Kidney Dialysis and Hypertension Specialists

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we may use and disclose your health information.

Without specific written authorization, we are permitted to sued and disclose your health care records for the purpose of treatment, payment and health care operations.

- TREATMENT means providing, coordinations, or managing health care and related services by one or more health care providers. Examples of treatment would include breathing treatments, immunizations, diagnostic testing services, etc.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for your medical services.
- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of out documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related issues, and/or provide information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when health authorities that are authorized by law to collect information to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have certain rights in regard to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations
- The right to access, inspect, and copy your PROTECTED HEALTH INFORMATION
- The right to request an amendment to your PROTECTED HEALTH INFORMATION
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide your with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of Notice of Privacy Practices currently in effect. We reserve the right to change the terms of your Notice of Privacy Practices and to make the new provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a copy of the Revised Notice from this office.

You have a right to file a formal, written complaint with use at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
HIPAA Privacy officer, Office Manager
Kidney Dialysis and Hypertension Specialists

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Kidney Dialysis and Hypertension Specialists
Luana Pillon, M.D.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Your protected health information will be used by Kidney Dialysis & Hypertension Specialists or disclosed to others for the purpose of treatment, obtaining payment, or supporting day-to-day health care operations of the practice.

NOTICE OF PRIVACY PRACTICE

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed.

REQUESTING A RESTRICTION OF THE USE OR DISCLOSURE OF YOUR INFORMATION:

You may request a restriction on the use or disclosure of your protected health information. Kidney Dialysis & Hypertension specialists may or may not agree to restrict the use or disclosure of your protected health information. If kidney dialysis & Hypertension Specialists agree to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restitution 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 the date on which your revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICE:

Kidney Dialysis & Hypertension Specialists reserves the right to modify the privacy practices outlines in this notice.

AUTHORIZED PERSONS TO RECEIVE DISCLOSED INFORMATION

NAME:_____ RELATIONSHIP: _____
PERSON WHO IS AUTHORIZED TO RECEIVE RECORDS — RELATIONSHIP TO PATIENT

NAME:_____ RELATIONSHIP: _____
PERSON WHO IS AUTHORIZED TO RECEIVE RECORDS — RELATIONSHIP TO PATIENT

NAME:_____ RELATIONSHIP: _____
PERSON WHO IS AUTHORIZED TO RECEIVE RECORDS — RELATIONSHIP TO PATIENT

NAME:_____ RELATIONSHIP: _____
PERSON WHO IS AUTHORIZED TO RECEIVE RECORDS — RELATIONSHIP TO PATIENT

I have reviewed this consent form and give my permission to Kidney Dialysis & Hypertension Specialist to use and disclose my health information in accordance with it.

NAME:_____DATE: _____
PATIENT FULL NAME (PRINT)

SIGNATURE: _____

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS

Dr. Luana Pillon, MD Nephrologist (Internal Medicine)
Phone: 702-600-8086
Fax: 866-606-0690

Welcome

We would like to formally welcome you to Kidney Dialysis & Hypertension Specialists where we strive to treat you with the best time and care we can possibly provide. We strive to spend the time required by each patient for their personal case. It is understood that you may have to stay in treatment for a longer time than expected or scheduled in order to ensure proper care as each patient and case is unique.

Authorization for Treatment:

By signing this document, you are agreeing to treatment. You, the patient, agree and are responsible for coming to treatment on time, bringing in any documentation required for treatment. Documentation required for treatment includes but is not limited to: an identification card, updated insurance card, and a current referral for treatment.

Assignment of Insurance Benefits and Release information:

In order to receive payment from your insurance company, you agree to release your private health information to the office staff for the sole purpose of obtaining payment for treatment.

Personal Valuables: All items brought in with you to treatment are your responsibility. We are not liable for any loss or damages that occur to your property while you are in our facility.

Dependents/Visitors:

You may bring visitors with you to the treatment room, it is understood that you have given them consent to hear about your PERSONAL AND PROTECTED HEALTH INFORMATION. It is understood that any person accompanying you to appointments is already privy to your personal information, and their presence is seen as implied consent.

Notice of Privacy Policy:

In the case that our Privacy Policy is updated, it will be posted. However, you may request full text of our Privacy Policy at any time during your treatment.

Release of Information:

I authorize Dr. Pillon to release any and all information regarding my appointments, treatments, and financial responsibilities to the following person(s) for up to 7 years from the date of my signature below.

Name: _____ Relation:_____ DOB:_____

Name: _____ Relation:_____ DOB:_____

I HAVE READ AND UNDERSTOOD ALL THE ABOVE INFORMATION. I ACCEPT ALL TERMS WITHIN.

