ALBEMARLE NEPHROLOGY, PLLC

PATIENT INFORMATION SHEET

DATE: _____ Who is your Primary Care Physician? _____

FULL NAME: _____

FIRST MIDDLE LAST

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

HOME PHONE#: _____ CELL PHONE#: _____

EMAIL ADDRESS: _____

PLEASE CHECK ONE: ( ) SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED

MAILING ADDRESS: _____ SEX: _____ RACE: _____

_____

EMPLOYER: _____ Work #: _____

DO YOU HAVE A MEDICAL POWER OF ATTORNEY? PLEASE LIST: _____ DNAR: Y N

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE# _____

(Please have Insurance cards and Driver's license available for scanning)

ALBEMARLE NEPHROLOGY, PLLC

Insurance Assignment & Release Authorization

I, the undersigned, have insurance with _____

and assign directly to **ALBEMARLE NEPHROLOGY, PLLC** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I further authorize **ALBEMARLE NEPHROLOGY, PLLC** to disclose information in my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records, to other physicians and healthcare providers to whom **ALBEMARLE NEPHROLOGY, PLLC** may refer me for treatment.

_____ _____

DATE SIGNATURE OF INSURED/GUARDIAN

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor. I accept full financial responsibility for all charges not covered by insurance.

_____ _____

DATE SIGNATUR E OF INSURED /GUARDIAN

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, have received a copy of Albemarle Nephrology's Notice of Privacy Practices.

_____ _____

DATE SIGNATURE

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY[1]

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care: _____.

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of Albemarle Nephrology, PLLC unless and until I notify Albemarle Nephrology, PLLC in writing of any changes.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

[1] Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

PATIENT ACKNOWLEDGMENT AND CONSENT

For New Patients Only

I have been given a copy of Albemarle Nephrology, PLLC's Notice of Privacy Practices, version effective September 1, 2013. I consent to the uses and disclosures of my health information as outlined in the Notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR ALBEMARLE NEPHROLOGY, PLLC's USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

_____

Karl Brandspigel, MD, FACP
Ravi Ramsamooj, MD

Kidney Disease • Hypertension
Internal Medicine • Metabolism

Greg Warren, DO
Lori Kitner, ANP-C

Stones & Bones • Preventive Care
Nutrition • Critical & Palliative Care

CONSENT FOR RELEASE OF MEDICAL RECORDS

FROM: Patient's Name _____

Patient's Address _____

Patient's Birth Date _____

Patient's Social Security Number _____

TO: _____

_____

_____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who received the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

I consent to release my prescription history from any and all external sources.

Please send copies of all requested information as soon as possible to the address listed below:

- ☐ *SEND ALL MY RECORDS*
- ☐ *SEND RECORDS FROM (DATE)*_____ *TO (DATE)* _____
- ☐ *SEND RECORDS TO:*

_____

_____

_____

_____ _____ _____

Patient's Name *Date* *Witness*