7331 Hanover Parkway
Suite B
Greenbelt, MD 20770

1127 West Street
Suite 105
Annapolis, MD 21401

CENTRAL MARYLAND NEPHROLOGY ASSOCIATES, L.L.C.
Ali Ipakchi, M.D. Arun Jayakumar, M.D. Sanil Nath, M.D.
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NOTICE TO PATIENTS

This notice describes how medical information about you may be used and disclosed. We are required by law to protect the privacy of your protected health information. This document also explains how you can gain access to your medical information and who to contact should you have any complaint. Please read this document carefully and sign the bottom of this form to acknowledge that you have received it.

A. The general consent for release of medical records that you sign authorizes Central Maryland Nephrology to disclose the information in your medical record for treatment, payment and health operations.

    1. For the purpose of providing treatment to you. Your information may be shared with e.g. employees and contractors of the provider, or with other health care providers who are treating you or consulting in your care.
    2. For the purpose of arranging payment for your care. Your information may be shared with your insurer or other third-party payor who is responsible for paying all or part of the cost for your care.
    3. For the purpose of health care operations. We may use and disclose Information that is necessary for our operations e.g. internal quality assessments, contacting other health care providers about treatment alternatives. We may also disclose information to other doctors, nurses and technicians. We may use information about you to remind you of an appointment for treatment of medical care.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. For example if we receive a subpoena for the records or if public

responsibility requires disclosures e.g. to protect public health. We will keep all disclosures of your medical records to the minimum necessary.

E. Your rights regarding health information about you.

1. You have the right to inspect and copy your health information.
2. If you feel that the health information we have about you is incomplete or inaccurate, you have the right to request an amendment to your medical records. The request must be made in writing with reason that supports your request. If we do not agree with your request you have the right to ask that your statement be placed in the medical record.
3. You have the right to find out how your health information is used and to whom it is disclosed. You may request an accounting of your medical record disclosures made by us except for disclosures made for treatment, payment and health care operations.
4. You have the right to receive a paper copy of this notice.

F. We are required by law to maintain the privacy of your protected health information and if you believe that your rights have been violated you may complain to the Secretary of the U.S. Department of Health and Human Services or complain to us by talking to us, calling us, or writing to us with details. Please ask to speak to or contact our privacy complaints contact person whom is our Office Manager. We will not retaliate in any way against a patient for making a complaint.

G. We reserve the right to change our privacy practices and to make new policies effective for all protected health information that we maintain. If we should do so we will issue an updated "notice to patients" to all of our patients.

Please acknowledge receipt and review of this notice by signing below. For further information please call the Office Manager, at 301-345-0605.

Name of patient: _____Date: _____

Signature of Patient or lawfully authorized representative: _____

Date patient was given a copy of this notice: _____

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Office: 301-345-0605
Fax: 301-345-0606

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Annapolis, MD 21401
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Family and Friends Contact Form

Persons who are involved in you care, (family, friends, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note in emergency situations or other situations outlined on our Notice of Privacy Practice we may share information with others who are not specifically listed on this form)

Please list those persons (including Family & Friends) with whom we may share your information:

_____ _____

_____ _____

_____ _____

From time to time we will leave a message for you (as stated in our Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include details (such as diagnosis, Lab results, Radiology results, medication information, appointment changes) at this number?**

Phone number we can leave a message on: (_____) _____Circle:Home Work Cell
or (_____) _____ Circle: Home Work Cell

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

_____
Date of Birth

_____ _____
Print Name of Patient or Legal Representative **Relationship to Patient**

Central Maryland Nephrology, LLC

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Central Maryland Nephrology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Central Maryland Nephrology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I receive services from Central Maryland Nephrology, unless revoked by me in writing.

By signing this consent I also confirm that I have received and understand the Notice of Privacy Practices and how the practice may use and/or disclose protected health information. I understand that Central Maryland Nephrology cannot be responsible for use or re-disclosure of information by third parties.

