Nephrology & Hypertension MEDICAL ASSOCIATES

RETURN 5 DAYS PRIOR TO SCHEDULED APPOINTMENT

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION **Referred By:**

Name:_____Soc Sec #:_____
First Mid Last

Address:_____
Street / PO Box City State Zip

Telephone: Home (_____) _____ Work (_____)_____Cell (_____)_____

Sex: M F Date of Birth: _____/_____/_____ E-Mail: _____
Email is required for our Patient Portal and other educational communications.

Primary Care Physician: _____
Name Phone Address

Marital Status: _____ Race:_____ Ethnicity: Hispanic_____ Non-Hispanic_____

Emergency Contact:_____
Name Phone Relationship to Patient

Spouse Info (*If Applicable*):_____
Name Date of Birth Phone Employer

EMPLOYMENT INFORMATION

Employed By_____Occupation_____

Business Address_____Business Telephone_____

Employment Status: FT_____ PT_____ Self____ Retired____ Military____ Not Employed_____ Student_____

PRIMARY INSURANCE ___Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:_____
Name HMO / PPO / OPEN ACCESS

Policy #_____Group #_____Specialist Co-Pay_____

Address_____City _____State_____Zip_____

Name of Insured_____ Insured SS #_____

Relationship to Patient_____ Date of Birth of Insured_____

Patient Preference: _____
Hospital Laboratory Pharmacy/Address

SECONDARY INSURANCE _____Not Applicable ___Medicare ____Medicaid ____Self Pay _____Commercial

Insurance Company:_____
Name HMO / PPO / OPEN ACCESS

Policy #_____Group #_____Specialist Co-Pay_____

Address_____City _____State_____Zip_____

Name of Insured_____ Insured SS #_____

Relationship to Patient_____ Date of Birth of Insured_____

ASSIGNMENT AND RELEASE

Authorization to treat and release information to insurance carrier for direct payment to the provider: I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance carrier. I authorize direct payment from my insurance company to my provider. At any time should I decide that I want to file my own claims, I understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred. In the event it becomes necessary to collect the amount due on my account by legal litigation, the handling fees, service charges or court costs will be paid by the guarantor listed above, which could include a 25% collection fee. In order to prevent the application of the above, fees should be paid timely upon completion of rendered services. I authorize the release of medical records to Nephrology and Hypertension Medical Associates PC as necessary for continuity of care. Also, I understand that the practice will provide, at my request, a copy of the HIPAA Notice of Privacy, which is clearly posted in the lobby area.

_____ _____ _____
PATIENT'S SIGNATURE PRINT NAME DATE

_____ _____ _____
GUARANTOR'S SIGNATURE (If other than patient) PRINT NAME DATE

NEPHROLOGY & HYPERTENSION MEDICAL ASSOCIATES Return 5 days prior to appointment

PATIENT NAME _____AGE ___ BIRTHDATE _____ TODAY'S DATE _____

What is your reason for today's visit? _____

REVIEW OF SYSTEMS (ROS) *Check symptoms you currently have or have had in the past year.*

GENERAL
Height _____
Usual weight _____lbs.
Date of last physical exam _____

- ▢ Chills
- ▢ Fever
- ▢ Sweats
- ▢ Loss of sleep
- ▢ Loss of weight
- ▢ Tired
- ▢ Weight gain

EYES
- ▢ Blurred vision
- ▢ Pain in eyes
- ▢ Vision Changes
- ▢ Vision – Halos

EARS, NOSE, THROAT
- ▢ Earache/drainage
- ▢ Loss of hearing
- ▢ Ringing in ears
- ▢ Nasal drainage
- ▢ Nosebleeds
- ▢ Sinus Problems
- ▢ Hoarseness
- ▢ Bleeding Gums
- ▢ Swallowing difficulty

