

Mississippi Kidney

Batesville Office
Clarksdale Office
Grenada Office
Holly Springs Office
Oxford Office

Tupelo Office - *The Wooldridge Clinic*

PATIENT NAME: _____

EMAIL ADDRESS: _____

SSN: _____ DOB: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: HOME _____

WORK _____

MOBILE _____

MARITAL STATUS _____

PREFERRED LANGUAGE _____

RACE: _____ ETHNICITY: _____

EMERGENCY CONTACT INFORMATION

NAME: _____

NAME: _____

RELATIONSHIP: _____

RELATIONSHIP: _____

PHONE NUMBER: _____

PHONE NUMBER: _____

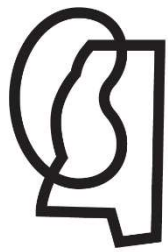
PRIMARY CARE PROVIDER: _____ LOCATION: _____

INSURANCE COVERAGE: **PLEASE BRING YOUR CARDS TO YOUR VISIT**

****If pre-cert is required for initial visit, this will be the responsibility of the patient or the patients referring provider.
This must be obtained prior to the first appointment.**

Patient Signature: _____ **Date:** _____

**** please bring your medication bottles with you to your visit****



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PRIMARY INSURANCE

INSURED'S NAME: _____
INS. CO. NAME: _____ ID # _____ GROUP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF SOMEONE OTHER THAN YOURSELF CARRIES THE POLICY, PLEASE FILL OUT:

HIS/HER NAME: _____ RELATIONSHIP: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
PLACE OF EMPLOYMENT: _____

SECONDARY INSURANCE

INSURED'S NAME: _____
INS. CO. NAME: _____ ID # _____ GROUP: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IF SOMEONE OTHER THAN YOURSELF CARRIES THE POLICY, PLEASE FILL OUT:

HIS/HER NAME: _____ RELATIONSHIP: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
PLACE OF EMPLOYMENT: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment to obtain reimbursement, I authorize disclosure of portions of the patient's records.

☐ I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and other health plans to NEPHROLOGY AND HYPERTENSION ASSOCIATES, LTD., d/b/a Mississippi Kidney (Thomas D. Wooldridge, M.D.; J. Martin Lee, Jr., M.D.; Morris R. Hamilton, M.D.; Christopher D. Miller, M.D.; Marcus Louis Britton, M.D.; Son G. Lam, M.D.; Amita Maibam, M.D.; J. William Elliott, D.O.; Nathan Bell, D.O.; Vikram B. Beemidi, M.D.; Calvin C. Baker, M.D.; S. Thomas Johnston, M.D.; Kathy Thomas, AGACNP; Christy Jagers, FNP-BC; Fred A. Rayburn, FNP-BC; Jamesha Tumblin, DNP-BC; Brandy M. McCain, FNP-BC; William Corey McCain, FNP-C; Inez Blanchard, AGNP-C; Kathy L. Alfred, FNP; Kristen Roberts, FNP-C). This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient or responsible party:

Date:

☐ I have **no insurance coverage** of any type and I understand that I am fully responsible for any charges that may incur at Nephrology and Hypertension Associates, LTD. d/b/a Mississippi Kidney.

Patient or responsible party:

Date:



CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of medical records to NEPHROLOGY AND HYPERTENSION ASSOCIATES d/b/a Mississippi Kidney. The records should be from the health record of:

Patient Name

Patient DOB:

Records Requested:

☐ Entire Patient Record

☐ _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

This facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed

Patient or Representative

Relationship to Patient

Date of Signature

Please fax records to one of the following:

Batesville Office – 662-236-2922

Clarksdale Office – 662-627-3014

Oxford Office – 662-236-2922

Tupelo Office – *The Wooldridge Clinic* – 662-844-9619



BATESVILLE OFFICE

CLARKSDALE OFFICE

GRENADA OFFICE

HOLLY SPRINGS OFFICE

OXFORD OFFICE

TUPELO OFFICE- *The Wooldridge Clinic*

Cancellation/No-Show Policy/Late policy

Quality care for our patients is our top priority. Please take a few moments to review of our no-show policy and sign at the bottom of the form. If you have questions, please let us know.

Definition of a “No-Show” appointment

Nephrology and Hypertension Associates, LTD. d/b/a Mississippi Kidney defines a “No-Show” appointment as any scheduled appointment in which the patient does not arrive for the appointment.

Impact of a “No-Show” appointment

“No-Show” appointments have a significant impact on our practice and the healthcare we provide our patients. When a patient “No-shows” for a scheduled appointment it:

- Potentially jeopardizes the health of the patient is a “No-show”
- Prevents another patient from being scheduled in that time slot.
- Effects the providers time negatively.

How to avoid “No-Show” appointment

- Provide the receptionist with a current phone number and address at EVERY visit.
- Confirm your appointment date and time when receiving a reminder call.
- Arrive 15 minutes early to complete any necessary paperwork at each visit.
- Come prepared with your most recent insurance card and a picture ID at EVERY visit.
- Give at least a 24 hour notice when cancelling your appointment.

Consequences of a “No-show” appointment

If you have three (3) no show appointments in your record within a year, you may be discharged from the practice.

Late arrival policy

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

Patient Signature or Patient Representative

Date



Mississippi Kidney

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

If you would like to be provided a copy of the Privacy Policy for Nephrology and Hypertension Associates, LTD., D/B/A Mississippi Kidney, this can be obtained at the front desk, by calling our office to request a copy be mailed to you, or by visiting our website at www.mskidney.com

I acknowledge that I have been offered a copy of Nephrology and Hypertension Associates, LTD. d/b/a Mississippi Kidney Notice of Privacy Practices.

