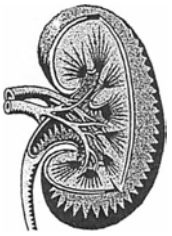

NEVADA

NEPHROLOGY

CONSULTANTS

Mark J. Adaimy, M.D.

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2820 W. Charleston Boulevard

Suite 33

Las Vegas. NV 89102

P: {702) 880-1558

F: (702) 870-6821

Dear

Thank you for choosing Nevada Nephrology Consultants. We are pleased for the opportunity to help you improve your kidney health. It is the policy of NNC to treat all patients and not to discriminate with regards to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.
To assist us in managing your nephrology care and to assure you a thorough understanding of your rights and responsibilities as a patient, we ask that you review and complete the enclosed forms, prior to your first appointment.

When you arrive at our office, a member of our staff will ask you for the **completed forms,** along with your **health insurance card, a photo identification card,** and if required by your insurance provider, referral documentation from your primary care physician. **At this time, your co-payment or a coinsurance remittance will be due.**

In order for us to provide for your nephrology needs, you will be required to have renal labs done no older than 30-days prior to your appointment and office notes from your referring physician.

In the event that you need to cancel or reschedule your appointment, we ask that you notify our office at least 24 hours in advance. As we have many patients that need to be seen, we ask that you be considerate of your appointment time and afford us the ability to schedule someone else should you cancel your appointment. We make every effort to provide a courtesy reminder call before your appointment, but ultimately, it is your responsibility to reschedule or cancel if you are unable to keep your appointment. As such, a **$25 "no show" fee is charged to patients who fail to comply with this request.** To cancel or change an appointment, or for directions to one of our offices, please call (702) 880-1558.

Feel free to contact us if you have any questions about our policies or any of the information contained in the enclosed forms. Our staff will be happy to assist you in any way they can.
We recognize the trust you put in us, and the responsibility we have in providing high quality medical care. We ask in return that you respect our office by abiding by our policies and always treating all staff members with respect. Inappropriate behavior in the office will not be tolerated.

We appreciate your confidence in our group and look forward to seeing you soon.

Privacy Policy Statement

NEVADA NEPHROLOGY CONSULTANTS
2820 West Charleston Blvd, Suite 33
Las Vegas, NV 89102

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

Privacy Officer: Practice Administrator, 702-880-1558

Purpose: The following privacy policy is to ensure that Nevada Nephrology Consultants (NNC) complies with requirements of the Health Insurance Portability & Accountability Act of 1996 (HIPPA) as well as Nevada privacy protection laws and regulations. Protection of patient privacy is of paramount importance to NNC. Violations of any of these provisions knowingly or unknowingly will result in disciplinary action including termination of employment and possible referral for criminal prosecution.

Notice of Privacy Practices
This Notice of Privacy Policy will be provided to patients at their first encounter and all uses and disclosures of protected health information (PHI) will be accord with NNC's notice of privacy practices. NNC has copies of the most current Notice of Privacy Policy available for review and for distribution at the reception desk.

Assigning Privacy and Security Responsibilities
NNC Practice Administrator is assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rules' requirements.

Deceased Individuals
NNC privacy protections extend to information concerning deceased individuals.

Minimum Necessary Use and Disclosure of Protected Health Information
NNC will ensure that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made for treatment purposes; to or as authorized by the patient; or as required by law for HIPAA compliance) such uses and disclosures of PHI must be limited to the minimum amount of information needed to accomplish the purpose of disclosure.

Verification of Identity
NNC will ensure that the identity of all persons who request access to protected health information be verified before such access is granted.

Safeguards
Appropriate safeguards will be in place at NNC to reasonably protect health information from any intentional or unintentional use or disclosure that is in violation of the HIPAA Privacy Rule. These safeguards include physical protection of premises and PHI, technical protection of PHI maintained electronically and administrative protection of PHI. These safeguards will extend to the oral communication of PHI and to PHI removed from NNC.

Business Associates
NNC will ensure business associates comply with the HIPAA Privacy Rules to the same extent as NNC, and that they be contractually bound to protect health information to the

same degree as set forth in this policy. Business associates permitted to receive PHI include for example NNC's billing service (Management Solutions, LLC), patient's health insurers, and other healthcare providers with whom we consult and coordinate patient's care or to whom we refer patients for specialized care.

Training and Awareness

NNC, will ensure that all employees are trained on the policies and procedures governing protected health information and how NNC complies with the HIPPA Privacy. New employees will receive training within a reasonable time of employment.

Sanctions

NNC will ensure that sanctions will be in effect for any member of the workforce who Intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel file.

Retention of Records

NNC will adhere to the HIPAA Privacy records retention requirement of six years. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at t NC's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Complaints

NNC will investigate and resolve all complaints relating to the protection of health in a timely fashion. All complaints will be directed to the NNC Practice Administrator, who is duly authorized to investigate complaints and implement resolutions.

Prohibited Activities No Retaliation or Intimidation

No employee or contractor of NNC may engage in any intimidating or retaliatory acts against persons who file complaints or otherwise exercise their rights under HIPAA regulations. No employee or contractor may condition treatment or payment on the provision of an authorization to disclose protected health information.

Cooperation with Privacy Oversight Authorities

NNC will ensure that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services will receive cooperation in any investigation relative to protection of health information within NNC. All personnel will cooperate fully with all privacy reviews and investigations.

Investigation and Enforcement

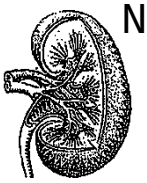
In addition to cooperation with Privacy Oversight Authorities, NNC will follow procedures to ensure that investigations are supported internally and staff of NNC will not be retaliated against for cooperation with any authority. It is our policy to attempt to resolve all investigations and avoid any penalty phase if at all possible.

For more information about HIPPA or to file a complaint:

Nevada Department of Health and Services
4126 Technology Way
Carson City, NV 89706

Front Desk Check-in

initials:_____



Nevada Nephrology Consultants

2820 W. Charleston Blvd, Suite 33

Las Vegas, NV 89102

Office Location: _____

Today's Date: _____

☐ New Patient

☐ Name Change

☐ Address Change

☐ Insurance Change

Patient Information

Please Complete All Sections

Name (First, MI, Last)_____ Date of Birth_____ Age:___Sex: M / F

Mailing Address (street)_____Apt #_____

City State _____

Home Phone (_) _____ Daytime Phone ( ) Mobile Phone ( )_____

SS# _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed

Email Address:_____

Employer:_____ Phone Number_____

Employer Address _____

Name of referring Physician _____ Phone Number _____

Name of Primary Care Physician_____ Phone Number _____

Other family members that are patients _____

Parent, Spouse, or Responsible Party

Name (First, Ml, Last)_____Date of Birth_____ Age:___Sex: M / F

Mailing Address Street_____Apt# _____

City_____State_____ Zip Code_____

Home Phone ( )_____Mobile Phone ( )_____ SS# _____

Insurance Coverage - Primary

Name of Policy Holder (Insured)_____ Date of Birth ___/___/___

Insurance Company Name _____Ins Phone Number ( )_____

SS#_____ Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Other_____

Address of Claim Center (street, city, state, zip)_____

Policy #_____ Group Name or Number _____

Policy Type: ☐ PPO ☐ EPO ☐ POS ☐ HMO If HMO, Name of Medical Group _____

Employer _____ Phone Number _____

Employer Address _____

Insurance Coverage - Secondary

Name of Policy Holder (Insured) _____ Date of Birth ___/___/___

Insurance Company Name _____ Ins Phone Number_____

SS# _____ Patient's relationship to Insured: O Self O Spouse Other

Address of Claim Center (street, city, state, zip) _____

Policy #_____ Group Name or Number_____

Policy Type: ☐ PPO ☐ EPO ☐ POS ☐ HMO If HMO, Name of Medical Group _____

Employer_____Phone Number_____

Employer Address:_____

PLEASE TURN TO NEXT PAGE AND COMPLETE

Nevada
Nephrology
Consultants

2820 W. Charleston Blvd, Suite 33
Las Vegas, NV 89102

Patient Information
Continued

In case of emergency

Name of friend or relative not residing with you _____

Relationship to patient _____ Address _____

Day phone# _____ Evening phone # _____

Pharmacy Information

Pharmacy Name _____

Address _____

Phone Number _____ Fax Number (___) _____

Release of information and assignment of benefits

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature _____ Date__/__/__

Payment Policy

Payment is required for all services at the time they are rendered unless you are enrolled in an insurance plan in which we participate. **Any applicable co-payments, co-insurances and/or deductibles will be collected at the time of service.** We accept payment in the form of cash, check or credit card. Your insurance plan will be billed for the charges incurred. Please note that the patient is responsible for any & all charges not paid for by the insurance company. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is preformed, it is the patient's financial responsibility to pay any balance due to any outside facility utilized to complete and determine the diagnosis for such procedure. Your signature below signifies your understanding and willingness to comply with these policies.

A $25.00 "No Show" fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. While we will make every effort to provide a courtesy reminder call prior to your visit, it is your responsibility to cancel your appointment.

A fee will be charged for any returned checks.

Insurance Coverage

If your insurance-company requires a referral from your primary care physician, it is your responsibility to obtain and bring it with you prior to your visit. If you do not have a referral number, and your insurance company requires it, it may be necessary to reschedule your appointment.

I have read the Payment Policy and Insurance coverage described above. I understand and agree to all it's provisions.

Patient Signature _____ Date __/__/__

Nevada Nephrology Consultants
2820 W. Charleston Blvd., Suite 33
Las Vegas, NV 89102

PROTECTED HEALTH INFORMATION AUTHORIZATION

Please allow access of my Protected Health Information (PHI) to:

Person's name:	Relationship:
_____	_____
_____	_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Registrations pertaining to medical assignment of benefits apply. If not signed by patient, please indicate relationship (e. g. spouse)

Printed Name:_____

Signature:_____

Date: _____

NEVADA NEPHROLOGY CONSULTANTS

CONSENT TO RELEASE INFORMATION

Please transfer the medical records of:

Name: _____

DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell#: _____

Release Information from:

Name: _____

Phone#: _____

Fax #: _____

Release Information to:

Nevada Nephrology Consultants
2820 W. Charleston Blvd., Suite 33
Las Vegas, NV 89102
PHONE: 702-880-1558
FAX: 702-870-6821

The signature below serves as authorization to transfer the records. I understand that these records may include psychiatric, chemical and substance abuse, HIV, and AIDS information, and that I may withdraw this authorization in writing, at any time, except to the extent that action has been taken based on this authorization.

_____ _____
Authorized Signature Date

_____
Please Print Name

Office Use Only:

1st Request sent: Date: _____ By: _____
2nd Request sent: Date: _____ By: _____
3rd Request sent: Date: _____ By: _____

NEVADA

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ATTENTION PATIENTS

We would like to inform you that a copy of your clinical care summary will be provided to you within one business day of your appointment.

For any additional information please feel free to contact us at (702) 880-1558 and we will be glad to assist you.

Sincerely,

Liliya Meadows, M.S.
Practice Administrator

I hereby acknowledge receipt of this notice

Patient's Signature: _____

Printed Name: _____

Date: _____

2820 W. Charleston Boulevard
Suite 33
Las Vegas. NV 89102
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F: (702) 870-6821

Updated 01/02/2020