KIDNEY & HYPERTENSION CLINIC OF ALASKA

Patient Registration

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
Preferred Name: _____ Date of Birth: _____ Sex: ☐M ☐F ☐Other
Mailing Address: _____
City, State, Zip: _____ Social Sec. #: _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Other Race: _____
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino Preferred Language: _____
Referring Provider: _____ Preferred Pharmacy: _____
Primary Care Provider: _____ Preferred Lab & Imaging: _____

CONTACT INFORMATION

Home#: _____ Mobile#: _____ Work#: _____ Preference: _____
OK to leave detailed message: ☐Home ☐Mobile ☐Work Email Address: _____
I would like to receive automated notifications via: ☐Phone ☐Text ☐Email ☐None

Emergency Contact: _____ Relationship: _____ Ph. #: _____

KHCA is authorized to discuss my medical condition with the following non-medical individuals:
Name/Relationship: _____ Ph.#: _____ ☐Medical ☐Billing ☐Scheduling
Name/Relationship: _____ Ph.#: _____ ☐Medical ☐Billing ☐Scheduling

PATIENT EMPLOYER INFORMATION

☐Employed ☐Retired ☐Unemployed ☐Disabled ☐Other
Employer: _____ Occupation: _____ Ph.#: _____

RESPONSIBLE PARTY

☐Self ☐Spouse ☐Other _____
Last Name: _____ First Name: _____ Ph. #: _____

INSURANCE COVERAGE	**Primary Insurance**	**Secondary Insurance**
Name of Insurance Company:		
Policy Holder:		
Policy Holder's Date of Birth:		
Policy Holder's Social Sec.		
Relationship to Insured:	☐Self ☐Spouse ☐Child ☐Other	☐Self ☐Spouse ☐Child ☐Other
Policy Number:		
Group Number:		

Certification of Accuracy, Authorizations & Guarantee of Account

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to KHCA. I understand that I am financially responsible for all services rendered to me whether they are or are not covered by my Insurance. I further understand that I am financially responsible for any balance, including deductible, copayment, and coinsurance. I authorize KHCA or Insurance Company to release any information required to process my claims.

_____ _____
Signature of Patient or Patient Representative **Date**

Provider Use Only
Form will expire on: _____ Staff Initials: _____ Date: _____
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KIDNEY & HYPERTENSION CLINIC OF ALASKA

Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, all patients must complete prior to any treatment in our clinic.

- Payment is due at the time of service.
- We accept cash, checks, Visa, MasterCard, American Express and Discover. There is a $35 service charge on all returned checks.
- We offer a reasonable payment plan, upon request.
- There is a $50 fee for any appointments missed or cancelled/rescheduled within 24 business hours of original appointment.
- If you miss 3 or more appointments in a 12 month period, you may not be allowed to schedule appointments.

Regarding Insurance

- It is our goal to provide fast and efficient billing. It is your responsibility to provide us with complete, accurate, and timely insurance information, and to inform us of any changes.
- Please have your insurance card at every visit in the event it may be required.
- All deductibles and co-pays are due and payable at the time of treatment. Knowledge of your deductible, co-pays, and plan benefits is your responsibility.
- As a courtesy, we bill most insurance plans on your behalf. You authorize the clinic to release any information to process your claims, and for insurance benefits to be paid directly to KHCA.
- Please note, we are not an 'In Network Provider' for all insurances. It is your responsibility to verify and work with your insurance. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Please be aware that you are responsible for any charges not covered by your insurance for any reason.

Usual and Customary Rates

Our Practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our specialty in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Financial Policy. Please let us know if you have any question or concerns. **I have read, understand and agree to this Financial Policy:**

_____ _____

Signature of Patient or Patient Representative **Date**

Provider Use Only
Form will expire on: _____ Staff Initials: _____ Date: _____

KIDNEY & HYPERTENSION
CLINIC OF ALASKA

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____

Our Commitment to Your Privacy

Our Practice is dedicated to maintaining the privacy of your Individually Identifiable Health Information. We are required by law to maintain the confidentiality of Health Information that identifies you. By signing this form, you acknowledge that Kidney & Hypertension Clinic of Alaska has made an available copy to you of its Notice of Privacy Practices, which explains how your health information will be handled. HIPPA, the Federal Law concerning Medical Privacy, requires this notice.

I have read the Notice of Privacy Practices. Kidney & Hypertension Clinic of Alaska has given me the opportunity to ask any questions about this notice, and all my questions have been answered.

_____ _____

Signature of Patient or Patient Representative **Date**

Provider Use Only
If the patient was not able, or did not want to sign, please document if the patient was given the notice and reason why the patient did not sign below.

Patient was given the notice: _____ Yes _____ No

Reason signature was not obtained:

Staff Signature:

Date:

KHC
KIDNEY & HYPERTENSION CLINIC OF ALASKA, INC.

Patient Copy 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.

Kidney & Hypertension Clinic of Alaska ("The Practice") is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office a record is made that describes the treatments and services provided. We are required by law to maintain the privacy of your Protected Health Information (PHI). This notice outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical/ mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices and examples of how your information may be used or disclosed.

The Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

How Kidney and Hypertension Clinic of Alaska May Use and Disclose Your Protected Heath Information (PHI)

The Practice may use your protected health information for the following purposes without your authorization:

1. **Treatment**: We may use and disclose your identifiable health information to treat you and to manage and coordinate your medical care. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may ask you to have laboratory tests and use the results to help us reach a diagnosis.
2. **Organ and Tissue Donation:** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
3. **Military and Veterans:** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
4. **Payment**: We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
5. **Health Care Operations**: We may use and disclose PHI to operate our business. For example, your health information may be used to evaluate the quality of care we provide, or to evaluate the performance of our team members in caring for you. We also may disclose information to medical students, and other authorized personnel for educational and learning purposes.
6. **Appointment Reminders / Treatment Options**: We may use and disclose your information to contact you to remind you of appointments, or to contact you to tell you about possible treatment options or other health-related services which may be of interest to you.
7. **Business Associates**: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our offices such as after-hours telephone answering, billing, etc. Our Business Associates agree to protect the privacy of your health information.
8. **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
9. **Disclosures Required by Law**: The Practice may disclose your health information without your authorization when permitted or required by international, federal or state law, including:
    - For public health risks/activities including reporting of certain communicable diseases
    - For workers' compensation or similar programs as required by law
    - Maintaining vital records, such as births and deaths
    - To authorities when we suspect abuse, neglect or domestic violence

- To health Oversight Agencies for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- In response to a court/administrative order or subpoena, but only if efforts have been made to tell you about the request. We may also use your PHI to defend ourselves in the event of a lawsuit.
- To a Medical Examiner, coroner or funeral director, so they can carry out their duties.
- To avert a serious threat to your health and safety or that of others
- In the event of an emergency or for disaster relief, to coordinate care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, The Practice may provide you with an authorization form to complete and return to the address listed on it.

Your Rights Regarding Your PHI

Your health record is the physical property of the practice. The information contained in it belongs to you. Below is a list of your rights regarding your PHI. All requests related to these items must be made in writing to our Privacy Officer at the address listed below. We will provide you with appropriate forms to exercise these rights. We will notify you, in writing, if your request cannot be granted.

1. **Right to Restrictions on Use and Disclosure**: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals or entities involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Right to Confidential Communications**: You have the right to request that we communicate with you in a particular manner at a certain location. For example, you may request that we only contact you at home. You must make any such request in writing specifying how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
3. **Right to Request Record Amendment**: You have the right to request amendments to your health records created by and for this Company if you feel they are incorrect or incomplete. You must submit your request in writing to the Privacy Officer. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
4. **Right to Accounting of Disclosures**: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures The Practice has made on your records. Use of your information as part of the routine patient care in The Practice is not required to be documented. You must submit your request in writing to the Privacy Officer. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
5. **Right to Copy of Notice**: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.
6. **Right to Inspect and Copy.** You have the right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
7. **Right to a Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agrees to this alternative form and pay the associated fees.
8. **Right to an Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record

be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

9. **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
10. **Right to Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

11. **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
12. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your PHI, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.
13. **Out-of-Pocket-Payments.** If you paid out-of-pocket and have requested that we not bill your health plan, for a specific item or service, you have the right to ask that your PHI, with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
14. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed below. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your PHI, you may also contact your physician directly.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

If you speak German, Chinese, Thai, Tongan, Ukrainian, Vietnamese, Japanese, Lao, Polish, Spanish, Korean, Hmong, Russian, language assistance services, free of charge, are available to you. If you have questions about this notice, please contact The Practice's Privacy Officer.

KIDNEY & HYPERTENSION
CLINIC OF ALASKA

Jeremy Gitomer, MD
Trang Ngo, MD
Shuang Ying Bao, MD
Ryan McDonald, MD
Mark Smith, MD
Rahul Abraham, MD
Osman Yilmam, MD
Stephanie McQuillin, APRN
Shannon Yoder, APRN
Juliana Abreu, PA-C

RELEASE OF HEALTHCARE INFORMATION

Patient's Name:	Date of Birth:
Parent/Guardian Name (if minor):	

I request and authorize Kidney & Hypertension Clinic of Alaska to release/share healthcare information including diagnosis, records, examination results, medication dosage, claims information, and scheduling. This information may be released to:

❑ Spouse _____ Phone _____

❑ Parent/Guardian _____ Phone _____

❑ Child _____ Phone _____

❑ Other _____ Phone _____

❑ Information is not to be released to anyone other than me

MESSAGES

Please call ❑ my home phone number _____ ❑ my cell number _____

If you are unable to reach me: ❑ You may leave a detailed message OR ❑ Leave message for return call

❑ Do not leave messages on my phone mailbox

This release of information will remain in effect until terminated by me in writing. This release *specifically excludes* any psychiatry and psychology evaluation/records which are further restricted by HIPAA regulations.

Patient Printed Name: _____

Patient Signature: _____

Date Signed: _____

Parent/Guardian: _____

Witness: _____

4015 Lake Otis Pkwy Ste. 201, Anchorage, AK 99508
Phone: 907-375-5200 Fax: 907-375-5201