cholesterol		
Urinary Infections		
Skin Diseases		

Check If You Have Ever Had:	**Yes**	**No**
Breast Lumps		
Testicular or ovarian lumps or cysts		

Habits	**Yes**	**No**
Do You Smoke? (How many/day)		
Do You Drink? (How many/day)		
Have You Lost Weight?		
Have You Gained Weight?		
Do You Exercise?		
What Kind of Exercise?		

Do You Use Drugs?		

Do you take any kind of prescribed or nonprescribed medicine? (Including Aspirin, Tylenol, Laxative, Antacids, etc.)

Name of Medicine	How Often?
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Has Any Blood Relative Had:	**Yes**	**No**	**Relationship**
TB (Tuberculosis)			
High Blood Pressure			
Heart Trouble			
Kidney Disease			
Sugar Diabetes			
Cancer or Tumor			
Anemia or Low Blood			
Gall Bladder Problems			
Asthma or Hay Fever			
Thyroid Problems			
Glaucoma			
Other			

Signature _____

PATIENT NAME: _____
NOMBRE DE PATIENTE

PHARMACY NAME: _____
NOMBRE DE FARMACIA

PHARMACY PHONE#: _____
NUMERO DE LA FARMACIA

PLEASE LIST ALL CURRENT MEDICATION AND INCLUDE STRENGTH AND DOSE
FAVOR DE INCLUIR TODO MEDICAMENTO CON LOS MILIGRAMOS Y DOSIS

MEDICATION MEDICACION	STRENGH MILIGRAMOS	DOSE DOSIS

NEPHROLOGY ASSOCIATES OF CENTRAL FLORIDA

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME FOR SERVICE.

WE ACCEPT CASH, CHECKS AND VISA/MASTERCARD.

We will bill only the following carriers for office visits: Medicare Part B, Blue Shield of Florida, Federal Blue Shield, Medicaid, and Medigap Medicare supplement, and all HMO/PPO or PPC plans with which we participate. For HMO patients, we will only bill your insurance if we have your referral from your primary care physician at the time of service. Otherwise, we will expect payment in full at the time of service. In the event that you are hospitalized, we will accept assignment of your insurance benefits. We cannot bill your insurance unless you provide us with their required information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits from your insurance carrier, we extend this for a period of sixty days (60). If no payment is received from them by that time we require you to make payment. We will assist you in acquiring reimbursement. Please be aware that some or all of the services we provide may not be covered by your carrier and not considered reasonable and necessary under the Medicare Program and/or other medical insurance, this reimbursement is fully your responsibility.

UCR (Usual and Customary Rates)

Our practice is committed to providing you the best treatment possible and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor and the parents (or Guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatments require pre-authorization.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge $25.00 for missed appointments. Please help us better care for all our patients by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the above Financial Policy. I understand said Financial Policy and agree to the same.

_____ _____

Signature of Patient or Representative Date

NEPHROLOGY ASSOCIATES OF CENTRAL FLORIDA

PATIENT SELF DETERMINATION ACT QUESTIONAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745 of Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

( ) I have made such a declaration.

( ) I have NOT made such a declaration.

Health Care Surrogate

( ) I have a designated Health Care Surrogate.

( ) I have NOT designated a Health Care Surrogate.

Durable Power of Attorney

( ) I have appointed a Durable Power of Attorney for health care decisions.

( ) I have NOT appointed a Durable Power of Attorney for health care decisions.

_____ _____

Signature of Patient or Representative Date

NEPHROLOGY ASSOCIATES OF CENTRAL FLORIDA
CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Nephrology Associates (the "Practice") in order to carry out treatment, patient education and continuity of care, payment, or health care operations. The Patient should review the Nephrology Associates Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

Nephrology Associates reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Nephrology Associates does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that Nephrology Associates may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient: _____

_____

The Patient agrees that the Nephrology Associates may disclose the following types of information contained in the Patient's medical records (please initial the appropriate categories listed below):

_____ HIV/AIDS Information

_____ Mental Health Information

_____ Substance Abuse Information

_____ Sexually Transmitted Disease Information

_____ If Patient is under the age of eighteen (18), Pregnancy Information

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please initial the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is:

_____.

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and unique personal identifier).