MENTAL
- ▢ Anxiety
- ▢ Nervousness
- ▢ Depression

CARDIOVASCULAR
- ▢ Abdominal EKG
- ▢ Chest pain, tightness, pressure
- ▢ Fainting, blacking out
- ▢ High blood pressure
- ▢ Irregular heart beat
- ▢ Leg pain when walking
- ▢ Low blood pressure
- ▢ Poor circulation
- ▢ Rapid heart beat
- ▢ Swelling of ankles or feet
- ▢ Varicose veins
- ▢ Cold/numb feet or hands

GASTROINTESTINAL
- ▢ Appetite poor
- ▢ Bloating
- ▢ Bowel changes
- ▢ Constipation
- ▢ Diarrhea
- ▢ Eating habit changes
- ▢ Excessive hunger
- ▢ Gas
- ▢ Hemorrhoids
- ▢ Indigestion
- ▢ Nausea and/or vomiting
- ▢ Rectal bleeding

NEUROLOGICAL
- ▢ Convulsions, fits, seizures
- ▢ Dizziness
- ▢ Double vision
- ▢ Forgetfulness
- ▢ Headache
- ▢ Numbness

HEMATOLOGIC
- ▢ Bleeding tendency

SKIN
- ▢ Bruise easily
- ▢ Change in moles
- ▢ Change in skin color
- ▢ Scars
- ▢ Sore that won't heal

RESPIRATORY
- ▢ Chest colds (frequent)
- ▢ Persistent cough
- ▢ Coughing of blood
- ▢ Difficulty breathing
- ▢ Wheezing

GENITOURINARY
- ▢ Blood in urine

Urination:
- ▢ > twice overnight
- ▢ Painful
- ▢ Loss of control
- ▢ Dribbling urine
- ▢ Pass more water than used to
- ▢ Lose urine when cough/sneeze
- ▢ Decrease in force/function

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:

▢Arms	▢Hips	▢Elbows
▢Back	▢Legs	▢Wrist
▢Feet	▢Neck	▢Ankle
▢Hands	▢Shoulder	▢Feet
	▢Knees	

- ▢Trouble walking

ALLERGIC
- ▢Hives
- ▢Rash or itching

ENDOCRINE
- ▢Excessive thirst

MEN ONLY
- ▢Breast lump
- ▢Erection difficulties
- ▢Lump in testicles
- ▢Penis discharge
- ▢Sore on penis
- ▢Enlarged prostate
- ▢Other _____

WOMEN ONLY
- ▢Abnormal Pap Smear
- ▢Bleeding between periods
- ▢Breast lump
- ▢Extreme menstrual pain
- ▢Hot flashes
- ▢Nipple discharge
- ▢Painful intercourse
- ▢Vaginal discharge
- ▢Other_____

Date of Last Pap Smear

_____

Date of Last Mammogram

_____

Are you pregnant?
▢ No ▢ Yes

Number of Children ___

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY (check conditions you currently have or have had in the past)

- ▢ AIDS
- ▢ Alcoholism
- ▢ Anemia
- ▢ Anorexia
- ▢ Arthritis
- ▢ Asthma
- ▢Bladder/Kidney Infections
- ▢ Bleeding Disorders
- ▢ Breast Lump
- ▢ Bronchitis
- ▢ Cancer
- ▢ Cardiac Cath when? _____
- ▢ Cataracts
- ▢ Chemical Dependency
- ▢ Diabetes
- ▢ Emphysema
- ▢ Epilepsy
- ▢ Gallbladder Disease
- ▢ Glaucoma
- ▢ Goiter
- ▢ Gout
- ▢ Hay Fever
- ▢ Heart Attack, MI when? _____
- ▢ Heart Disease
- ▢ Hepatitis
- ▢ High Blood Pressure
- ▢ High Cholesterol
- ▢ HIV Positive
- ▢ Jaundice
- ▢ Liver Disease
- ▢ Kidney Disease
- ▢ Migraine Headaches
- ▢ Miscarriage
- ▢ Mononucleosis
- ▢ Multiple Sclerosis
- ▢ Osteoporosis
- ▢ Pacemaker
- ▢ Pneumonia
- ▢ Psychiatric Care/Problems
- ▢ Prostate Problems
- ▢ Rheumatic Fever
- ▢ Stroke
- ▢ Suicide Attempt
- ▢ Thyroid Problems
- ▢ Tuberculosis
- ▢ Ulcers
- ▢ Vaginal Infections