I certify that I have read this form and/or it has been read to me.

Date: _____

Print Name (Patient): _____ **DOB:**_____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this consent, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ **Date:** _____

Prescription Refill Policy

To Our Patients:

We want to help you with your prescription refills. In our office, we have numerous calls, electronic requests and faxes throughout the day from pharmacies for our patients' prescription needs.

So that we are able to get medications you need in a timely fashion, here are some things you can do to work with us.

1. **Watch your medication dates**- ask for your refills two to four business days before they run out(or several weeks if sending away for your prescriptions).

2. **Please call your pharmacy directly** to ask for refills.

3. **Please try not to go to the pharmacy and wait for them to call us** for a refill approval without two business days advance notice. If your doctor is not available, you may not get immediate service on routine refill requests.

4. **Patients must be seen within the year in order for us to refill your prescription request.**

5. **Please furnish us with your pharmacy information.**

Patient Name: _____

Name & Address of Pharmacy: _____

Pharmacy phone number: _____

Prescription(s) be refilled: _____

PLEASE READ COMPLETELY AND SIGN

POLICY REGARDING MISSED APPOINTMENTS

MISSED APPOINTMENTS- Twenty-four (24) hours notice is required prior to the appointment to let us know that you will not be keeping your appointment. You can call our office at 301-345-0605 to cancel or reschedule your appointment. You may always leave a message with our answering service if you need to call outside our routine business hours.

There will be a $40.00 charge if you do not call within the required 24 hours and you must pay the charge before rescheduling or being seen for your next appointment.

Patient/Guarantor Name: _____

Signature: _____ Date: _____

Welcome to Central Maryland Nephrology
Please complete this form for our records

Name:_____

Phone number:_____

Today's date:_____

Address:_____

_____

Your primary doctor:_____

Birthdate:_____

Other doctors you've seen recently:_____

What is the primary purpose of your visit today?

Describe your medical problems (past and present), especially kidney problems:

1)
2)
3)
4)
5)
6)

What medications are you currently taking?

Name of medicine	Dose	Name of medicine	Dose
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

List your drug allergies (describe the allergic reaction): _____

_____

Tell us about yourself:

Describe your tobacco use (past & present):_____

Describe your alcohol use (past & present):_____

Are you currently employed?_____

What is (was) your occupation?_____

Patient name:_____
Date:_____

Tell us about your family's health:

Describe your mother's medical history:_____
_____

Describe your father's medical history:_____
_____

List all your children and their medical histories:_____
_____
_____

List all your siblings and their medical histories:_____
_____

List all relatives with any history of diabetes:_____
_____

List all relatives with any history of high blood pressure:_____
_____

List all relatives with any history of kidney problems:_____
_____

Check the box if you have any of the medical conditions listed below:

___Fatigue	___Swollen glands	___Abdominal pain	___Joint pains
___Headaches	___Palpatations	___Vomiting blood	___Blackouts
___Earaches	___Chronic cough	___Urinary tract infect	___Itching
___Neck pain	___Constipation	___Incontinent of urine	___Dentures
___Chest pain	___Hemorrhoids	___Muscle pains	___Ear ringing
___Asthma	___frothy urine	___Dizziness/vertigo	___Short of breath
___Diarrhea	___Frequent urination	___Dry skin	___Short of breath at night
___Vomiting	___Muscle weakness	___Weakness	___Blood in stool
___Bloody urine	___Seizures	___Hearing loss	___Hepatitis B or C
___Urinate at night	___Acne	___Mouth sores	___Difficult/painful urination
___Leg swelling	___Fever	___Goiter	
___Tremors	___Double vision		___Poor sensation in limbs
___Rashes	___Sore throat	___Emphysema	___Hair or nail changes
___Weight loss	___Thyroid problems	___Incontinence	___Blood clots
___Vision problems	___Sinus problems	___Fainting	___Ulcers

Physician signature:_____