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Nephrology Associates in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

Nephrology Associates may refuse to treat Patient if he/she (or an authorized representatve) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, Nephrology Associates has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that Nephrology Associates is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time _____ AM/PM

_____

Signature of Patient (or Authorized Representative*)

_____

Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

_____

_____

_____

_____

_____

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: _____
(SOURCE DOCTOR OR HOSPITAL)

_____
(STREET ADDRESS)

_____
(SUITE / P.O. BOX NUMBERS)

_____
(CITY, STATE, ZIP CODE)

I hereby authorize the above-named source to release or disclose to Nephrology Associates of Central Florida, PA, their members and employees, all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment (s), including x-rays, psychological, psychiatric, alcoholism, drug abuse/dependency, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for or infection with human immunodeficiency virus (HIV).

I understand that these records may contain information from other health care providers as well as administrative data which is not strictly medical in nature. I additionally understand that once released, you have no responsibility for any further release of the information by those I have authorized to receive it.

Finally, I release you from all responsibility or liability that may arise from this authorization.

_____ _____
Patient's Printed Name Patient's Social Security #

_____ _____
Signature (Patient or Authorized Representative) Patient's Date of Birth

_____ _____
Witness Printed Name Witness Signature

Date: _____

Nephrology Associates of Central Florida, P.A.

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 REVIEW IT CAREFULLY.

1. Introduction

Nephrology Associates of Central Florida, P.A. is required by law to maintain the privacy and security of your health information and provide individuals with notice of its legal duties and privacy practices with respect to health information. Nephrology Associates of Central Florida, P.A. is required to abide by the terms of the Notice currently in effect. Nephrology Associates of Central Florida, P.A. reserves the right to change the terms of this Notice at any time and to make new Notice provisions effective for all health information that it maintains. Upon your request, we will provide you with a current copy of this Notice.

This Notice of Privacy Practices outlines our practices and legal duties to maintain the confidentiality of your protected health information ("PHI") under the privacy and security regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

PHI includes demographic information that can be used to identify you such as your name, address, and telephone number; information concerning your past, present, or future physical or mental health condition; information concerning the provision of health care to you; and information concerning the past, present, or future payment for health care. Your PHI may be maintained by us electronically and/or on paper.

This Notice describes uses and disclosures of PHI to which you have consented, that you may be asked to authorize in the future, and that are permitted or required by state or federal law. Also, it advises you of your rights to access and control your PHI.

We regard the safeguarding of your PHI as an important duty. The elements of this Notice and any authorizations you may sign are required by state and federal law for your protection and to ensure your informed consent to the use and disclosure of PHI necessary to support your relationship with Nephrology Associates of Central Florida, P.A.

If you have any questions about Nephrology Associates of Central Florida, P.A.'s Notice of Privacy Practices, please contact the Privacy Officer at 407-894-4693.

2. Safeguarding Your PHI

We have in place appropriate administrative, technical, and physical safeguards to protect and secure the privacy and security of your PHI. We train our employees on the regulations and policies that are in place to protect the privacy and security of your PHI. Medical records are maintained in secure areas within our practice and electronic medical record systems are monitored and updated to address security risks in compliance with the HIPAA Security Rule. Only employees who have a legitimate "need to know" are permitted access to your medical records and PHI. Our employees understand their legal and ethical obligations to protect your PHI and that a violation of this Notice of Privacy Practices may result in disciplinary action.

3. Uses and Disclosures of PHI

As part of our registration materials, we will request your written consent for our practice to use and disclose your PHI for the following types of activities:

- **Treatment.** Treatment means the provision, coordination, or management of your health care and related services by Nephrology Associates of Central Florida, P.A. and health care providers involved in your care. It includes the coordination or management of health care by a provider with a third party insurance carrier, communication with lab or imaging providers for test results, consultation between our clinical staff and other health care providers relating to your care, or our referral of you to a specialist physician or facility.
- **Payment.** Payment means our activities to obtain reimbursement for the medical services provided to you, including billing, claims management, and collection activities. Payment also may include your insurance carrier's efforts in determining eligibility, claims processing, assessing medical necessity, and utilization review. Payment may also include activities carried out on our behalf by one or more of our collection agencies or agents in order to secure payment on delinquent bills.
- **Health Care Operations.** Health care operations mean the legitimate business activities of our practice. These activities may include quality assessment and improvement activities; fraud and abuse compliance; business planning and development; and business management and general administrative activities. These can also include our telephoning you to remind you of appointments, or using a translation service if we need to communicate with you in person, or on the telephone, in a language other than English.

  When we involve third parties in our business activities, we will have them sign a Business Associate Agreement obligating them to safeguard your PHI according to the same legal standards we follow.

4. Electronic Exchange of PHI

We may transfer your PHI to other treating health care providers electronically. We may also transmit your information to your insurance carrier electronically.

