Metro Renal Associates Notice of Privacy Practices

The notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At **Metro Renal Associates**, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this office.

The law permits us to share or disclose your health information to those involved in your treatment, for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all your health information when required by law.

If this practice is sold, your information will become the property of the new owner unless the practice notifies you otherwise.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address and telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. **$20 ADMINISTRATION FEE PLUS $1.10 PER PAGE. You will also be responsible for postage.**

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S. W. . Room 509F. Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding you health information privacy, please contact our privacy officer Brenda Smith. 202-877-5408. This notice goes into effect as of August 1, 2012.

Acknowledgement

I have received a copy of the Metro Renal Associates Notice of Privacy Practices.

Date_____

Signed_____ **Print Name**_____

If signing as a parent or Guardian, Please provide the Patient's name:_____

Cosette O. Jamieson, MD & Kevin O. Griffiths, MD
INTERNAL MEDICINE / NEPHROLOGY
106 Irving St. N.W. Suite N 2500
Washington, D.C., 20010
202-877-5408 Fax: 202-722-0505

DX: _____

Admission Date: _____
Medical Record No: _____

Patient Name: _____
(Please Print) Last First MI

THIS IS TO CERTIFY THAT THE UNDERSIGNED HEREBY:

Authorizes Cosette O. Jamieson, M.D. or Kevin O. Griffiths, M.D., to act as agents in the billing of Medicare or any other insurance or reimbursing agency for this hospitalization and any other related claim, and to release such information for hospital records relating to my identity, diagnosis, prognosis or treatments as may be required or requested in connection therewith; requests that payment of authorized benefits be made to the above named hospital, physicians and medical groups in behalf of the patient; and certifies that the information given in applying for payment under the Social Security Act or health insurance companies is correct and authorizes verification therefore. I also understand that this consent to release information from hospital records to file claim forms and the assignment of benefits made herein is revocable except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for such time as is necessary to effectuate the purpose for which it is given. I understand that I have the right to inspect my record of mental health information and that this authorization for disclosure of any of my mental health information is limited to information that is now in existence. I further understand that my mental health information cannot be disclosed without my authorization and that the law requires this notice. The unauthorized disclosure of mental health information violates the provisions of the District of Columbia mental Health Information act of 1978. Disclosure may only be made pursuant to valid authorization by the client or as provided in Titles III or IV of that ACT. The act provides for civil damages and criminal penalties and violations.

Signature of Patient: _____ Date: _____

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IF THE PATIENT IS UNDER THE AGE OF 18, IS INCOMPETENT OR OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

The undersigned is the parent, legal guardian, or closest relative of the patient and executes this form in their behalf.

Signature: _____ Relationship to Patient: _____

Cosette O. Jamieson, MD & Kevin O. Griffiths, MD
INTERNAL MEDICINE / NEPHROLOGY
106 Irving St. N.W. Suite N 2500
Washington, D.C., 20010
202-877-5408 Fax 202-722-0505

PATIENT INFORMATION SHEET

Name: _____
Last First MI

Address: _____

_____
City State Zip County

Telephone: Home: ( ) _____ **Work: ( )** _____ **Cell: ( )** _____

Age: _____ **Sex:** _____ **Race:** _____ **Ethnicity:** _____ **Martial Status:** _____

Date of Birth: _____ **Religion:** _____ **Language:** _____

Social Security #: _____ **Mother's Name:** _____

Referring Physician: _____ **Phone Number:** _____

Patient Occupation: _____ **How Long:** _____

*If retired, Date of Retirement: _____

* If spouse retired, Date of Retirement: _____

Employer: _____ **Phone Number:** _____

Address: _____

PLEASE COMPLETE SECTION BELOW- IF YOU LEAVE THIS SECTION BLANK, YOU WILL BE BILLED AS SELF-PAY CLIENT

Insurance Information

1, Medicare No. _____ **A or B**

2. Medicaid No. _____ **Place: DC** ____ **MD** ____ **VA** _____

3. Blue Cross/Blue Shield of: DC: ___ **MD:** ___ **VA:** ___ **Other:** _____

ID No. _____ **Group No:** _____

Subscriber's Name: _____

4. Private/ Commercial Coverage: Policy No.: _____ **Group No:** _____

Company Name: _____

Address for submitting claims: _____

_____ **Phone No:** _____

Subscriber's Name: _____

****

Name of Nearest Relative/ Emergency Contact: _____
Complete Address: _____
Phone No: _____ **Cell No:** _____ **Relationship:** _____

Today's Date: _____

PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Do you have any **ALLERGIES** or had any **REACTIONS** to any medicines? Yes _____ No ____
If yes, Please list medicines and reactions:

_____

_____

Please list all medicines you are currently taking:

Medications	Directions	How long?	Dr. Prescribed

Immunization Status:
Have you had the Hepatitis B vaccine? Yes ___ No _____
Have you had the influenza or pneumovax vaccine? Yes _____ No _____
When was your last tetanus vaccine/booster? _____

MEDICAL HISTORY REVIEW:

Have you had or do you currently have:

- ☐ Renal disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart disease
- ☐ Chest pain
- ☐ Seizures/ blackouts
- ☐ Cancer: type _____
- ☐ Depression / mental illness
- ☐ Wt. problem: over __ under__
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Drug abuse problems
- ☐ Asthma / Hay fever
- ☐ Liver problems
- ☐ Other

Do you have a family history of : Relationship

- ☐ Renal disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart disease
- ☐ Chest pain
- ☐ Seizures/ blackout
- ☐ Cancer: type___
- ☐ Depression/ mental illness
- ☐ Wt. Problem: over __ under __
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Drug abuse problems
- ☐ Asthma/ Hay fever
- ☐ Liver problems
- ☐ Other

Past Hospitalizations / Surgery ? Yes ___ No ____ If yes, please list :

_____

_____

_____

Other relevant history ?

_____

_____

Do you receive health from other doctors? Please list and indicate the reason

_____

_____

_____

FEMALES ONLY	MALES ONLY
Menstruation: Age of Onset: _____ Regular _____ Irregular _____ Flow: Heavy ___ Moderate ____ Light ____ Pain/ cramps with menstrual flow: Yes __ No ___ Bleeding after sex: Yes _____ No _____ No. of Pregnancies: _____ No. of live births: _____ Birth Control Method: _____ Are you currently pregnant: Yes ____ No ____ Flushing / Menopause? Yes _____ No _____	Do you perform monthly self Testicular exam Yes _____ No _____ Do have you have problems with impotence? Yes ___ No _____ Do you have problems starting your urine stream? Yes ____ No _____

SOCIAL HISTORY

Tobacco use? Yes ___ No ___ Numbers of packs per Day _____ for _____ years
Are you an ex-smoker ? Yes ___ No ___ Numbers of packs per Day _____ for ___ years
Alcohol user ? Yes ___ No ___ Amount per day _____ How often _____
Coffee user ? Yes ____ No ____ Number of cups per day _____
Do you have a regular exercise program? Yes ____ No ____
Do you wear a seatbelt? Yes ____ No ____
Have you ever / or currently use street drugs? Yes ____ No ____

PREVENTION and SURVEILLANCE:

When was the last time you:
Had stool cards to examine for occult blood? _____
Had a digital rectal exam to screen for tumors? _____
Had a sigmoidoscopy/ colonoscopy _____
Had an eye exam? _____
Had a dental exam? _____
Had a chest X-ray or PPD test? _____
Had an EKG? _____
IF MALE:
Had blood for PSA level _____
Had a prostate exam _____
IF FEMALE:
Last Pap smear Date: _____ Dr._____
Last Mammogram Date: _____
Do you practice monthly self- breast exam? Yes ___ No___
Had a breast exam by a doctor? _____

Date completed: _____

Washington, DC 20010
(202) 877-5408
Fax: (202) 722-0505

Office and Billing Policy

The following is our office policy:

1. All Referrals will be processed within 2 -3 business days. If you provide a FAX number, we will be happy to fax your referrals to your consultant, otherwise, we will assume that patients will come to pick it up. *We will not be able to back date referrals done on the internet, so please try to notify us* ***before*** *your appointment date.*

2. Prescriptions will be processed in 1 business day. For prescription refills, please have your pharmacy fax the request to our office.

3. All missed appointments will be subject to a **$25 charge,** unless a 24 hour notice is given or an appropriate explanation is obtained. *This also includes* ***same day appointments*** *in that if a patient does not attempt to contact the office or calls AFTER the appointment is missed, a $25 fee will be charged.* ***If there are any extenuating circumstances, PLEASE call us to discuss it.***

4. There is a $25 charge for all RETURNED checks.

5. **An interest of 1.5-percent per month AND $10 BILLING FEE** will be added to patients balance after **EACH** 30 days should there be no payment arrangements made previously with our office.

6. **For those patients with outstanding balances**: it is the patient's responsibility to contact the office and make payment arrangements that are mutually agreed upon. In the event, payments are not made, accounts will be forwarded to a collection agency ***after ninety days***. A collection fee of $50 will be added to your balance. Patients will be requested to find alternative medical care within 30 days from being referred to the collection agency. Patients will be responsible for all collection and legal fees. From that point, we will not be able to provide further service until payment is received in full.

The office will be happy to discuss any questions, comments or problems at the patient's request. Your cooperation is greatly appreciated.

Sincerely,

Metro Renal Associates

I have read the above policy and agree to the terms.

Patient's
Signature:_____Date_____