

Eastside Premier Nephrology & Hypertension

Dr. Ekundayo A. Falase, MD, FACP - Dr. Sitharam C. Nandigam, MD –

Dr. Yilikal T. Kassa, MD- Dr. Nardos Belayneh

Patient Information Sheet

ALL INFORMATION IS REQUIRED

Name: _____ Date of Birth: ____/____/____

Guardian: _____ Social Security #: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Information:

Home: _____ Cell: _____

Work: _____ Email: _____

Preferred Contact Method (circle one): Home Work Cell Email

Sex: _____ Race: _____ Ethnicity: Hispanic? Yes No

Marital Status: _____ Preferred Language: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name/City _____ Phone _____

Nearest Relative NOT Living with Patient: Name: _____

Phone: _____ Relationship: _____

Emergency Contact: Name: _____

Phone: _____ Relationship: _____

Employment Information (circle one):

Retired Full Time Part Time Not Employed Disabled Student

Insurance:

Primary: _____ Secondary: _____

Please Provide Staff with your Insurance Cards

Authorization to Release Information via Phone or second Party:

I hereby Authorize Eastside Premier Nephrology and/or it's agents to:

**Leave messages on my answering machine and/or call recording device:

Yes No

**I authorize the following family members to retrieve my medical information:

Eastside Premier Nephrology & Hypertension
Patient Release, Authorization, Responsibility and Assignment

1. Consent for Medical Treatment:

The undersigned hereby authorizes the attending physicians to furnish the necessary treatments, x-rays, ultrasounds, drugs and supplies, and diagnostic procedures ordered and/or performed by the attending physicians. I acknowledge that no assurance has been made to me as to the results of the treatment.

2. Authorization for the Release of Medical Information:

Authorization is hereby granted to Eastside Premier Nephrology & Hypertension and treating physicians to release my insurance company or companies, their agents, or other third party payers confidential information (including copies of records) as may be required or necessary for the completion of claim processing relative to my treatment at the center.

3. Assignment of Insurance Benefits and Guarantee of Payment:

The undersigned hereby assigns and authorizes payments directly to Eastside Premier Nephrology the insurance benefits otherwise payable to the undersigned. The undersigned remains financially responsible for any and all charges covered and/or not covered by this assignment of benefits and personally guarantees payment of all amounts not paid by the insurance. I, the undersigned, hereby instruct and direct my insurance company to pay Eastside Premier Nephrology and mail it to Eastside Premier Nephrology. If my current policy prohibits direct assignment to Eastside Premier Nephrology, I hereby instruct and direct my insurance company to make the benefit payable to me and to mail the check to me in care of Eastside Premier Nephrology. I hereby grant power of attorney to Eastside Premier Nephrology to endorse any and all checks made payable to me for medical benefits provided by Eastside Premier Nephrology. I authorize Eastside Premier Nephrology to initiate a complaint on my behalf to the insurance commissioner for any reason.

4. Past Due Accounts:

If your account becomes 60 days past due you will receive a final notice, then your account will be sent to a collection agency and a 29% fee will be added. You will be responsible for any collection charges incurred by the collection agency for your account.

5. Additional Charges:

If, for any reason, my check to this office is returned I will pay a \$35.00 returned check charge.

A photocopy of these assignments shall be valid as the original.

Signature of Patient or Guardian

Date

Signature of Witness

Date

Eastside Premier Nephrology & Hypertension

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Dr. Yilkal T. Kassa MD & Dr. Nardos K. Belayneh, MD

1612 Milstead Rd, Suite A Conyers GA 30012

Appointments, Medications, and Insurance Policies

MISSED APPOINTMENTS: In an effort to provide quality service, we require a 24 hour notice when cancelling or rescheduling an appointment. There will be a \$25.00 service charge fee for any appointments that are not cancelled within 24 hours of your scheduled appointment slot allotted for you. This amount must be paid upon arrival of your next visit along with any co-pays, deductible, or past due balances before service is rendered.

TARDINESS: If you are going to be late, please inform us in a timely manner. If you are less than 30 minutes late we will work you in accordingly. If more than 30 minutes late you may be rescheduled.