5. Uses and Disclosures of PHI Requiring Your Written Authorization

Uses and disclosures of your PHI made for purposes of psychotherapy, marketing and disclosures that constitute a sale of PHI will be made only with your written authorization.

Other uses and disclosures of your PHI will be made only with your specific written authorization. This allows you to request that Nephrology Associates of Central Florida, P.A. disclose limited PHI to specified individuals or companies for a defined purpose and timeframe. For example, you may wish to authorize disclosures to individuals who are not involved in treatment, payment, or health care operations, such as a family member or a school physical education program. If you wish us to make disclosures in these situations, we will ask you to sign an authorization allowing us to disclose this PHI to the designated parties.

If Nephrology Associates of Central Florida, P.A. intends to engage in fundraising, you have the right to opt out of receiving such communications. If you authorize us to use or disclose your PHI for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose your PHI for the reasons contained within your authorization. However, we cannot take back disclosures already made with your permission.

6. Uses and Disclosures of PHI Permitted or Required by Law

In some circumstances, we may be legally permitted or required to use or disclose your PHI without your consent or authorization. State and federal privacy law permit or require such use or disclosure regardless of your consent or authorization in certain situations, including, but not limited to:

- **Emergencies.** If you are incapacitated and require emergency medical treatment, we will use and disclose your PHI to ensure you receive the necessary medical services. We will attempt to obtain your consent as soon as practical following your treatment.
- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a family member, close friend or other person you designate only that PHI that directly relates to that individual's involvement in your health care and treatment. We may also need to use PHI to notify a family member, personal representative or someone else responsible for your care of your location and general condition.
- **Communication Barriers.** If we try but cannot obtain your consent to use or disclose your PHI because of substantial communication barriers and your physician, using his or her professional judgment, infers that you consent to such use or disclosure, or the physician determines that a limited disclosure is in your best interests, we may permit such use or disclosure.
- **Required by Law:** We may disclose your PHI to the extent that its use or disclosure is required by law. This disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Public Health/Regulatory Activities:** We may disclose your PHI to an authorized public health authority to prevent or control disease, injury, or disability or to comply with state child or adult abuse or neglect law. We are obligated to report suspicion of abuse and neglect to appropriate regulatory agencies.
- **Food and Drug Administration:** We may disclose your PHI to a person or company as required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations as well as to track product usage, enable product recalls, make repairs or replacements or to conduct post-marketing surveillance.
- **Health Oversight Activities.** We may disclose your PHI to a health oversight agency for audits, investigations, inspections, and other activities necessary for the appropriate oversight of the health care system and government benefit programs such as Medicare and Medicaid.
- **Judicial and Administrative Proceedings.** We may only disclose your PHI in the course of any judicial or administrative proceeding in response to a court order expressly directing disclosure, or in accordance with specific statutory obligations compelling us to do so, or with your permission.
- **Law Enforcement Activities.** We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purpose. Under some limited circumstances we will request your authorization prior to permitting disclosure.
- **Coroners and Medical Examiners,** We may disclose your PHI to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other lawful purpose.
- **Funeral Directors and Organ Donation Organizations**. We may disclose your PHI to enable a funeral director to carry out his or her lawful duties. PHI may also be disclosed to organ banks for cadaveric organ, eye, bone, tissue and other donation purposes.
- **Research.** We may disclose your PHI for certain medical or scientific research where approved by an institutional review board and where the researchers have a protocol to ensure the privacy and security of your PHI.
- **Serious Threats to Health or Safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Military and National Security Activities.** We may disclose the PHI of members of the armed forces for activities deemed necessary by appropriate military authorities to assure proper execution of military missions. We also may disclose your PHI to certain federal officials for lawful intelligence and other national security activities.
- **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation laws.
- **Inmates of a Correctional Facility:** We may use or disclose PHI if you are an inmate of a correctional facility and our practice created or received your PHI in the course of providing care to you while in custody.

- **US Department of Health and Human Services:** We must disclose your PHI to you upon request and to the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with privacy and security laws.
- **Disaster Relief Activities:** We may disclose your PHI to local, state or federal agencies engaged in disaster relief and to private disaster relief assistance organizations (such as the Red Cross if authorized to assist in disaster relief efforts).

7. Your Rights Regarding PHI

- **Right to Request Restrictions for Certain of Uses and Disclosures.** You have the right to request that we not use or disclose your PHI unless such a use or disclosure is required by law. Such a request must be made in writing and include the specific PHI you wish restricted as well as the individual(s) who should not receive the restricted PHI. If we agree to your request, we will not use or disclose the restricted PHI unless it is necessary for emergency treatment. However, we are not required to agree to your requested restriction except in the case of restricting disclosure of PHI to a health plan as described below.

