Midwest Nephrology & Hypertension Associates

Dr. Ifath Bashiruddin Dr. Rashid Dalal Dr. Marcia Wendland
Ph: 618-239-9500 **Fax: 618-239-9555**
www.midwestnha.com

Patient Registration

Patient Name: _____
Last First M.I

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

SSN: _____ Date of Birth: ____ /____ / ____ Sex: M F

Martial Status: ____ S ____ M O Spouse's Name: _____

Primary Doctor: _____ Referred By: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone#: _____

Person Responsible for Bill: _____

Address if different from patient: _____

Insurance Information: Please have your insurance card available to copy for our records.

Primary Ins: _____
Name Address City State Zip Code

Identification Number (SSN or Plan#) _____

Owner of Policy (Name) _____ Date of Birth ____ / ____ / ____

Secondary Ins: _____
Name Address City State Zip Code

Identification Number (SSN or Plan#) _____

Owner of Policy (Name) Date of Birth / /

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Employer Information:

Patient's Employer: _____

Spouse's Employer: _____

Please Sign and Date

_____ _____

Signature Patient, Parent, or Legal Guardian Date

Contact Preferences

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please check the boxes next to each method of communication you would like us to use:

Home

☐OK to leave message with detailed information
☐Leave message with call-back number only
☐OK to mail

Work

☐OK to leave message with detailed information
☐Leave message with call-back number only
☐OK to mail
☐OK to fax

Cell phone

☐OK to leave message with detailed information
☐Leave message with call-back number only

Other:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Please see the accompanying Notice of Privacy Practices for more information on our policies. Please list any individuals among your friends, family, or caretakers with whom we are authorized to discuss your protected health information. You should write your spouse's name here if he/she is authorized. This is optional; if you do not wish us to discuss your PHI with anyone but yourself and your healthcare providers please leave this blank:

Name	Phone Number	Relationship

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By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Today's Date

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Authorization

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or to another physician's office. I also permit a copy of this authorization to be used in place of the original. This agreement will remain in effect until revoked by me in writing.

SIGNATURE:_____ DATE:_____

I,_____, hereby request that you release to

Midwest Nephrology and Hypertension Associates/Infectious Disease Consultants Group
4550 Memorial Drive, Ste. 360
Medical Office Building One
Belleville, IL 62226
Phone (618) 239-9500
Fax (618) 239-9555

A report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me from _____to_____.

_____ _____
(Date of Request) (Patients Signature)

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Authorization Form
Release of Confidential Health Information

I, _____ , hereby authorize _____

to release to:

(Name of Patient of Authorized Agent) (Name of Physician)

_____

(Name of Health Care Facility, Physician, Agency, etc.)

_____

(Street Address, City, State, and Zip Code)

the following information contained in the patient record of _____

(Patient's Name)

born ___ / ___ / ___ , residing at _____

:

(Month, Day, Year) (Street Address, City, State, and Zip Code)

- ☐ The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

To be disclosed, the following items must specifically be checked:

- ☐ Mental Health Treatment Records
- ☐ Alcoholism Treatment Records
- ☐ Drug Abuse Treatment Records
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS) records
- ☐ Laboratory Reports
- ☐ X-Ray Reports
- ☐ Operative Notes
- ☐ Genetic Testing
- ☐ Other: _____

The above information for the following period of time shall be released:

From: _____ to _____ .

(Date) (Date)

The purpose(s) of the authorization is (are) _____

_____

_____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

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I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosed to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

(11/09)

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Privacy Practice Notice
Patient Copy

Notice available upon request beginning on the revision's effective date. The revised notice is posted in the practice's reception area and made available to all patients, including those who have received a previous Notice. Upon receipt of a revised Notice, a patient is asked to acknowledge receipt of the Notice.

Complaints: The practice allows all patients and their agents to file complaints with the practice and with the Secretary of the Federal Department of Health and Human Services (DHHS). A patient or his or her agent may file a complaint with the practice whenever he or she believes that the practice has violated their rights.

Complaints to the practice must be in writing, must describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware or should have become aware of the violation. Complaints must be addressed to the attention of the practice's privacy office at the practice address. The practice investigates each complaint and may, at its discretion, reply to the patient of the patient's agent.

The practice does not take any adverse action against any patient who files a complaint (either directly or through an agent) against the practice.

Contact Person: The practice has a privacy officer that serves as the contact person for all issues related to the Privacy Rule. If you have any questions about this Notice, pleas contact our privacy officer at (618)239-9500 or by mailing it to Midwest NHA & Infectious Disease Consultants Attention: Privacy Officer - 4550 Memorial Drive – Medical Building A – Suite 360, Belleville, Illinois 62226.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The practice reasonably ensures that the protected health information (PHI) it requests, uses, and discloses for any purpose is the minimum amount of PHI necessary for that purpose.

The practice treats all qualified individuals as personal representatives of patients. The practice generally allows individuals to act as personal representatives of patients. The two general exceptions to allowing individuals to act as personal representatives relate to the unemancipated minors and abuse, neglect, or endangerment situations.

The practice makes reasonable efforts to ensure that protected health information is only used by and disclosed to individuals that have a right to the protected health information. Toward that end, that the practice makes reasonable efforts to verify the identity of those using or receiving protected health information.

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Uses and Disclosures – Treatment, Payment, and Health Care Operations

The practice uses and discloses protected health information for payment, treatment, and health care operations. Treatment includes those activities related to providing services to the patient, including releasing information to other health care providers involved in the patient's care. Payment relates to all activities associated with getting reimbursed for services provided.

2010

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

Individual refused to sign.
Communications barriers prohibited obtaining the acknowledgement.
An emergency situation prevented us from obtaining acknowledgement
Other (Please specify).

_____
_____
_____

_____ _____
Office Signature Date