Pikes Peak Nephrology Associates, P.C.
Diplomats of the American Board of Internal Medicine and Sub-Specialty Board of Nephrology
1914 Lelaray Street
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www.pikespeaknephrology.com
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Mark R. Cook, D.O.
Jesse A. Flaxenburg, M.D.
Melinda L. Hockensmith, M.D.
Brad H. Yuan, M.D.
Michael Ross, M.D.

George A. DeVault, Jr., M.D.
Stephen D. Fox, M.D.
Roger L. Mallory, M.D.
Maria J. Mercier, NP-C

Dear_____:

Welcome to Pikes Peak Nephrology Associates, P.C. Your appointment has been scheduled with:

_____Dr. DeVault _____Dr. Fox _____ Dr. Hockensmith
_____Dr. Mallory _____Dr. Yuan _____ Dr. Flaxenburg
_____Dr. Cook _____Dr. Ross

On: M/T/W/TH/F _____ at ___: ___ am/pm

OFFICE LOCATION:

1914 Lelaray St	**850 Eagleridge Blvd**	**2115 Stuart Ave**
Colo Sprgs, CO 80909	**Pueblo, CO 81008**	**Alamosa, CO 81101**

We are happy to be of service to you. You will find several forms enclosed in your new patient information packet for you to complete and bring with you to your first visit – please do not mail. Your referring physician has given us limited clinical information about your medical condition. However, the personal information you provide will allow us to better serve you.

Please arrive **30 minutes prior to your scheduled appointment** to complete the registration process or you may be asked to rescheduled your appointment. You may be contacted by one of our staff members prior to your appointment to allow pre-registration of some of your information.

We look forward to serving your health care needs. If, for any reason, you are not able to keep your appointment, please advise us as soon as possible to allow us to be of service to other patients needing care. **IF CANCELLATION IS NOT RECEIVED 48 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT OR YOUR APPOINTMENT IS MISSED, YOUR REFERRING PHYSICIAN WILL BE NOTIFIED AND YOU WILL INCUR A $25.00 CHARGE. RESCHEDULED APPOINTMENTS MAY TAKE 3-4 MONTHS TO ACCOMMODATE.**

Thank you.

Pikes Peak Nephrology Associates P.C.

Patient Information

CORHIO (Colorado Regional Health Information Organization) Notification

Pikes Peak Nephrology Associates, P.C. endorses, supports, and co participates in electronic **Health Information Exchange (HIE)** as a means to improve the quality of your health and healthcare experience.

HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network.

Using HIE helps your health care providers to more effectively share information and provide you with better care.

The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care.

Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO – HIE, or cancel an opt-out choice, at any time. Ask for more information from our staff if you chose to opt-out of this electronic system.

Prescription Policy

When requesting a refill of a medication prescribed by our office, contact your pharmacy before you run out of the medication. Requests and refills for written prescriptions will be processed within 2 business days. Refills are not processed on holidays or weekends.

Colorado state law requires that our providers report all controlled prescriptions received from this office. Drug class II through V prescription information will be entered into **Colorado's Electronic Prescription Drug Monitoring Program** database when the medication is dispensed to you.

PIKES PEAK NEPHROLOGY ASSOCIATES, P.C.

PERSONAL HEALTH HISTORY

Patient Name: _____ Date: _____

Date of Birth: _____ Marital Status (circle one): Single / Married / Divorced / Widowed

Primary Physician: _____ Hospital Preference: _____

Do you smoke or have you ever smoked? _____ How many cigarettes do you smoke a day? _____

What age did you start smoking? _____ When did you quit? _____

Do you use medicinal or recreational marijuana?_____ How often?_____

Do you drink alcohol? _____ How often do you drink? _____

What is your occupation? _____ Disabled? _____ Retired? _____

Do you follow a special diet? _____ If so, what type? _____

Do you exercise on a routine basis? _____ If so, what type? _____

PERSONAL HISTORY:

	Yes	No	Explanation/Complications
Bleeding Disorder			
Blood Clots			
Cancer			
Diabetes			
Heart Attack			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Lupus			
Tuberculosis			
Congestive Heart Failure			
Other:			

SURGERIES:

	Yes	No	Explanation/Complications
Vascular Surgery			
Appendectomy			
Gall Bladder			
Hysterectomy			Ovaries still present?
Heart Surgery			
Other:			

FAMILY HISTORY:

	Age	Deceased? Y or N	Cause of Death/ Medical Problems
Mother			
Father			
Siblings			
Children			

PIKES PEAK NEPHROLOGY ASSOCIATES, P.C.

REVIEW OF SYSTEMS

(Please ***circle*** all that apply to your condition in the last 6 months)

Patient Name: _____ Date of Birth: _____ Date: _____

Constitutional:

Fever
Night sweats
Loss of appetite
Unintentional weight loss

Eyes:

Loss of vision
Double vision
Cataracts
Laser surgery for bleeding

Ear, Nose, Mouth, Throat:

Hearing loss
Dizziness or "spinning" sensation
Ringing in ears
Sinus problems
Nosebleeds
Strep throat
Recent dental problems

Respiratory:

Chronic cough
Sputum production
Coughing up blood
Asthma or wheezing
Exposure to tuberculosis
Current smoker
Snoring
Poor quality sleep

Cardiovascular:

Chest pain or short of breath with activity
Fainting spells
Palpitations or fluttering sensation in chest
Shortness of breath at night
Leg or ankle swelling
Calf pain with walking

Gastrointestinal:

Nausea
Frequent vomiting
Heartburn
History of ulcers
Chronic diarrhea
Hepatitis
Bloody stools
Black stools
Colonoscopy in past 2 years