NAME:_____DATE: _____
PATIENT FULL NAME (PRINT)

SIGNATURE: _____

FINANCIAL POLICY

Financial Agreement

It is the patient's responsibility to bring in all documentation in order to be treated. It is understood and expected that the patient is responsible for their care, including but not limited to abiding by all of their insurance company policies. If a patient fails to follow protocol, and correct procedure via your insurance company you agree and understand that you are financially liable and responsible for all expenses. You the patient are ultimately responsible for any fees and charges incurred at your scheduled visit.

Credit/Debit Card Payments

All payments will be processed at the time of your scheduled appointment.

Cancellation / No-Show Policy

All cancellations must be given with at least 24 hour notice. Otherwise, we reserve the right to charge a no call no show fee of $50.

Delinquent and Collection Accounts

1. An account becomes delinquent when the minimal monthly payment has not been recievd within 30 days of the "Statement Date".
2. An account delinquent for 30 days may be charged a delinquent handling fee of 20% pf the account balance of $50.00 (whichever is greater).
3. Delinquent accounts 60 days past due will accrue interest at the rate of 24% per annum, until paid in full.
4. An account delinquent for 60 days will be assigned to AcctCorp of Southern Nevada. If your account becomes responsible for all collection fees associated.
5. If legal action is required to collect your account, you will be responsible for any incurred legal fees. This will include but will not be limited to, attorney fees, court fees, service fees, skip tracing fees, and any miscellaneous fees the court of jurisdiction may award.

Exceptions and Exemptions

- Allowed charges under Medicare Title XIX (Nevada Medicaid) contracts;
- There may be exceptions to all or part of the account; and
- Balances not paid by your insurance carrier within 90days automatically become your responsibility.

In the event my account becomes a delinquent account or a collection account, I agree to pay _____ or/and it's designated Collection Agency all incurred delinquent account handling fees, collection handling fees, legal fees, incurred delinquent account handling fees, and incurred collection costs as set forth in the above "Financial Policy" as it relates to "Delinquent and Collection Accounts".

Signature of Responsible Party(ies)_____ Date _____

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS

Name:_____
(LAST) (FIRST) (MIDDLE)

Address:_____
(STREET) (APT #) (CITY) (STATE) (ZIP)

E-Mail Address:_____
Home Phone: (____) - _____ - _____ Cell Phone: (____) - _____ - _____ Work Phone: (____) - _____ - _____
SS#: _____ - ___ - _____ Date of Birth:_____ Sex: M / F / Other: _____

Marital Status: Single Married Divorced Widowed

Sexual Orientation: Heterosexual Homosexual Other:_____

Race: American Indian or Alaska Native Asian Black Hispanic/Latino Pacific Islander White

Ethnicity: Hispanic Non-Hispanic

Employer:_____ Employer Phone:(____) - _____ - _____Occupation:_____

Employer Address:_____
(STREET) (APT #) (CITY) (STATE) (ZIP)

Referred By: _____ Fax #:_____ Reason for referral: _____

Guarantor & Emergency Contact

Guarantor Name : _____ DOB: _____ SS#:_____-____-_____
Relationship:_____ Employer:_____ Occupation:_____
Emergency Contact :_____ Relationship:_____ Phone #: _____

Insurance Information

Primary Insurance Co.: _____ Employer: _____
Member ID:_____ Group ID_____Phone Number: _____
Insurance Company Phone #_____ Policy #_____
Name of Insured: _____ Insured D.O.B _____ Relation: _____
Insured SS#_____ Date(s) Effective: _____ Type/Plan: _____
Insurance Company Phone #_____ Policy #_____

Secondary Insurance Co.: _____ Employer: _____
Member ID:_____ Group ID_____Phone Number: _____
Insurance Company Phone #_____ Policy #_____
Name of Insured: _____ Insured D.O.B _____ Relation: _____
Insured SS#_____ Date(s) Effective: _____ Type/Plan: _____

The above information is complete and correct. **AUTHORIZATION AND ASSIGNMENT OF BENEFITS:** I hereby authorize release of information necessary to file a claim. I understand that I am responsible I am responsible for any deductibles, co-payments, or amounts for services not covered by my insurance plan. All professional services rendered are charged to patient, or guardian (if a minor). In the event of collection proceeding due to lack of payment, there may be additional charges for any and all collection fees. I also acknowledge if I provide false information or do not update my information regarding insurance I will be charged for the services in full. A copy of the signature is as valid as the original. I authorize the release of any medical records or information to process my claims.

Signature: _____ Date: _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS

Name: _____ Date:_____

Please fill in the following list of your current prescribed medications, along with over the counter medication and any supplements that you are currently taking:

List of Medications				
Medication Name	Dates Taken	Dosage	Frequency	Reason for Taking

I certify that the information above is correct and complete.