SIGNATURE OF PATIENT: _____

DATE: _____

PLEASE LIST THREE PEOPLE (FAMILY/FRIENDS) WHO MAY CONTACT US REGARDING YOUR PROTECTED HEALTH INFORMATION:

1. _____

2. _____

3. _____

☐

BY CHECKING I ACKNOWLEDGE THAT I DO NOT WANT MY HEALTH INFORMATION DISCUSSED WITH ANYONE WHO MAY CALL THIS OFFICE WITH THE EXCEPTION OF OTHER HEALTHCARE PROVIDERS.

FOR USE BY OFFICE PERSONNEL ONLY: COMPLETE IF PATIENT ACKNOWLEDGEMENT NOT OBTAINED:

THE PATIENT WAS PROVIDED THIS **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** AND A GOOD FAITH ATTEMPT WAS MADE TO OBTAIN THE PATIENT'S SIGNATURE ACKNOWLEDGING RECEIPT.

AN ACKNOWLEDGEMENT WAS NOT OBTAINED BECAUSE _____

SIGNATURE OF OFFICE PERSONNEL: _____ DATE: _____



THOMAS D. WOOLDRIDGE, M.D.
J. MARTIN LEE, JR., M.D.
TZONKO V. MILEV, M.D.
MORRIS R. HAMILTON, M.D.
CHRISTOPHER D. MILLER, M.D.
MARCUS LOUIS BRITTON, M.D.
SON G. LAM, M.D.
AMITA MAIBAM, M.D.
J. WILLIAM ELLIOTT, D.O.
T. NATHAN BELL, D.O.
VIKRAM B. BEEMIDI, M.D.
CALVIN C. BAKER, M.D.
S. THOMAS JOHNSTON, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Nephrology & Hypertension Associates, Ltd., d/b/a Mississippi Kidney is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information we maintain. If we revise the terms of this notice, we will post a revised notice and will make paper copies of this notice available upon request.

When we use the terms “we” or “MS Kidney” we mean Nephrology & Hypertension Associates, Ltd., d/b/a Mississippi Kidney, its affiliates, laboratory, medical professionals and others who assist us in our business.

If you have any questions about this notice or if you need more information, please contact our privacy officer:

Wendi Long
1542 Medical Park Circle
Tupelo, MS 38801
662-844-4711 (phone)
662-844-9619 (fax)
wlong@nephrologyms.com

WHAT IS PROTECTED HEALTH INFORMATION? “Protected health information” is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your healthcare.

HOW YOUR PROTECTED HEALTH INFORMATION WILL BE USED AND DISCLOSED:

TREATMENT: We may use or disclose your protected health information to provide medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

We may also share protected health information about you to schedule tests and procedures that you need. We may also disclose protected health information about you to people who are involved in your care such as family members, other physicians, or pharmacists.

PAYMENT: We may use and disclose your protected health information 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.

HEALTH CARE OPERATIONS: We may use and disclose your Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.

APPOINTMENT REMINDERS/TREATMENT ALTERNATIVES/HEALTH RELATED BENEFITS AND SERVICES: We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

INDIVIDUALS INVOLVED IN YOUR CARE: We may use or disclose your protected health information to notify a family member, a personal representative or another person responsible for your care, general condition or death.

RESEARCH: We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researches to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

AS REQUIRED BY LAW: We will disclose Protected Health Information about you when required to do so by international, federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

BUSINESS ASSOCIATES: We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.

ORGAN AND TISSUE DONATION: If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS: If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of the foreign military.

WORKERS' COMPENSATION: We may use or disclose Protected Health Information for workers compensation or similar programs that provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS: We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent control of disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

ABUSE, NEGLECT OR DOMESTIC VIOLENCE: We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

HEALTH OVERSIGHT ACTIVITIES: We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for examples, 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.

DATA BREACH NOTIFICATION PURPOSES: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

LAWSUITS AND DISPUTES: If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

LAW ENFORCEMENT: We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

MILITARY ACTIVITY AND NATIONAL SECURITY: If you are involved with military, nation security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so that they may carry out their legal duties under the law.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

INMATES: if you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official 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

- **INDIVIDUALS INVOLVED WITH 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 Protected Health Information that directly relates to the 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 professional judgement.
- **DISASTER RELIEF.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your 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.
- **FUNDRAISING ACTIVITIES:** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization.

- Uses and disclosures of Protected Health Information for marketing purposes; and
- Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION:

You have the following rights, subject to certain limitations, regarding your Protected Health Information.

- **RIGHT TO INSPECT AND COPY:** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information 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 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 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.
- **RIGHT TO A SUMMARY OR EXPLANATION:** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information that has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **RIGHT TO AN ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS:** If your Protected Health Information 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 Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information 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 for or format, a readable hardcopy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

- **RIGHT TO GET A NOTICE OF A BREACH:** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **RIGHT TO REQUEST ADMENDMENTS:** If you feel that the Protected Health Information 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.
- **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 Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this notice. It excludes the 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.
- **RIGHT TO REQUEST RESTRICTIONS:** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Protected Health Information 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 Protected Health Information, 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 Protected Health Information 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 Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **OUT OF POCKET PAYMENTS:** If you paid out of pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information 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.
- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we can contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **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 at the beginning of this notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this notice, contact our privacy officer by phone or mail.

CHANGES TO THIS NOTICE: We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current notice is posted in our office.

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) 696-6675) 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 filling a complaint.