Musculoskeletal:

Arthritis
Joint replacement
Osteoporosis
Chronic back pain
Muscle pain
Trouble getting out of a chair or climbing stairs
Use of a walker or cane
Fractures requiring surgery for repair

Hematologic/Lymphatic:

Easy bruising
Anemia
Frequent infections
Swollen glands
Prior blood transfusion

Genitourinary:

Bloody or tea-colored urine
Foamy urine
Frequent urination at night
Weak urine stream
Kidney stones
Kidney infections
Prostate problems

Neurological:

Prior stroke
Seizures
Frequent headaches
Trouble with memory
Numbness of feet

Skin:

Skin rash
Ulcers of skin or legs or feet
Purple toes or fingers
Worrisome moles
Skin cancers
Bothersome itching

Endocrine:

Thyroid disease
Parathyroid disease
Diabetes mellitus
Adrenal gland disease

Psychiatric:

Excessive sadness
Anxiety
Thoughts of self-harm
Trouble sleeping

Allergic/Immunologic:

Hay fever
Allergies to medicines
Prednisone or other steroid use
Treatment with immune suppressing drugs for cancer or other illness

Medication Chart

Please tell us what prescriptions and over the counter medications you take and any drug allergies.

Name: _____ **DOB:**_____ **Date:**_____

Name of medication	Dose (total milligrams)	How many times per day?	Who prescribed it for you? (Physician's last name)	Why do you take it?	Do you have any side effects? Please describe.
Over the counter medications, herbal remedies and vitamins					
Drug Allergies					

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Pikes Peak Nephrology Associates, P.C.

Patient Authorization

Patient Name: _____ Date: _____

To respect your privacy, please indicate to us the telephone number we should contact with correspondence (appointment reminders, lab results) from our office.

Home #_____OK to leave a message? Yes No

Work#_____ OK to leave a message? Yes No

Cell # _____ OK to leave a message? Yes No

Email: _____

If we are unable to speak with you directly and must leave a message, please indicate with who we may leave a message:

Spouse: _____ Other Contact: _____

I understand that I may revoke this authorization at any time in writing to this practice.

Required information collection as part of the ARRA, American Recovery & Reinvestment Act, 2009

What is your preferred language? _____ Declined

What is your race? Please circle one: American Indian or Alaskan Native Asian White

Black or African American Native Hawaiian or Other Pacific Islander Declined

What is your ethnicity? Please circle one: Hispanic or Latino Not Hispanic or Latino Declined

HIPAA

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices (pages 9 & 10), which states how we may use and/or disclose your health information. Please sign below to acknowledge receipt of this notice. You may refuse to sign this acknowledgement, if you wish.

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

PATIENT SIGNATURE_____ ***DATE_____***

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign
- We were not able to communicate with the patient
- Other(Provide specific details)_____

Staff initials_____

Pikes Peak Nephrology Associates, P.C.

Financial Policy and Billing Agreement

Patient Name: _____ _____ Date of Birth: _____
Address: _____
Primary Insurance: _____ _____ Secondary Insurance: _____
Insurance ID Number#_____ _Effective Date of Insurance: _____
Policy Holders Name: _____Policy Holder Date of Birth: _____

You will be asked to confirm or update this information at each visit. It is your responsibility to notify us of any changes in your health care coverage. All patients are required to provide social security information for themselves or the responsible party. If you opt not to provide this information, we require payment in full at the time of service

All applicable co-payments and/or cost shares, and any outstanding patient due balances are due at the time of service. If co-payments are not paid on the date of service, a $10 billing fee may be charged to your account. We accept cash, check, debit and credit cards. **Obtaining referrals to our office is your responsibility.**

It is your responsibility to understand and comply with the terms of the insurance agreement you have purchased. We are not contracted to act as a fiscal intermediaries between you and your insurance. Please be aware that some services we provide, and perhaps all, may be non-covered services or may not be considered medically necessary under Medicare or other insurance companies. In these cases you are responsible for all charges. Patients with High Deductible Plans (HDP) will be asked to pay for the services after the visit.

If you do not have insurance coverage in effect please be prepared to pay for your services unless payment arrangements have been made in advance with the billing department at PPNA.

Missed Appointments keep other patients waiting longer to see their Nephrologist. We understand that on occasion an appointment will have to be rescheduled. Kindly give us a 48 hour notice of cancelation. It is our policy to charge $25 for a missed appointment. This is not payable by your insurance and is your responsibility.

For checks returned to us as unpaid by your bank, we will charge a $30 fee.

In the event your account becomes past due, additional billing fees may be assessed. If your account becomes delinquent, it may be forwarded to an outside collection agency. If this happens, you will be responsible for all additional charges related to this process.

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization. I authorize the release of any medical or other information obtained by our office necessary to determine these benefits or the benefits payable for services to the organization, the Health Care Financing Administration, my insurance carrier or the medical entity.

I understand that I am financially responsible to this organization for any charges not covered by my health care benefits.

Please contact our Billing Office at (719)955-7261 if you have any questions or concerns.

Patient /Guardian Signature: _____Date:_____

NOTICE OF PRIVACY PRACTICES
PIKES PEAK NEPHROLOGY ASSOCIATES, PC
09/2014

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 1, 2014 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer at our office. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $15.00 up to 15 pages and a charge of $25.00 for records more than16 pages.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $15.00 up to 15 pages and $25.00 for copies greater than 16 pages. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Pikes Peak Nephrology Associates, PC **Attn: Privacy Officer**

1914 Lelaray Street, Colorado Springs, CO 80909 **719-632-7641**