PERSONAL HABITS – SOCIAL HISTORY (check all that apply)

TOBACCO
- ▢ Cigarettes # per day __
- ▢ Pipe
- ▢ Cigars

when did you start smoking?
Age/years ___
when did you stop smoking?
Age/Years ___

- ▢ Illegal drugs

ALCOHOL
- ▢ Hard Liquor
  - ▢ less than 1oz/day
  - ▢ 1-3oz/day
  - ▢ Over 3 oz/day
- ▢ Beer
  - ▢ 1 bottle/day
  - ▢ 1-3 bottles/day
  - ▢ Over 3 bottles/day
- ▢ Wine
- ▢ 1 glass/day
- ▢ 1-3 glasses/day
- ▢ Over 3 glasses/day
- ▢ Coffee ___cups/day
- ▢ Other Caffeine _____
- ▢ Use of a lot of salt
- ▢ Special food restrictions _____

SLEEPING
- ▢ Difficulty falling asleep
- ▢ Continuity disturbances
- ▢ Early morning awakening
- ▢ Daytime drowsiness

EXERCISE
- ▢Routine exercise program
- ▢Exercise at least 3 times/week

EDUCATION ▢ GED ▢ Technical School ▢ Graduate School ▢ High School ▢ College

CARETAKER ▢ Self care ▢ Relative ▢ Other _____

Return 5 days prior to appointment

PRIOR HOSPITALIZATION/ILLNESSES/INJURIES		
Year	Hospital	Reasons for Hospitalization and Outcome

OCCUPATIONAL: CHECK IF YOUR WORK EXPOSES YOU TO THE FOLLOWING			
	Heavy Lifting		Hazardous Substances
	Stress		Other

Occupation:_____

- ▢ Work more than 60 hours per week
- ▢ Work more than one job
- ▢ Disabled
- ▢ Retired
- ▢ Currently unemployed
- ▢ Housewife / Homemaker

Year	Serious Illness/Injuries	Outcome

Other Physicians Currently Seeing

MEDICATIONS (List all current prescription and non-prescription medications)		

ALLERGIES

FAMILY HISTORY: Fill in health information about your family. Put a Check or fill in information in those boxes applicable to you.

	Father	Mother	Brother				Sister				Spouse	Children					
Age (if Living)			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy / Seizures																	
Kidney Disease																	
Lupus																	
Rheumatoid Arthritis																	
Asthma, Hay Fever																	
Blood Disease																	
Age of Death																	
Cause of Death																	

Signature:_____ Date: _____

Nephrology & Hypertension MEDICAL ASSOCIATES

Statement of Financial Policy

It is our firm belief that all patients who come to this office expect and deserve quality medical care. In order for us to provide this level of service, it is important that our patients understand our financial policies. Therefore, we are asking that you read and sign the following important information:

1. If we are a participating provider in your plan, we will be listed in your group's "provider list" or "preferred provider" directory. This is not a guarantee of payment. We will bill your insurance company directly and receive payment from them directly. Most plans require a "co-payment" per visit and/or have yearly "deductibles". Some plans require you to pay a 20% co-payment when diagnostic tests are provided. We require that co-payments and/or deductibles be paid prior to services being rendered or the appointment can either be rescheduled or patient may have an additional $25.00 added to their account.
2. If your insurance requires referral approval, necessary documentation is your responsibility. You must give your referral form and/or number to the receptionist when you check in to see the doctor. Failure to comply with the requirements of your insurance company could leave you responsible for services rendered.
3. If your insurance information is up-to-date, we will file up to two separate insurance claim forms for services you receive. It is your responsibility to tell us about changes in your insurance plan. It is important to remember that your insurance coverage is a contract between you and your insurance company. Although we file claims for you, you are still responsible for your bill, regardless of the amount your insurance company pays, except in cases of pre-negotiated insurance agreements and where legally prohibited.
4. If you do not have insurance, payment is expected at the time you receive services. Payment will be accepted in cash, by check or credit card. If check is returned for non-sufficient funds, an additional service fee of $30.00 will be added to the patient's account. If payment in full is not possible at the time of service, arrangements must be made through our billing office.
5. In the event that payment is not received after 3 payment notifications have been mailed, a 25% collection fee will be added to the account prior to being submitted to the collection agency. It is the responsibility of the patient to notify the office of any insurance, address or other demographic changes.
6. In order to assist patient requests for an immediate appointment, we require at least 48 hour advance notice should your appointment need to be cancelled or rescheduled. If you do not provide us notice **at least 48 hour advance notice a $50 charge** may be added to your account.
7. A self pay discount plan is available only if paid in advance of seeing the provider. If not paid in full prior to the appointment, the full charge will apply.

We hope this Statement of Financial Policy helps you understand the importance of prompt payment of your bill. Please feel free to call our billing office at (912)354-4813 if you have any questions.

****

I have read the above information and understand that I am responsible for notification for notification of my insurance plan mandates.

Patient / Guarantor's Signature _____ Date _____

Patient's Name _____ Patient's Date of Birth _____

Self-Pay Policy for Office Visits

Nephrology and Hypertension Medical Associates understands not everyone has medical insurance or may want to avoid using their medical insurance. To help provide the care you need, we have implemented a discounted rate policy.

To obtain a full discounted payment, the payments listed below will need to be made prior to being seen

- For patients seen within the last 3 years, an established patient, the discounted rate would be $135.00 including any additional services; or,
- For patients that are being seen by our providers for the first time, New Patient, the discounted rate would be $205.00 including any additional services.

For those that are still unable to pay the full discounted amount upfront need to comply with the following:

- A minimum of $75.00 is placed as a down payment and you will be responsible for the full charge amount with no discount. This discount does not cover any other services that may be done during the visit, such as laboratory procedures, but these will be billed to the patient.
    a. For patients seen within the last 3 years, an established patient, the full charge can be up to $401.00 not including any additional services; or,
    b. For patients that are being seen by our providers for the first time, New Patient, the full charge can be up to $618.00 not including any additional services.

We hope our Self-Pay Policy for Office Visits helps you understand the discounts that are available if paid in advance of being seen. Please feel free to call our billing office at (912)354-4813 if you have any questions.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

The states of Georgia, South Carolina, and the federal government all have laws to protect you from balance billing, though they are different. State rules apply only to fully insured commercial health insurance plans and some government plans. Federal rules may also apply to commercial health insurance in situations where you received healthcare services in another state, your health insurance is regulated by a state other than Georgia or the healthcare service you received is not regulated by the state law. Most of the differences between the state and federal laws are in the way the rules affect providers and health insurers, so you usually won't need to worry about that. However, the grievance processes are different, as indicated on the government websites listed below.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. Under Georgia law, this rule also applies to imaging centers, birthing centers and similar facilities, in addition to hospitals and ambulatory surgical centers. If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

The best way to find an in-network provider is to use the online provider directory on your health plan's website.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

For Georgia, if you believe you've been wrongly billed, first contact your provider and/or your health plan for an explanation. If they can't resolve your concerns, you can contact the Georgia Office of the Commissioner of Insurance and Safety Fire online at https://oci.georgia.gov/ or by phone at 404-656-2070.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit https://oci.georgia.gov/how-do-i-file-complaint for more information about your rights under Georgia law.

For South Carolina, if you believe you've been wrongly billed, first contact your provider and/or your health plan for an explanation. If they can't resolve your concerns, you can contact the Office of Consumer Services online at https://doi.sc.gov/1001/No-Surprises-Act-Information or by phone at 803-737-6160

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit https://doi.sc.gov/1001/No-Surprises-Act-Information for more information about your rights under South Carolina law.

PATIENT CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Updated for HIPAA & 42 CFR Part 2 Requirements Effective February 16, 2026)

I, _____, understand that Nephrology and Hypertension Medical Associates maintains paper and electronic records describing my medical history, symptoms, examinations, test results, diagnoses, treatment, and future care plans.

PURPOSES OF USE AND DISCLOSURE

My protected health information (PHI) may be used or disclosed for:

- Treatment – coordination of care among healthcare providers
- Payment – billing and payment verification by insurers
- Healthcare Operations – quality review, training, auditing, and administrative functions

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered the Notice of Privacy Practices explaining how my information may be used and disclosed and my rights under federal law.

PATIENT RIGHTS

I understand I have the right to:

- Access, inspect, and obtain copies of my records
- Request amendments to my information
- Request restrictions and confidential communications
- Receive an accounting of disclosures
- Receive breach notifications without unreasonable delay
- File a complaint without retaliation

SUBSTANCE USE DISORDER INFORMATION (42 CFR PART 2)

Certain records relating to substance use disorder treatment are protected by federal law. With my written consent, such information may be used and disclosed for treatment, payment, and healthcare operations consistent with HIPAA safeguards.

Once disclosed with my consent, this information may be redisclosed as permitted by HIPAA. I understand I will not be discriminated against based on this information and will be notified of any breach involving such information.

REPRODUCTIVE HEALTH PRIVACY PROTECTIONS

Federal law prohibits the use or disclosure of protected health information to investigate or impose liability related to lawful reproductive healthcare. Certain disclosures require legal attestation before release.

REVOCATION

I may revoke this consent in writing at any time, except to the extent action has already been taken in reliance on it.

HEALTH INFORMATION EXCHANGE

I consent to sharing my information with other providers through secure electronic exchange for treatment, payment, and healthcare operations.

_____

Patient Signature

_____ _____

Printed Name Date

FOR OFFICE USE ONLY:

Consent received by _____ Date _____

Consent refused by patient and treatment refused as permitted

Consent added to the medical record on _____

PATIENT RECORD OF DISCLOSURES

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

I wish to be contacted in the following manner: *(check all that apply)*

- ☐ **Work Telephone**
  - ☐ OK to leave detailed message
  - ☐ Leave message with call back number only
- ☐ **Home Telephone**
  - ☐ OK to leave detailed message
  - ☐ Leave message with call back number only
- ☐ **Cell Phone**
  - ☐ OK to leave detailed message
  - ☐ OK to send text message
- ☐ **Written Communication**
  - ☐ OK to email to this address _____
  - ☐ OK to mail to home address
  - ☐ OK to mail to work/office
  - ☐ OK to fax to this telephone number_____

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Nephrology & Hypertension Medical Associates will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.
Please print:

1.	3.
2.	4.

Patient Signature:_____Date:_____

Please print name:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice of Privacy Practices for Nephrology & Hypertension Medical Associates detailing how my information may be used and disclosed as permitted under federal and state law.

Patient/Guardian Signed_____ Date:_____

Relation to patient:_____

For Office Use Only:
If patient or guardian refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign here:
*Presented by:*_____*(employee name and title)*
*Date:*_____*Time:*_____

PATIENT RIGHTS & RESPONSIBILITIES

Updated to reflect HIPAA & HHS requirements effective February 16, 2026

CONFIDENTIALITY AND PRIVACY

Nephrology & Hypertension Medical Associates, P.C. protects the privacy and security of your protected health information (PHI) in accordance with federal HIPAA law (45 CFR Parts 160 and 164) and applicable provisions of 42 CFR Part 2 governing substance use disorder (SUD) records. We maintain appropriate administrative, physical, and technical safeguards to protect your information.

We will notify you without unreasonable delay, and in no case later than required by federal law, if a breach compromises the privacy or security of your information.

Federal law provides additional protections for lawful reproductive health care information and prohibits certain uses or disclosures related to investigations or proceedings concerning such care unless expressly permitted by law.

Records relating to substance use disorder diagnosis, treatment, or referral are protected under 42 CFR Part 2. Such information may not be used or disclosed in civil, criminal, administrative, or legislative proceedings without your specific written consent or a court order that complies with federal regulations.

Any disclosure of SUD records made with your written consent for treatment, payment, or health care operations is subject to HIPAA safeguards. Recipients of this information are prohibited from re-disclosing it except as permitted by law.

PATIENT RIGHTS

- Receive respectful, considerate, and nondiscriminatory care.
- Access and obtain copies of your medical records in paper or electronic format within the timeframes required by federal law.
- Request amendments to incorrect or incomplete records.
- Request confidential communications and restrictions on certain disclosures, including restrictions on disclosures to health plans when you pay in full out-of-pocket.
- Receive an accounting of disclosures of your PHI as required by law.
- Receive written breach notification when required.
- Receive additional protections for substance use disorder records, including the right to provide or withhold written consent for disclosures.
- Be free from discrimination based on substance use disorder history or treatment information.
- File a complaint regarding privacy practices without fear of retaliation.

PATIENT RESPONSIBILITIES

1. Provide accurate and complete medical and insurance information.
2. Communicate openly and honestly with your providers regarding symptoms, medical history, medications, and concerns.
3. Request clarification when you do not understand your diagnosis, treatment plan, or instructions.
4. Follow agreed-upon treatment plans or notify your provider if you are unable or unwilling to comply.
5. Keep scheduled appointments or provide advance notice of cancellation.
6. Meet financial obligations related to your care or discuss financial hardship when applicable.
7. Engage in health maintenance and preventive behaviors when possible.
8. Avoid conduct that places others at unreasonable risk of harm, including transmission of infectious disease.
9. Consider advance directives and discuss end-of-life decisions when appropriate.
10. Refrain from participating in fraudulent health care practices and report unethical behavior when observed.

ACKNOWLEDGEMENT

I acknowledge that I have received, read, and understand the Patient Rights & Responsibilities and understand that my protected health information will be handled in accordance with HIPAA and applicable federal substance use disorder confidentiality regulations.

Patient Name: _____

Date of Birth: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Nephrology and Hypertension Medical Associates, PC
Effective Date: February 16, 2026

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.

OUR COMMITMENT TO YOUR PRIVACY

We are committed to protecting your health information. When you receive care from our practice, we create records about your health, treatment, and services. We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of Privacy Practices
- Follow the terms of this Notice currently in effect
- Notify you if a breach occurs involving your unsecured PHI

This Notice applies to all records we create or maintain. If we change our privacy practices, we will update this Notice and make the revised version available in our office and upon request.

If you have questions, please contact: Privacy Officer – (912) 354-4813

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use or disclose your PHI for the following purposes without your written authorization:

1. Treatment
We may use and share your PHI to provide, coordinate, or manage your medical care. Examples include ordering labs, writing prescriptions, consulting with other providers, or sharing information with caregivers involved in your treatment.

2. Payment
We may use and disclose your PHI to bill for services and obtain payment from you, your insurance company, or a third party. Examples include verifying coverage, submitting claims, or providing information needed for prior authorization.

3. Health Care Operations
We may use and disclose your PHI for activities necessary to operate our practice. Examples include quality assessment, staff training, auditing, and business planning.

4. Individuals Involved in Your Care
We may share your PHI with family members, friends, or others involved in your care or payment for your care, when appropriate.

5. Appointment Reminders & Health Information
We may contact you with appointment reminders or information about treatment options or health-related services.

6. As Required by Law
We will disclose PHI when required by federal, state, or local law.

SPECIAL SITUATIONS WHERE WE MAY DISCLOSE YOUR INFORMATION

We may also disclose your PHI in the following circumstances:

- Public health activities
- Health oversight activities
- Lawsuits and legal actions
- Law enforcement purposes
- To prevent a serious threat to health or safety
- Military and national security activities
- To correctional institutions or law enforcement if you are in custody
- Workers' compensation programs

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

We must obtain your written authorization before using or disclosing your PHI for:

- Most uses and disclosures of psychotherapy notes (Note: Our office does not create or maintain a hospital directory or psychotherapy notes)
- Marketing (unless an exception applies)
- Sale of PHI
- Most sharing of Substance Use Disorder (SUD) treatment records protected under 42 CFR Part 2

You may revoke your authorization at any time in writing.

SUBSTANCE USE DISORDER (SUD) INFORMATION – 42 CFR PART 2 (Updated)

Some health information relating to substance use disorder treatment is protected under federal law (42 CFR Part 2). With your written consent, this information may be used and disclosed for treatment, payment, and health care operations in accordance with HIPAA and applicable law.

Once disclosed with your consent, this information may be redisclosed as permitted by HIPAA privacy regulations and applicable safeguards.

We will not discriminate against you based on substance use disorder information, including decisions related to treatment, employment, housing, or access to benefits as prohibited by law.

You have the right to receive an accounting of disclosures of your SUD information and to be notified of a breach involving such information consistent with federal breach notification requirements.

You may revoke your consent in writing at any time, except to the extent that action has already been taken in reliance on it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights:

1. Right to Request Confidential Communications
You may request that we contact you in a specific way. Submit requests in writing to: Privacy Officer – (912) 354-4813.

2. Right to Request Restrictions
You may request restrictions on how we use or disclose your PHI. We are not required to agree, except when you request that we not disclose information to your health plan for services paid in full out-of-pocket.

3. Right to Inspect and Obtain Copies
You may inspect or obtain a copy of your medical and billing records. We may charge a reasonable fee for copies.

4. Right to Request an Amendment
If you believe your information is incorrect or incomplete, you may request an amendment in writing.

5. Right to an Accounting of Disclosures
You may request a list of certain disclosures we have made of your PHI for the past six years, excluding those made for treatment, payment, or operations.

6. Right to a Paper Copy of This Notice
You may request a paper copy at any time.

7. Right to File a Complaint
If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

CONTACT INFORMATION

Privacy Officer
Nephrology and Hypertension Medical Associates, PC
(912) 354-4813

Appendix A to Part 92—Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Nondiscrimination Statement:

Discrimination is Against the Law

Nephrology and Hypertension Medical Associates PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Nephrology and Hypertension Medical Associates PC do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Nephrology and Hypertension Medical Associates PC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Nicole Miranda, LPN (Director of Clinical Operations) or Trish Rotureau (Practice Administrator)

If you believe that Nephrology and Hypertension Medical Associates PC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Nicole Miranda, LPN (Director of Clinical Operations) or Trish Rotureau (Practice Administrator)

1115 Lexington Avenue
Savannah, GA 31404
912/354-4813
FAX 912/354-7569

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Trish Rotureau, Practice Administrator, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

MRN: _____

Telemedicine Informed Consent Form

Telemedicine services involve the use of interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I, _____, understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.

3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

   If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. I may revoke my refusal at any time by contacting Nephrology and Hypertension Medical Associates at 912-354-4813.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in- person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3)

_____I am located in the state of Georgia and will be in Georgia during my telemedicine visit(s) or
_____I am located in the state of South Carolina and will be in South Carolina during my telemedicine visit(s).

_____ Date: _____

SIGNATURE