MEDICATIONS: We require all our patients to bring their medications to every appointment to ensure their safety and the patient's wellbeing. The doctors will not write any prescriptions or refills for patients who fail to bring their medications with them to their appointment. If you have any questions or concerns about this policy please speak to your doctor

INSURANCE: As a courtesy to you, our office will file your insurance claims to the appropriate insurance company. It is your responsibility to pay the amount that is due before seeing the physician.

Our patients are valuable to us and we strive to render all services in a fair manner. So, thank you for your compliance to these policies to help us better serve you.

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Information About Your Medical Record

- A medical record is the documentation of your health history. It contains notes your doctor has written, diagnoses, test results, medications, telephone messages and other important and personal information about your medical history.
- You will be given a print out of your Visit Note after your appointment upon request or you can access your information directly through your Patient Portal account via the Internet. We will also forward a copy of your Visit Note to your Referring and/or Primary Care physician.
- The Patient Portal will allow you to:
 - View health summary information in your electronic record: medication list at time of discharge, medical problem list, allergies, your lab results and imaging reports after your appointment with the doctor. This portal will not give you access to read your entire medical record.
 - View and update demographic / insurance information.
 - Print or save an electronic copy of the health summary, labs and imaging reports.
- Your Patient Portal account information will be given to you by the office staff. It is your responsibility to keep your username and password safe and secure.
- **PLEASE NOTE: A FACE TO FACE VISIT WITH YOUR PHYSICIAN IS ESSENTIAL TO YOUR WELL BEING. THEREFORE, YOUR VISIT NOTE, LAB AND IMAGING REPORTS WILL NOT BE AVAILABLE ON THE PATIENT PORTAL UNTIL AFTER YOUR SCHEDULED APPOINTMENT WITH THE DOCTOR.**
- You may use this print out or information you download from the Patient Portal for your own record keeping purposes or share it with other physicians involved in your care.
- ***This is your personal medical information.*** It is your responsibility to keep this information secure, safe and inaccessible to persons whom you do not want to know your personal information, regardless of whether you received a paper copy in our office or you download the information electronically to your own device. It is advised that you only access the Patient Portal from your own personal device and not a shared computer, such as at a library, to avoid unauthorized access.
- ***Eastside Premier Nephrology & Hypertension, PC is not liable for the loss, theft or access by unauthorized persons of your medical record.***
- If you have any questions or concerns please contact our office at 678-413-3261

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Notice of Patient Rights and Responsibilities

I have been informed of my patient rights and responsibilities. I am also aware that if there are any questions or concerns about my rights, responsibilities or my medical records that I am to contact the Privacy Officer for Eastside Premier Nephrology & Hypertension.

I have reviewed a copy of “Notice of Privacy Practices” and will request a hard copy if desired.

I am aware that I can request a copy of my medical records if I so desire and that fees will apply to said request.

If I have a Living Will or Durable Power of Attorney, otherwise known as Advance Directives, I will provide Eastside Premier Nephrology & Hypertension a copy for their records.

Eastside Premier Nephrology & Hypertension

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Patient Acknowledgment of Receipt of Notices & Policies

Patient Name: _____

- Please carefully read the attached Notices and Policies documents.
- Initial below that they have been provided to you and that you understand the contents.
- Please see the office staff if you have questions regarding the contents of the documents.

_____ **1. Appointments, Medications, and Insurance Policies**

_____ **2. Notice of Patient Rights and Responsibilities**

I have a Living Will or Durable Power of Attorney, otherwise known as Advance Directives: _____ **Yes** _____ **No**

If Yes, I will provide Eastside Premier Nephrology & Hypertension a copy for their records.

If No, I would like information on Advance Directives or I would like to speak to someone about Advance Directives: _____ **Yes** _____ **No**

_____ **3. Notice of Privacy Practices**

_____ **4. Information About Your Medical Record**

Patient Signature _____ Date _____

Eastside Premier Nephrology & Hypertension, PC
1612 Milstead Road, Suite A
Conyers, GA 30012.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 3/12/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time; provided applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at anytime. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: we may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include: quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patients Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences or your best interest allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information

required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address listed at the end of this Notice. If you request copies, we will charge you \$.10 for each page, \$12.50 administrative fee for staff to locate and copy your health information, and postage if you want copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the past 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Breach Notification: You have the right to be notified as we are required to do so by law if unauthorized access of your personal information has occurred.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (E-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services or us.

Contact Officer: Tara Freeman (678) 413-3261 1612 Milstead Road, Suite A, Conyers, GA 30012