Nephrology Hypertension Associates of CNY

Welcome to our practice. Your appointment with Dr._____is scheduled for

_____ in our _____office.

PLEASE COMPLETE THIS PACKET AND BRING IT WITH YOU. WE ASK THAT YOU ARRIVE 15 MINUTES BEFORE YOUR SCHEDULED TIME SO THAT WE MAY PROCESS YOUR PAPERWORK AND OBTAIN A URINE SAMPLE BEFORE YOU SEE THE PROVIDER. PLEASE DO NOT URINATE CLOSE TO YOUR APPOINTMENT TIME SO YOU ARE ABLE TO VOID WHEN YOU ARRIVE. DUE TO THE LENGTH AND COMPLEXITY OF YOUR NEW PATIENT APPOINTMENT, IF YOU ARRIVE LATE YOU MAY BE ASKED TO RESCHEDULE.

Please bring a self-updated list of your medications or medication bottles to you appointment. We kindly ask that you do not bring a list from another provider's office as these are not always current and/or accurate.

You will need to have your insurance cards and picture ID, please have these ready when you check in. Co-payments are due at the time of service before you see the provider. As a participating provider with your insurance company, we are required to collect these from you.

You will be scheduled with a doctor for your first appointment and secondary follow up appointment to go over any test results. Your routine follow up care will be scheduled with one of our highly qualified physicians assistants or nurse practitioners. They will work together with the physician to give you the best care and this also allows us to schedule your return appointments in an efficient and timely manner.

Please give at least a 24 hour notice if you cannot make your appointment. If you reschedule or cancel the same day, there will be a new patient fee of $25. If you do not contact us and do not show up, there will be a new patient no show fee of $50.

If you have any questions or concerns, please feel free to call our office. We look forward to seeing you soon.

Locations

6846 Buckley Road North Syracuse, NY 13212	Phone: 315-410-6400
6 Euclid Ave Building 2, Suite 1 Cortland, NY 13045	Phone: 607-756-0161
61 Delano Street Pulaski, NY 13142	Phone: 315-410-6400

Nephrology Hypertension Associates of CNY, PC

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Nephrology Hypertension Associates of CNY, PC** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Nephrology Hypertension Associates of CNY, PC** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **Nephrology Hypertension Associates of CNY, PC** to access my electronic health information through HealtheConnections.

☐ **3. I DENY CONSENT** for **Nephrology Hypertension Associates of CNY, PC** to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: **315-410-6400**; or visit HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation. If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

NEPHROLOGY HYPERTENSION ASSOCIATES OF CNY, P.C.

Last Name	First	M	Sex	DOB
Street Address	City	State	Zip	County
Home Phone	Work Phone			Cell Phone
Pharmacy Name	Address			Phone Number
Race	Ethnicity			Languages Spoken
Emergency Contact	Phone Number			Relationship
Primary Care Physician				Referring Physician
Primary Insurance	Policy Number	Insured Name	DOB	Effective Date
Secondary Insurance	Policy Number	Insured Name	DOB	Effective Date
Tertiarty Insurance	Policy Number	Insured Name	DOB	Effective Date

If you are a minor and are/or are covered under your parents insurance:

Parent Name:	Address	Phone Number

I herby authorize Nephrology Hypertension Associates of CNY, P.C. to release any medical information pertaining to my treatment to insurance, medical providers, pharmacies, state and federal agencies as needed to secure reimbursement. I herby authorize my health insurance carrier(s) to make payment of benefits directly to Nephrology Hypertension Associates of CNY, P.C. for services rendered.

Patients or Patient Representative Signature Date

Nephrology Hypertension Associates of CNY

Salil Gupta, M.D. FACP
Pawan K. Rao, M.D., FASN
Board Certified in Nephrology
Diplomates American Board of Internal Medicine

Andrea J. Noffey, RPA-C
Jaimie W. Newman, RPA-C
Maureen D. Lupica, FNP-C
Jaime M. Sheffler, FNP-C
Christopher J. O'Brien, RPA-C

Financial Consent

Patient's Name: DOB:

As a patient, you have certain responsibilities in regards to your insurance contract:

1. To pay amounts not covered by your policy including applicable copays, co-insurance and deductibles.
2. To be knowledgeable about your plan's covered and non-covered services.
3. To provide your provider's office with accurate and up to date insurance coverage.

By signing this patient financial agreement, you agree to be billed as a self- pay patient should you fail to supply valid, accurate insurance information at the time of service.

Due to strict timely filing rules and government regulations, you also agree to notify us right away- no later than 30 days after you receive notification that you are eligible for additional coverage(s) including Medicaid, Medicare, Medicare Advantage plans or other supplemental policies. Should you fail to give us timely notification of additional coverage (including Medicaid or Medicare eligibility) you will be considered a self -pay patient and agree to be held personally responsible for payment of your charges.

Signature: _____ Date: _____

For Office Use Only

Medent Acct Number_____

NEPHROLOGY HYPERTENSION ASSOCIATES OF CNY, P.C.

Consent to Use and Disclosure of Protected Health Information

Your protected health information will be used by Nephrology Hypertension Associates of CNY, P.C. or disclosed to others for the purposes of treatment, obtaining payment and coordination of care.

Notice of Privacy Practices

You can review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. This information is displayed in our office and a copy is available to you upon request.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Nephrology Hypertension Associates of CNY, P.C., may or may not agree to restrict the use or disclosure of your protected health information. There may be extenuating circumstances that by law, we may have to disclose your information regardless of your restrictions. If we agree to your request, the restrictions will be binding to the practice. Use or disclosure of protected information in violation of an agreed upon restriction 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 disclose 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 Practices

Nephrology Hypertension Associates of CNY, P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature of the patient or patients representative:.

