WEL COME TO OUR OFFICE — NEW UPDATE

DESERT KIDNEY ASSOCIATES, PLC
MESA, AZ
(480) 834-9039

PLEASE FILL OUT COMPLETELY
Thank you for choosing our office.
In order to serve you properly we will need the following information.

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential) Date______________________

PATIENT'S LAST NAME ____ FIRST NAME ____ MIDDLE ____ HOME PHONE (____)____

LOCAL ADDRESS ____ CITY ____ STATE ____ ZIP ____

PERMANENT ADDRESS If Different

SOCIAL SECURITY NUMBER ____ DRIVING LICENSE NUMBER ____ DATE OF BIRTH ____ AGE ____ SEX: MALE FEMALE

MARITAL STATUS SINGLE MARRIED WIDOWED SEPARATED DIVORCED

EMPLOYED BY ____ WORK PHONE ____

EMPLOYER'S ADDRESS ____ OCCUPATION ____

SPOUSE INFORMATION

NAME ____ DATE OF BIRTH ____ SS# ____

SPOUSES EMPLOYER ____ ADDRESS ____ WORK PHONE ____

INCASE OF EMERGENCY

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY ____ RELATIONSHIP ____ EMERGENCY PHONE (____)____

STREET ADDRESS ____ CITY ____ STATE ____ ZIP ____

IF THE PATIENT IS A MINOR OR STUDENT

RESPONSIBLE PARTY ____ RELATIONSHIP ____ DATE OF BIRTH ____ HOME PHONE ____

ADDRESS ____ CITY ____ STATE ____ ZIP ____

EMPLOYER ____ ADDRESS ____ OCCUPATION ____ WORK PHONE ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPNY ____ IS THE THROUGH EMPLOYER? YES NO

ADDRESS ____ EFFECTIVE DATE ____ GROUP NUMBER ____

SUBSCRIBER'S NAME ____ SUBSCRIBER'S DATE OF BIRTH ____ SUBSCRIBER'S S S N# ____ SUBSCRIBER'S I.D. NUMBER (Policy No.) ____

SUBSCRIBER'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER____________________

SECONDARY INSURANCE COMPANY ____ IS THIS THROUGH EMPLOYER? YES NO

ADDRESS ____ EFFECTIVE DATE ____ GROUP NUMBER ____

SUBSCRIBER'S NAME ____ SUBSCRIBER'S DATE OF BIRTH ____ SUBSCRIBER'S S S N# ____ SUBSCRIBER'S I.D. NUMBER (Policy ____

SUBSCRIBER'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER____________________

REFERRED TO DOCTOR BY ______________________________

DOCTOR'S ADDRESS ____ PHONE NO. ____

SEE REVERSE SIDE

I hereby authorize Desert Kidney Associates to release to all my insurance carriers or their representatives, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I authorize my doctor or his representative to act as my agent on helping me obtain payment from my insurance carriers.

I also authorize and request your company to pay directly to the above named clinic the amount due me in my pending claim for medical, major medical or surgical treatment or services by reason of such treatment of services rendered to:

____ Date: ______________________

Signature of patient

I understand that if my Desert Kidney Associates financial account needs collection, all collection fees will be added to the original balance, including in annual interest charge of 10%.

____ Date: ______________________

Signature of patient

I understand that if my Desert Kidney Associates financial account needs collection, all collection fees will be added to the original balance, including in annual interest change of 10%.

____ Date: ______________________

Signature of patient

If under 18, responsible part signature ____ Relation______________________

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.? ______________________ LIST ________________________

____

____

DRUG ALLERGY ___________ NAME OF MEDICATION(S) ____

REACTION____

DO YOU USE TOBACCO NOW? _______ IN THE PAST? ______ TYPE & DAILY AMOUNT_______ HOW LONG? ______________

DO YOU USE ALCOHOLIC BEVERAGES? __________ TYPE ____________ WEEKLY AMOUNT _______ HOW LONG? ________

DO YOU USE STREET DRUGS NOW? ___________ IN THE PAST ? _________ TYPE___________ HOW OFTEN?____________

PLEASE CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

SMALLPOX _______ TETANUS _______ TYPHOID _______ POLIO ____ INFLUENZA___________

PREVIOUS OPERATIONS: PLEASE LIST GIVING DATES, HOSPITAL WHERE PERFORMED & NAME OF SURGEON __________

____

____

____

PREVIOUS X-RAY THERAPY OR SIMILAR THEREATMENT: ____

____

MEDICATIONS USING CURRENTLY:

NAME OF MEDICINE	DOSAGE	HOW OFTEN
______________________	________	___________________
______________________	________	___________________
______________________	________	___________________
______________________	________	___________________
______________________	________	___________________
______________________	________	___________________
______________________	________	___________________
______________________	________	___________________