Signature: _____ Date:_____

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS

LUANA PILLON, MD
Phone: 702-600-8086 | Fax: 866-606-0690

Patient Name_____ Date:_____
E-Mail Address:_____
Home Phone: (____) - _____ - _____ Cell Phone: (____) - _____ - _____ Work Phone: (____) - _____ - _____

Preferred Pharmacy

Name:_____ Phone #_____ Fax #_____
Address:_____
(STREET) (SUITE #) (CITY) (STATE) (ZIP)

Preferred Lab

Name:_____ Phone #_____ Fax #_____
Address:_____
(STREET) (SUITE #) (CITY) (STATE) (ZIP)

Physicians that you would like to receive a copy of your office visit notes:

Primary Care Physician_____ Phone #:_____ Fax #:_____

Cardiologist:_____ Phone #:_____ Fax #:_____

Physician Name/Specialty:_____ Phone #:_____ Fax #:_____

Physician Name/Specialty:_____ Phone #:_____ Fax #:_____

Physician Name/Specialty:_____ Phone #:_____ Fax #:_____

Physician Name/Specialty:_____ Phone #:_____ Fax #:_____

Physician Name/Specialty:_____ Phone #:_____ Fax #:_____

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS

Medical History

Patient Name: _____ DOB:_____

Allergies: Y / N
If yes, please include allergen name, and reaction: _____
_____
_____

Medical History: Do you have or have you ever had any of the following?

- ❑ Anemia_____
- ❑ Atrial fibrillation_____
- ❑ Arthritis Conditions_____
- ❑ Asthma_____
- ❑ Autoimmune Disorder_____
- ❑ Bleeding Problems_____
- ❑ CAD_____
- ❑ Cancer_____
- ❑ Cardiac Arrest_____
- ❑ Chronic Fatigue Syndrome_____
- ❑ COPD_____
- ❑ Congestive Heart Failure_____
- ❑ Diabetes: I / II_____
- ❑ Drug/Alcohol Abuse_____
- ❑ Edema/Swelling_____
- ❑ Electrolyte imbalance_____
- ❑ Enlarged Prostate/BPH_____
- ❑ Erectile Dysfunction_____
- ❑ GERD_____
- ❑ Hepatitis_____
- ❑ High Cholesterol_____
- ❑ Hypertension_____
- ❑ Illicit Drugs_____
- ❑ Infection problems_____
- ❑ Kidney Problems_____
- ❑ Kidney Transplant_____
- ❑ Liver Disease_____
- ❑ Lupus_____
- ❑ Marijuana/THC_____
- ❑ Neuropathy_____
- ❑ Nephrectomy_____
- ❑ Organ Injury_____
- ❑ Osteoporosis_____
- ❑ Stroke_____
- ❑ Thyroid disease_____
- ❑ Vascular Disease_____
- ❑ Other:_____

_____

Pain Medication

Do you take NSAIDs (i.e. advil, ibuprofen, naproxen)? Y / N
If yes, which ones and how often?_____
_____

Surgical & Hospitalization History

Date Hospital Reason for Hospitalization / Surgery

Date	Hospital	Reason for Hospitalization/Surgery

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS

Medical History, continued

Patient Name:_____ DOB:_____

Current Compaint(s):

_____

_____

_____

Family History

Does anyone in your family have any of the following? Have they been diagnosed or treated for them previously?

Illness	Relation & Explanation
Cancer	
Coronary Artery Disease	
Diabetes	
Hypertension	
Peripheral Disease	
Renal Dysfunction	
Stroke	
Thyroid Disorder	
Other (please specify condition(s))	

Any other Family History that we might need to know about:

_____

_____

_____

Emergency Contact & Power of Attorney Information

Do you have a durable power of attorney or living will? Y / N

If yes, please provide a copy. If not, would you like information on one? Y / N

Would you like all lifesaving procedures if you are unable to make these decisions (Eg. CPR, Ventilator, Dialysis, etc.)? Y / N

EMERGENCY CONTACT:

Name:_____ Relationship:_____ Number:_____

I, _____ certify that all the information entered above and throughout is complete and correct.

SIGNATURE:_____ DATE:_____

KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS
Phone: 702-600-8086 | Fax: 866-606-0690

MEDICAL RECORDS REQUEST FORM

DATE:_____
DR:_____
FAX:_____

PLEASE FAX THE FOLLOWING RECORDS REQUEST TO FAX #: 866-606-0690

PATIENT NAME: _____ DOB:_____

Medical Records Requested:

- ❑ LABS
- ❑ IMAGING (MRI, X-RAY, ULTRASOUND, CT, etc.)
- ❑ OFFICE NOTES
- ❑ HOSPITAL RECORDS
- ❑ OTHER:_____

_____

_____

I, _____ HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL REQUESTED MEDICAL RECORDS TO KIDNEY, DIALYSIS & HYPERTENSION SPECIALISTS.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE