DALLAS KIDNEY DKS SPECIALISTS, P.A.

Adriana B. Cano, M.D. ♦ Swathi P. Ganaraj, M.D. ♦ Peter Choi, M.D.
Sailaja Adari, M.D. ♦ Jeffrey R. Thompson, M.D.

Appointment Policy for Dallas Kidney Specialists

Due to the increase amount of patients not showing up for scheduled appointments, Dallas Kidney Specialist has adopted the following policy.

All patients are required to pay a fee if appointment is not cancelled or rescheduled by 12PM at least one business day prior to your appointment. We have reserved this time just for you, having an empty appointment caused by failure to keep your scheduled appointment is both costly to our office and unfair to other patients in need of an appointment. The fee will be required before you can be seen by physician.

New Patients

90 minutes will be reserved for New Patients

If you do NOT cancel or reschedule your appointment by noon, at least one business day ahead of your appointment, you will be responsible for the **$50.00** fee. If you keep the appointment, you will only be charged for the appointment, not the cancellation fee.

Established Patient

30 minutes will be reserved for Established Patients

If you do NOT cancel or reschedule your appointment by noon, at least one business day ahead of your appointment, you will be responsible for the **$25.00** fee. If you keep the appointment, you will only be charged for the appointment, not the cancellation fee.

Thank you for understanding.

Dallas Kidney Specialists

Signature of Patient or Legal Representative	Print Name of Patient or Legal Representative	Date

Dallas Kidney Specialists, PA

1341 Mockingbird Lane, Suite 240E, Dallas, TX 75247
Privacy Officer 214-638-6600

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

Continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective date: October 2016

Dallas Kidney Specialists, PA

1341 Mockingbird Lane, Suite 240E, Dallas, TX 75247
Privacy Officer 214-638-6600 x116, dksmanager@sbcglobal.net

Acknowledgement
To receipt of Notice of Privacy Practices

I understand that as a part of my healthcare, DALLAS KIDNEY SPECIALISTS, PA (PHYSICIAN), originates and maintains health records describing my health history, symptoms, examinations and treat results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and in other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals and as required or permitted by law without my consent.

The PHYSICIANS'S *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this acknowledgement. I understand the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of a revised *Notice of Privacy Practices*, the revised notice will be mailed to me if I provide my address below*.

I have been provided and have reviewed the PHYSICIANS *Notice of Privacy Practices* dated, October 2016.

_____
Signature of Patient or Legal Representative

_____
Print Name of Patient or Legal Representative

_____
Date

*I request that changes to the *Notice of Privacy Practices* be sent to me at this address:

_____

_____

DALLAS KIDNEY DKS SPECIALISTS, P.A.

Peter Choi, M.D. ♦ Swathi P. Ganaraj, M.D. ♦ Adriana B. Cano, M.D.

Sailaja Adari, M.D. ♦ Jeffery R. Thompson, M.D

ASSIGNMENT OF BENEFITS

I hereby assign to **Dallas Kidney Specialists, P.A.** all payments for medical services rendered to myself or my dependents. I understand that I may be responsible for any amount not covered by my insurance company.

_____ _____

Patient's Signature Date

FINANCIAL POLICY

I understand that any unpaid balance over 30 days with no payment will be subject to being turned over for collection and/or reported to the Credit Bureau as uncollectible.

I have read and understand the financial policy of **Dallas Kidney Specialists, P.A.**

_____ _____

Patient's Signature Date

NOTE: COPAY AND DEDUCTIBLE ARE DUE AT THE TIME OF VISIT

1341 W. Mockingbird Lane Suite 240E Dallas, TX 75247
Office (214) 638-6600 Fax (214) 638-6618

DALLAS KIDNEY DKS SPECIALISTS, P.A.

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Sailaja Adari, M.D. ♦ Jeffrey R. Thompson, M.D.

Patient's Full Name	**Patient's Social Security Number**
Address	**Patient's Date of Birth**
City, State, Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclose of protected information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   Dallas Kidney Specialists, P.A.

2. The following person (or class of person) may receive disclosure of protected health information about me:

Name		Name	
Address		Address	
City, State, Zip Code	Telephone#	City, State, Zip Code	Telephone#

3. The specific information that should be disclosed is (please give dates of service if possible)
   _____
   _____
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying DALLAS KIDNEY SPECIALISTS in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is _____.
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual* (The person about whom the information relates) OR, if applicable –	**Date of Individual's Signature**	**Date of Birth or SS#**
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal representative's Signature**	**Description of Authority to Act for the Individual**

Patient Assisted by ☐ **MA** ☐ **MOA** ☐ **Spouse** ☐ **Parent** ☐ **Special Dependent** ☐ **Other** _____

A copy of this completed, signed and dated form must be given to the Individual or other signatory

Office Use Only		
Received	**Processed By**	**Log#**

1341 W. Mockingbird Lane Suite 240E Dallas, TX 75247
Office (214) 638-6600 Fax (214) 638-6618

DALLAS KIDNEY DKS SPECIALISTS, P.A.

Adriana B. Cano, M.D. ♦ Swathi P. Ganaraj, M.D. ♦ Peter Choi, M.D.
Sailaja Adari, M.D. ♦ Jeffrey R. Thompson, M.D.

Patient's Full Name	**Patient's Social Security Number** NA
Address	**Patient's Date of Birth**
City, State, Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclose of protected information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me: _____
2. The following person (or class of person) may receive disclosure of protected health information about me:

Physician/Location Name		Physician/Location Name	
1341 W. Mockingbird Ln. Suite 240E			
Address		Address	
Dallas, TX 75247	214-638-6600		
City, State, Zip Code	Telephone#	City, State, Zip Code	Telephone#

3. The specific information that should be disclosed is (please give dates of service if possible) ALL / OR
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying DALLAS KIDNEY SPECIALISTS in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is help with my medical care.
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual* (The person about whom the information relates) OR, if applicable –	**Date of Individual's Signature**	**Date of Birth or SS#**
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal representative's Signature**	**Description of Authority to Act for the Individual**

Patient Assisted by ☐ **MA** ☐ **MOA** ☐ **Spouse** ☐ **Parent** ☐ **Special Dependent** ☐ **Other** _____

A copy of this completed, signed and dated form must be given to the Individual or other signatory

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PHONE MESSAGE CONSENT

From time to time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we like to leave messages where possible.

In order to protect your privacy, we have developed a policy on leaving messages.

We will not discuss any medical or financial information with anyone except the patient or legal guardian.
We will not leave any medical or financial information on an answering machine.
We will not leave any medical or financial information on a voice mail system.
We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment.

UNLESS

We have your written permission to leave a message for you. Please read the information below and consider carefully whom you want to have access to your medical and/or financial information, such as test results.
Please fill out only ONE of the following sections below to make your preference known.

A. I DO CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, give permission to Dallas Kidney Specialists, P.A. and their staff my permission to leave phone messages regarding my **medical care** and/or **financial status** with the following: (**please circle Medical and/or Financial or both**)

Initial for each one you wish to have your messages left

My home phone answering machine _____ Phone # _____

My work phone voice mail _____ Phone # _____

My spouse (name) _____ Phone # _____

Other (name) _____ Phone # _____

Signature: _____ Date: _____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care and/or financial status (*please circle Medical and/or Financial or both*) be left on an answering machine, voice mail or with others.

Signature: _____ Date: _____

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Patient Information / Please print

Email: _____ Today's Date: _____

Name: _____ Birthdate: _____/_____/_____

Sex: Male____ Female____ Race/Ethnicity: _____ Language Preferred: _____

Social Security Number: _____-_____-_____ Driver's License #: _____

Home Address: _____ City: _____ Zip: _____

Home/Cell#: _____ Wrk/Alt#: _____ Pref #: Hm Wrk Mobile Pgr Fx

Do you give Dallas Kidney Specialists, P. A. permission to leave voicemail: ☐Yes ☐No

Marital Status: _____ Spouse's Name (if applicable): _____

Employed: Yes____ No____ Employer(if applicable): _____

Work Address: _____ City: _____ Zip: _____

Emergency Contact

Person to Contact in the event of an emergency: _____

Relationship to you: _____ Phone #: _____

Primary Care Provider

Full Name of Provider: _____, Title: **MD, DO, DC, NP, PA, ND**

Tel#: _____ Address: _____

Insurance Information

Do you have medical insurance? Yes____ No____

HMO ___ PPO ___ POS ___ Choice Plus ___ Neither ___

*Primary Insurance Company (if applicable): _____

Insurance ID #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

Insured Person's Social Security Number (if different from patient): _____

Insured Person's Date of Birth: _____

*Secondary Insurance Company(if any): _____

Secondary Insurance ID #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

Insured Person's Social Security Number (if different from patient): _____

Insured Person's Date of Birth: _____

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DALLAS KIDNEY DKS SPECIALISTS, P.A.

Confidential Health Questionnaire

Name:	Date:

Referring Physician: Telephone: Address: City: State:
Primary Care Provider:
Other Physicians:

Prior Hospitalizations

Date	Hospital	Reason
Have you ever received a blood transfusion? Y/N How Many? Date:		

Surgical History

Date:	Operation:

Injuries (broken bones, concussions, dislocations, etc.)

Date:	Injury:

Childhood Illnesses	Yes	No	Vaccinations	Yes	No
Measles			Measles		
Chicken Pox			German Measles		
Mumps			Chicken Pox		
Other			Mumps		
			DPT Diphtheria, Pertussis & Tetanus		
			Pneumovax		
			Polio		

Date of last Tetanus:
Date of Last Influenza:
Tuberculosis skin Test: Yes / No Positive / Negative Date last tested:

Menstrual History (If Applicable)

Age when Period began:	Last normal menstrual period:
Bleeding between periods: Yes / No	Irregular menstrual periods: Yes / No
How many pregnancies:	How many children:
Were pregnancies complicates: If "yes", please explain:	
Any miscarriages or abortions:	
Ever used IUD:	Ever used birth control pills:

Medication Allergies

Name	Reaction

Medications

(Including prescribed, over-the-counter, vitamins, birth control pills, laxatives, aspirin, "herbs" and other remedies)

Name	Dose	Frequency	Duration of Therapy

Personal History

Birth date:	**Birthplace:**
Military Services:	**Highest education level**
Present Occupation:	**Past Occupation**
Religion:	
Marital Status:	**Spouse:**
Children:	
Do you smoke:	**Have you ever smoked:**
How many packs per day:	**How many years:**
Do you or have you ever drank alcoholic beverages:	
How many years:	
How many drinks (can of beer, 4oz. of wine, 1 oz. of liquor) per day:	
Have you ever used any recreational drugs in the past: **Please explain:**	
Any present drug use:	**Last used:**

Family History:

Any blood relative with diabetes mellitus, high blood pressure, kidney disease, kidney stones, allergies, asthma, stroke, anemia, cancer or leukemia, mental or emotional disturbance, alcoholism, heart disease, gout, liver disease, and/or sickle cell disease? Please List:	
Disease / Disorder:	Relation:

Have you ever had or been told you had:

Heart Disease		Kidney Biopsy		Chronic Diarrhea	
Angina (Heart Pain)		Kidney Stones		Phlebitis	
Heart Attack		Bladder / Kidney Infections		Mental Illness	
High Cholesterol		Blood in Urine		Nervous Breakdown	
Heart Murmur		Cyst in Kidney		Glaucoma	
Heart Failure		Swelling in feet or around eyes		Hard of Hearing	
Rheumatic Fever		Arthritis		Cancer/Leukemia	
Diabetes Mellitus		Joint Pain		Tuberculosis	
Thyroid Disease		Low Back Pain		Venereal Disease	
Thyroid Radiation		Lupus = Systemic Lupus Erythematosus		Gonorrhea	
Pituitary Disease		Skin Problems		Syphilis	
Asthma		Allergies		AIDS	
Bronchitis		Hernia		Bone Infection	
Emphysema		Gallstones		Osteomyelitis	
Pleurisy		Hepatitis		Malaria	
Meningitis		Cirrhosis		Sickle Cell Anemia	
Stoke / Paralysis		Liver Problems		Cataracts	
Epilepsy / Seizure		Colitis		Anemia	
Headaches		Stomach Ulcers		Hemophilia	
Passing Out Spells		Intestinal Problems		Hypertension	
Obesity				Other:	
Kidney Disease				Other:	

DALLAS KIDNEY DKS SPECIALISTS, P.A.

Name _____ Date Completed _____

Doctors we should know about	Phone	Role
_____	_____	Cardiologist
_____	_____	Dermatologist
_____	_____	Eye Doctor
_____	_____	Family Practice
_____	_____	Gastroenterologist
_____	_____	Hem-Oncology
_____	_____	Internist
_____	_____	Neurologist
_____	_____	Ob-Gyn
_____	_____	Rheumatologist
_____	_____	Urologist

DALLAS KIDNEY DKS SPECIALISTS, P.A.

Patient Name _____ Date Completed _____

Health Screening

Study/Test Vaccines	Date of Last	Where / Who
Colonoscopy		
Mammogram		
Pap Smear		
PSA and/or Digital Rectal Exam		
Flu Vaccine		
Pneumonia Vaccine (Pneumovax)		
Tetanus Vaccine		
Shingles Vaccine		
Bone Density		
Heart Stress Test		
Echocardiogram (heart sonogram)		
Eye Doctor Exam		