Print name of patient

Signature of patient or patients representative (must be legal)

Relationship to patient Date

Please list the name of the person(s) that you wish to give permission to receive information about your medical care on your behalf.

Name/Relationship Phone number

Name/Relationship Phone number

Name/Relationship Phone number

Name/Relationship Phone number

Patient signature Date

NEPHROLOGY HYPERTENSION ASSOCIATES OF CNY, P.C.

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and your understanding of our office policies.

Prescriptions: We require 2-3 days notice for all prescription refills. Please monitor your medications so you do not run out. Most prescriptions are done electronically and will be sent directly to your pharmacy for you. We do not mail prescriptions to patient's homes.

Lab/Test Results: Please give you five days for tests results to be available. We do not routinely call patients with test results unless there is a medical issue that needs to be addressed. Most lab/test results will be discussed at your next scheduled appointment.

Completion of Forms: We are happy to complete any forms or paperwork you may need. We charge a fee of $10 per form that must be paid before the forms are released. This cost is solely the responsibility of the patient, this fee does not get billed to your insurance company. We require at least five business days to complete any forms that you need.

Insurances: We participate with most insurance companies and will bill these directly for you. It is your responsibility to make sure we have the correct insurance information each time you come to your appointment. We do require a copy of your card so please bring all information with you. We also suggest that patients get familiar with their insurance policies and coverage.

Payment Policy: All co-payments and balances are due at time of service. Any charges left on your account after insurance has paid, is part of a deductible or you are a self-pay patient, are solely your responsibility. If you fail to pay on your account, this will affect the ability to schedule future appointments. We do not mail billing statements of $10 or less, you will be notified in the office if you have a small balance when you arrive for your appointment.

Scheduled Appointments: Our office requires 24 hour notice if you do not plan on keeping your appointment. Without notice, there is a $15 cancellation or reschedule fee. If you do not show for your appointment, there is a $25 fee for established patients and $50 fee for new patients. These charges will not be billed to your insurance company. Failure to pay may affect your ability to schedule future appointments.

I have read and understand the policies set forth by Nephrology Hypertension Associates of CNY, P.C.

_____

Signature of Patient or Patient Representative Date

Name:

DOB:

Medication List

NEPHROLOGY HYPERTENSION ASSOCIATES OF CNY, P.C.
MEDICAL HISTORY QUESTIONAIRE

Patient Name: _____ DOB: _____

Sex: M or F Height: _____ Weight: _____

Social History:

Martial Status: _____ Children: _____ Occupation: _____

Smoker: Y or N How Long: _____ How Much: _____ Quit: _____

Alcohol Use: Y or N Illegal Drugs: Y or N

Family Medical History: (If deceased, please give at what age and cause if known)

Mother: _____ Father: _____

Siblings: _____

Is there any family history of Kidney problems? _____

Please list any other family history that is important for us to know:

_____

Past Medical History:

Do you have or ever had any of the following: Please Circle

High Blood Pressure
Diabetes
Kidney Stones
Blood in your urine
Protein in your urine
Eye Problems
Thyroid Problems
GERD/Acid Reflux
Diverticulosis

Stroke
Seizures
Coronary Artery Disease
Irregular Heartbeat
Heart Attack
Congestive Heart Failure
Hepatitis
Blood Clots
Allergies

Anemia or Blood Disorder
High Cholesterol
Emphysema
Asthma
Cancer
Osteoporosis
Peptic Ulcers
Arthritis

Review of Systems:

Do you suffer from any of the following: (Please circle any or all that apply)

Constitutional: Fevers Weight Gain/Loss Loss of Appetite Weakness Fatigue

Eyes: Double Vision Blurry Vision Difficulty Seeing Watery Eyes Itchy Eyes

ENT: Sinus Problems Hearing Problems Hoarseness Chronic Ear or Throat Issues

Heart: Chest Pain Palpitations Fast or Irregular Heartbeat

Lungs: Shortness of Breath Cough Coughing up blood

Skin: Rashes Ulcers Lesions that to not heal

Digestive: Abdominal Pain Nausea Vomiting Diarrhea Constipation Blood in Stool

Neurologic: Loss of Balance Numbness Tingling Memory Loss Tremors

Urologic: Pain When Urinating Foamy Urine Blood in Urine Increased Frequency Incontinence Incomplete Emptying of Bladder

Psychiatric: Depression Anxiety Mood Swings Sleep Problems

Musculoskeletal: Joint Pain Stiffness

Endocrine: Heat Intolerance Cold Intolerance Increased Thirst Increased Urination

Women:

Gynecologic: Last GYN Visit _____ Last Mammogram _____

Please list any other medical problems not listed above:

_____

Do you have any medications allergies? Y or N

Please explain:

_____

Please list any prior hospitalization or surgeries:

_____

_____

Have you ever been seen by a kidney doctor before? Y or N

If yes please list name and date _____

_____

Do you take any medications for pain (including over the counter medication)? Y or N

Have you been on any medications that have been stopped recently? Y or N

If yes, please list _____

Have you had any recent radiology studies, scans or x-rays that required dye? Y or N

Do you have a pacemaker or any other metal parts in your body? Y or N

If yes, please list _____

Signature: _____ Date: _____

Signature of parent if patient is a minor:

_____ Date: _____