  If you request a restriction on certain uses and disclosures of your PHI to a health plan for a particular health care item or service where said health care item or service is paid for out of pocket and in full, we will abide by your request. Such a request must be made in writing to the practice Privacy Officer. Your request must describe in a clear and concise fashion the health care item or service you wish restricted.
- **Right to Access.** You have the right to inspect and obtain a copy of your PHI. You may request copies of your PHI in either paper or electronic form. In very limited circumstances, we may deny access to your PHI. To request access to your PHI, please submit a request in writing to the practice Privacy Officer including whether you want your copy in electronic or paper form. We will respond to your request as soon as possible, but no later than 30 days from the date of your request. If access is denied you will receive a denial letter within 30 days. If access is denied, an appeals process may be available in certain cases. We have the right to charge a reasonable fee for providing copies of your PHI (and for electronic media, if applicable). Furthermore, you may request that a copy of your PHI be transmitted directly to a third party provided such request is made in writing, signed by you and clearly identifies the designated third party and location to send your PHI.
- **Right to Confidential Communications.** You have the right to request to receive communication of PHI by alternative means or at alternative locations. For example, you may wish your bill to be sent to an address other than your home. Such requests must be made in writing to the practice Privacy Officer. We will not require an explanation of your reasons for the request, and will accommodate reasonable requests.
- **Right to Amend.** You have the right to request that we amend your PHI. Your request must be made in writing. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. If we deny your request for amendment, you have the right to submit a written statement disagreeing with the denial. Nephrology Associates of Central Florida, P.A. has the right to submit a rebuttal statement. A record of any disagreement regarding amendments will become part of your medical record and may be included in subsequent disclosures of your PHI.
- **Right to an Accounting of Disclosures.** Subject to certain limitations, you have the right to a written accounting of disclosures by us of your PHI for not more than 6 years prior to the date of your request. Your right to an accounting applies to disclosures other than those made for purposes of treatment, payment, or health care operations. Please make your request in writing to the practice Privacy Officer. We will respond to your request as soon as possible, but no later than 60 days from the date of your request. We will provide you with one accounting every 12 months free of charge. We will charge a reasonable fee based upon our costs for any subsequent accounting requests.
- **Right to a Copy of our Notice of Privacy Practices.** We will ask you to sign a written acknowledgement of receipt for our Notice of Privacy Practices. We may update this Notice of Privacy Practices at any time. Upon your request, we will provide you with a current copy of this Notice.
- **Right to Notice of Breach.** You have a right to receive notice if there has been a breach of your unsecured PHI.

8. Complaint Procedure

- **Within our Practice:** If you have a complaint about the denial of any of the specific rights listed above, about our Notice of Privacy Practices, or about our compliance with state and federal privacy laws you may receive more information about the complaint process by contacting the practice Privacy Officer at 407-894-4693.
- **Outside our Practice:** If you believe that Nephrology Associates of Central Florida, P.A. is not complying with its legal obligations to protect the privacy of your PHI, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.
- We will not retaliate against you for filing a complaint.

9. Effective Date.

- This Notice is effective as of September 23, 2013.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Nephrology Associates of Central Florida, P.A.'s *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Nephrology Associates of Central Florida, P.A. may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Nephrology Associates of Central Florida, P.A.'s *Notice of Privacy Practices* by submitting a request in writing for a current copy of Nephrology Associates of Central Florida, P.A.'s *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For Nephrology Associates of Central Florida, P.A. Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Nephrology Associates of Central Florida, P.A. made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

Nephrology Associates of Central Florida, P.A.

Diseases of the Kidney and Hypertension

Dear Valued Patient,

Your health care is very important to us. Please note the following:

- Refill requests- Refills should be requested through your pharmacy. If you choose to contact our office for refills, please leave **one** message that includes the medication(s) needed, the dose, how many times a day you take the medication and your pharmacy information. **You will not receive a call back. Refill requests may take up to 48 hours to complete. Please check with your pharmacy before calling again.**

- Lab orders- We require a 3-business day advance notice for all lab orders. Standing orders are valid for 6 months; please note the expiration date of your order to avoid the need for last minute order requests.

- Lab results- You will only receive a call with lab results if there are orders from your physician. If you do not receive a call, please apply the "no news is good news" rule. If you would still like to review your lab results, they are available on MyChart. If you have not been set up for MyChart, please speak with our front desk staff to assist you.

We look forward to taking care of your health care needs!

Sincerely,

Nephrology Associates of Central Florida, P.A.