MEDICATION USED IN THE PAST: ____

____

HAVE YOU TAKEN OVER THE COUNTER ANTI-INFLAMMATORIES (IBUPROFEN, MOTRIN, ADVIL)? _______________________

LAST PAP SMEAR _______ LAST MAMMOGRAM _____________ LAST PROSTRATE EXAM _____________

MENSTRUAL HISTORY: LAST PERIOD _________ PERIODS ARE: ___________ REGULAR ____________ IRREGULAR

NUMBER OF PREGNANCIES ______________ NUMBER OF MISCARRIAGES ____________________

HAVE YOU TAKEN CORTISONE TYPE DRUGS? _____________ ORAL CONTRACEPTIVES? ___________________

HAVE YOU RECEIVED A BLOOD TRANSFUSION? ________________ DATE: ______________________

RECENT HISTORY OF WEIGHT LOSS? ____________ HOW MANY POUNDS ? _______ HOW LONG? __________________

PLEASE WRITE THE REASON(S) YOU CAME TO THE DOCTOR AT THIS TIME __________________________________

____

WHAT IS YOUR MAIN MEDICAL PROBLEM & HOW LONG HAVE YOU HAD IT? __________________________________

____

WHAT IS YOUR MAIN SYMPTOM? (FOR EXAMPLE: PAIN IN CHEST, SHORTNESS OF BREATH) __________________________

____

____

REVIEWED _____________________________DATE ____________________
PHYSICIAN

FORMATION FOR YOUR PHYSIC

PLEASE ANSWER THE FOLLOWING QUESTION AND BRING THIS RECORD TO YOUR FIRST EXAMINATION. IT WILL HELP YOUR PHYSICIAN TO KNOW NOT ONLY ABOUT YOUR HEALTH, BUT ALSO ABOUT YOUR FAMILY AND RELATIVES.

DATE______________________________

YOUR FULL NAME_____________________________________ M _____ F_______ TELEPHONE NUMBER________________

DATE OF BIRTH_________________ PLACE OF BIRTH______________ RACE/NATIONALITY OF PARENTS_______________

RELIGION__________________________ EDUCATION____________________ AGE ON COMPLETION________________________
(HIGHEST LEVEL ATTAINED)

OCCUPATION____HOW LONG?____

WHERE & WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE OF THE U.S.& CANADA_______________________________________

	LIVING	AGE/AGE AT DEATH	PRESENT HEALTH OR CAUSE OF DEATHE
FATHER	YES ____ NO ____	____________________	____
MOTHER	YES ____ NO ____	____________________	____
SPOUSE	YES ____ NO ____	____________________	____

PRESENT MARRIAGE YEAR _______________PREVIOUS MARRIAGE-YEAR & DURATION__________________________________

BROTHERS-NO.LIVING____________ HEALTH____

NO DEAD ____________CAUSE OF HEALTH____

SISTER NO LIVING____________HEALTH____

NO DEAD____________ CAUSE OF HEALTH____

CHILDREN LIVING_________AGES AND HEALTH____

CHILDREN DEAD_________ AGES AND HEALTH____

PLEASE CIRCLE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

ALCOHOLISM	CANCER	HEART DISEASE	NERVOUS ILLNESS
ALLERGY	DIABETES	HIGH BLOOD PRESSURE	STROKE
BLEEDING TENDENCY	EPILEPSY	KIDNEY DISEASE	TUBERCULOSIS

PLEASE CIRCLE ILLNESSES OR CONDITIONA (S) YOU HAVE HAD

ANEMIA	GLAUCOMA	KIDNEY DISEASE	RHEUMATIC FEVER
ARTHRITIS	GONORRHEA	KIDNEY STONES	STREP INFECTION
ASTHMA	HEART TROUBLE	LUPUS	SYPHILIS
BLEEDING TENDENCIES	HEPATITIS	NEUROLOGIC DISORDER	TUBERCULOSIS
CANCER	HIV	PEPTIC ULCER	UTI
DIABETES	HYPERTENSION	PNEUMONIA	VEIN TROUBLE
DIABETES, INSULIN TAKING	JAUNDICE	PSYCHIATIRC DISORDER	

PLEASE LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

____

____

____

Effective Date of this Notice:______________

DESERT KIDNEY ASSOCIATES, plc
1450 S. Dobson Rd., Suite 309, Mesa AZ 85202
Phone: (480) 834-9039 Fax: (480) 964-7802

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU OCAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE, CONTACT:

Practice Administrator (480) 834-3995

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example we may ask you to have laboratory test (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you, Many of the people who work for our practice- including, but not limited to, our doctors and nurses- may use or disclose your IIHI in order treat you or to assist other in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents,

2.Payment. Our practice may use and disclose your IIHI in order to bill and collect to bill and collect payment for the service and items you may receive from us. For example, we may content your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for service and items.

3. Heath Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for practice.

OPTIONAL:
4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you
and remind you of an appointment.

OPTIONAL:
5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
Effective date of this Notice:____________

OPTIONAL:
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES.

The following categories describe unique scenarios in which we may use of disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths

- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful.

process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain and order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our office
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study, (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Practice Administrator (480) 834-3995, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the Practice Administrator (480) 834-3995. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Administrator (480) 834-3995 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Administrator (480) 834-3995. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the

Reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Administrator (480) 834-3995. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before. April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Administrator @ (480) 834-3995

7. **Righ to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator @ (480) 834-3995. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Administrator @ (480) 834-3995.

Desert Kidney Associates, PLC
1450 S. Dobson Rd., Suite 309, Mesa AZ 85202
Phone: (480) 834-9039 Fax: (480) 964-7802

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

You May Refuse to Sign This Acknowledgment

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_______________________________________ _______________________________________
Patient or legally authorized individual signature Date

_______________________________________ _______________________________________
Printed Name Relationship, if signed on behalf of the patient, (parent, legal guardian, personal representative, etc.)

I hereby authorize the following person(s) to have access to may Individually Identifiable Health Information (IIHI) providing they can provide DKA Staff members with the last four (4) digits of my social security number.

Name:________________________________ _____Spouse _____Son _____Daughter

Name:________________________________ _____Other (Relationship)_______________

_______________________________________ _______________________________________
Signature Date

****

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

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other (Please Specify: ____

____