Dear _____:

Welcome to Central Nephrology Clinic! _____ MD/NP has referred you to our clinic for an appointment on _____with Dr. _____.

*You MUST confirm your appointment by calling our office no later than 24 hours prior to the appointment time or it may be cancelled.If you need to reschedule this appointment, please call our office immediately because the time frame for seeing new patients is extremely limited.**While we make every effort to avoid this, due to the nephrologists schedule, you may receive a call to change your appointment time.***

All insurance pre-certification for your initial office visit is the patient's or referring physician's responsibility and must be obtained prior to your initial visit. We will request your medical records which are necessary for the physician to review at your visit, but you will need to ensure they are provided to avoid the rescheduling of your appointment.

1. The office hours are from 8:30 to 4:30 Monday through Friday. Questions may be handled during these hours by calling 601-981-1610 and following the prompts. If you have an emergency after clinic hours, please call the 601-981-1610 and the answering service will have an on-call doctor contact you.

2. Please be sure to bring all medications in a bag with you each time you are seen by the physician. CNC does not accept prescription refills by telephone. Please call your pharmacist for refills.

3. All co-pays must be paid at the time of service.You are responsible for providing correct and updated insurance information at the time of each appointment. Our billing office will file your insurance as a courtesy; however, you are responsible for co-pays, deductibles, and any amount not covered by insurance.

The enclosed forms regarding your medical history are necessary for the doctor to review at the time of your appointment. Please complete these forms and return in the envelope provided prior to your appointment to avoid unnecessary delays at check-in.THE PATIENT'S SIGNATURE IS REQUIRED ON THE FORMS (if patient is incapacitated, guarantor may sign).Please present your Power of Attorney at the check-in window when you arrive for your appointment if you signed for the patient.

We look forward to meeting you and becoming part of your quality health care team!

Sincerely,
The Physicians and Staff of Central Nephrology Clinic

Group: CNCPLLC

CENTRAL NEPHROLOGY CLINIC

New Patient Information Form

Please fill in the following information as completely as possible.

Appointment Date: _____

What is the best way to contact you regarding appointments? Home:_____Cell _____ Email_____

Do you have an Advanced Directive: Yes _____ No_____

Do you need Interpreter Services for this visit? Yes____ No___

Patient Information:

Relation to Guarantor: Self____ Spouse____ Child____ Other_____

Last Name _____ First Name _____ MI _____

Maiden Name _____ Social Security # ___ ___ ____

Address _____

Zip _____ City _____ State _____ Email _____

Home Ph ( ) _____ Referring Physician _____

Date of Birth ___/___/___ Age _____ Employer _____

Marital Status _____ Sex _____ Work Ph ( ) _____ Ext. _____ Cell Ph ( ) _____

Emergency Contact _____ Relation _____ Telephone ( ) _____

Race _____ Ethnicity _____ Language_____ Decline to Answer ___

Student: Yes ____ No ____ Full-time ____ Part-time ____ Name of School _____

Is today's visit the result of auto accident? Yes ____ No ____ Work Injury? ____ Date _____

Other Coverage_____

Spouse Name _____ Employer _____ Telephone ( ) _____

Insured (Policyholder) Information---Primary Carrier:

Please present your insurance card(s) to front counter.

Ins Co Name _____ Policy # _____

Address 1 _____ Group # _____

Address 2/City St Zip _____

Patient Relation to Insured: Self ____ Spouse ____ Child ____ Other ____

Policy Holder Name/Address 1 _____

Address 2/City St Zip _____

Telephone ( ) _____ Date of Birth ___/___/___ Sex _____

Employer _____

Insured (Policyholder) Information---Secondary Carrier:

Ins Co Name _____ Policy # _____

Address 1 _____ Group # _____

Address 2/City St Zip _____

Patient Relation to Insured: Self ____ Spouse ____ Child ____ Other ____

Policy Holder Name/Address 1 _____

Address 2/City St Zip _____

Telephone ( ) _____ Date of Birth ___/___/___ Sex _____

Employer _____

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to CENTRAL NEPHROLOGY CLINIC. I understand payment is due at time of service.

Signature of Responsible Party _____ Date _____

CNC
Central Nephrology Clinic

102 Riverview Drive, Suite A, Flowood, MS 39232 * Phone: 601-981-1610 Fax: 601-366-2887
www.centralnephrology.com

Mohit Ahuja, M.D. Daphne M. Bilbrew, M.D. Lee M. Ferguson, M.D.
Mark N.A. Klein, M.D. Lindsey T. Norris, M.D. Ami R. Patel, M.D.
F. M. Phillippi, M.D. Naveen S. Sandhu, M.D. Derrick H. Tesseneer, M.D.
Steven J. Wagner, M.D. Karthikeyan Venkatachalam, M.D.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

A. INFORMATION – This is the individual whose information will be released.
(Individuals over 18 years of age must complete their own form, except for legal Personal Representative situations.)

Person's Name: _____ D.O.B: _____

Address (Street, City, State, and Zip Code): _____

Telephone Number: _____ E-Mail Address: _____

If we are unable to contact you via phone, may we leave a detailed message on your voicemail Yes___ No___

B. AUTHORIZED PARTY – This is the person or organization who will receive the Member's information.

I authorize Central Nephrology Clinic. to release the above Member's Protected Health Information to:

Name: _____ DOB _____ Relationship: _____

Name: _____ DOB _____ Relationship _____

C. INFORMATION TO BE RELEASED – If limiting disclosures, please describe. ***Check one box only.***

☐ ALL information relating to provision or payment of healthcare benefits or services may be released.

☐ Other (please describe): _____

D. EXPIRATION AND REVOCATION - When this Authorization will end. **Check one box only.**

Expiration: *(check one box only)*

☐ On this specific date _____

☐ Or occurrence of this event: _____

Revocation: You may revoke this Authorization at any time by notification in writing.

I have received Central Nephrology Clinic's Notice of Privacy Practices. Yes_____ No_____

E. PATIENT SIGNATURE – Please sign and date below.

This Authorization is voluntary and completed at my own request. This consent permits the Cllinic to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information is included in our Notice of Privacy Practices. I understand that a photocopy shall be as valid as these originals. I authorize the release and disclosure of any and all information with reference to my health and medical history and treatment to/from CNC, to medical providers and insurance companies including Medicare and its agents and/or with which I have a medical business relationship. I further authorize payment of insurance benefits to be mad directly to CNC including Medicare benefits if applicable.
I understand I am financially responsible for all charges whether or not they are covered by insurance and agree to pay costs of collection in the event of default.

_____ _____

Signature of Patient (or Patient's Personal Representative) ** **Date**

** If the Patient is a dependent minor child, the child's parent or legal guardian must sign this form. This form may *not* be signed on behalf of the

F. PERSONAL REPRESENTATIVE INFORMATION – If you are signing this Authorization as the Person's Personal Representative, please complete this section and attach a copy of the legal document establishing this authority (except for parent of minor, dependent child).

Name of Personal Representative: _____

Relationship to the Patient: _____

☐ Parent of dependent minor child (copy of legal document is not necessary)

☐ Legal guardian or conservator ☐ Health Care Power of Attorney

☐ Executor or Administrator of Estate ☐ Other: _____

*** Other than the parent of a dependent minor child, all other Personal Representatives must attach proof of their legal authority to this Authorization

Patient Name _____Date:_____

IMPORTANT! LIST ANY KNOWN DRUG ALLERGIES:

_____

_____

VERY IMPORTANT: BRING ALL YOUR MEDICATIONS IN A PLASTIC BAG OR CONTAINER WITH YOU TO YOUR APPOINTMENT.

List name and number of your *LOCAL* pharmacy: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING BELOW:

PRESCRIPTION NAME	STRENGTH	DOSAGE
Example: Coreg	*25 mg*	*1 daily*

LIST ANY OVER THE COUNTER MEDS	STRENGTH	DOSAGE

Name: _____ *Last,*	_____ *First, M.I*	☐ M ☐ F	**DOB:___/___/_____**	_____ APPOINTMENT DATE

WELCOME TO CENTRAL NEPHROLOGY CLINIC

Dr.	APPOINTMENT TIME:			

PAST MEDICAL HISTORY – COMMON DISEASES

Do you have a personal history of any of the following?

Kidney Disease	☐ CKD Stage: 1 2 3 4 5 Unknown _____ ☐ Transplant ☐ Cadaveric ☐ Living - Related ☐ Living - Unrelated	☐ Dialysis ☐ HD ☐ PD ☐ Polycystic Kidney Disease ☐ Acute Kidney Injury ☐ Glomerulonephritis
Diabetes	☐ Type 1 ☐ Type 2	☐ Type Unknown
High Blood Pressure	☐ Essential ☐ Renovascular	☐ White Coat Hypertension ☐ Conn's Syndrome
Ischemic Heart Disease	☐ Heart attack ☐ Angina ☐ Angioplasty	☐ Coronary Stent ☐ CABG (Coronary Artery Bypass Graft)
Cancer	☐ Lung ☐ Breast ☐ Prostate ☐ Colon ☐ Melanoma ☐ Bladder	☐ Lymphoma ☐ Kidney ☐ Thyroid ☐ Leukemia ☐ Endometrial ☐ Pancreatic
Stroke	☐ Stroke	
Gout	☐ Gout	

PAST MEDICAL HISTORY – ADDITIONAL CONDITIONS

Do you have a personal history of any of the following?

EENT	☐ Blindness	☐ Hearing Problems
	☐ Cataracts	☐ Glaucoma
Cardiovascular	☐ Atrial Fibrillation	☐ Valvular Heart Disease
	☐ Pacemaker	☐ Congestive Heart Failure
	☐ AICD (Cardiac Defibrillator)	☐ Mitral Valve Prolapse
Respiratory	☐ COPD	☐ Pneumonia
	☐ Chronic Bronchitis	☐ Tuberculosis
	☐ Asthma	☐ Sleep Apnea
	☐ Emphysema	
Gastrointestinal	☐ GERD (Gastric Reflux)	☐ Inflammatory Bowel Disease
	☐ Stomach/Bowel Ulcers	☐ Irritable Bowel Syndrome
	☐ Gall Bladder Disease	☐ Gluten Intolerance
	☐ Hepatitis	☐ Lactose Intolerance

Name: _____ *Last,*	_____ *First, M.I*	☐ M ☐ F	**DOB:___/___/_____**	_____ APPOINTMENT DATE

WELCOME TO CENTRAL NEPHROLOGY CLINIC

Genitourinary	☐ Enlarged Prostate	☐ Frequent UTIs (Urinary Tract Infections)
	☐ Kidney Stones	
OB History	☐ Preeclampsia	☐ Gestational Diabetes
	☐ Pregnancy Induced Hypertension	☐ History of Complicated Pregnancy
Musculoskeletal	☐ Osteoarthritis	☐ Osteoporosis
Neurological	☐ Multiple Sclerosis	☐ Parkinson's
	☐ Seizures	☐ Dementia
Psychiatric	☐ Depression	☐ Anxiety Disorder
Endocrine	☐ Hypothyroidism	☐ Adrenal Insufficiency
	☐ Hyperthyroidism	
Hematology	☐ Anemia	☐ Blood Transfusion
	☐ Sickle Cell Disease	☐ Thalassemia
	☐ Sickle Cell Trait	
Immuno/Allergy	☐ HIV	☐ Rheumatoid Arthritis
	☐ AIDS	☐ Lupus

PAST MEDICAL HISTORY – SURGERY HISTORY

Have any of the following surgeries been performed on you?

☐ Appendectomy	☐ Hip Replacement	☐ Renal Transplant
☐ CABG	☐ Left ☐ Bilateral	☐ Thyroidectomy
☐ Carotid Endarterectomy	☐ Right	☐ Tonsillectomy
☐ Cataract Surgery	☐ Knee Replacement	☐ Valve Replacement
☐ D & C	☐ Left ☐ Bilateral	☐ AV Fistula
☐ Gall Bladder Removal	☐ Right	☐ AV Graft
☐ Gastric Bypass	☐ Hysterectomy	☐ PD Catheter
☐ Hemorrhoidectomy	☐ Prostatectomy	☐ Other_____
☐ Hernia Repair	☐ Nephrectomy	

Other Health Problems Not Listed Above:

Name: _____ Last,	_____ First, M.I	☐ M ☐ F	DOB:___/___/_____	_____ APPOINTMENT DATE

WELCOME TO CENTRAL NEPHROLOGY CLINIC

FAMILY HISTORY – ILLNESSES

Do the following family members have any of the following medical conditions?

Kidney Disease	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Diabetes	☐ Father	☐ Sibling
	☐ Mother	☐ Child
High Blood Pressure	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Ischemic Heart Disease	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Cancer	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Stroke	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Gout	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Polycystic Kidney Disease	☐ Father	☐ Sibling
	☐ Mother	☐ Child
Dementia	☐ Father	☐ Sibling
	☐ Mother	☐ Child

FAMILY HISTORY – STATUS

Father	☐ Living	☐ Deceased
		☐ Age at Death:_____
	☐ Unknown	☐ Cause of Death:_____
Mother	☐ Living	☐ Deceased
		☐ Age at Death:_____
	☐ Unknown	☐ Cause of Death:_____

SOCIAL HISTORY – GENERAL

Name: _____ *Last,*	_____ *First, M.I*	☐ M ☐ F	**DOB:___/___/_____**	_____ APPOINTMENT DATE

WELCOME TO CENTRAL NEPHROLOGY CLINIC

Current Marital Status	☐ Married	☐ Widowed
	☐ Separated	☐ Divorced
	☐ Single	
Living Arrangement	☐ Alone	☐ In Home Caregiver
	☐ Family Member	☐ Significant Other
	☐ Spouse	☐ Assisted Living Facility
Occupation	☐ Retired	
	☐ Unemployed	
	☐ Employed	
	☐ Full - time	
	☐ Part - time	
	☐ Student	
	List your Current or Former Occupation:_____	
Deficits	☐ Hearing Loss	☐ Poor Vision or Blindness
	☐ Limited Mobility	☐ Transportation Challenges

SOCIAL HISTORY – HABITS

Tobacco Use	☐ Current or Former User	☐ Never Used
	☐ Cigarettes	☐ Unknown
	☐ Chewing Tobacco	
	☐ Pipes	
	☐ Snuff	
	☐ Cigars	
	If a former user, what year did you quit?	_____
	Complete the following section if you are a current or former cigarette user:	
	How often do you currently smoke or how often did you smoke before you quit?	
	☐ Every Day ☐ Some Days ☐ Unknown	
	How many packs per day do you currently smoke or how many packs per day did you smoke before you quit? _____	
	How many total years have you used cigarettes? _____	

Name: _____ *Last,*	_____ *First, M.I*	☐ M ☐ F	**DOB:___/___/_____**	_____ APPOINTMENT DATE

WELCOME TO CENTRAL NEPHROLOGY CLINIC

Alcohol Use	☐ Current or Former User	☐ Never Used
	☐ Occasional	
	☐ 1-2 per Day	
	☐ 3 or more per Day	
	If a former user, what year did you quit?	_____
Recreational Drug Use	☐ Current or Former User	☐ Opium
	☐ Marijuana	☐ Cocaine
	☐ Amphetamines	☐ Barbiturates
	☐ LSD	☐ Other _____
	☐ Heroin	
	☐ Ecstasy	If a former user, what year did you quit? _____
	☐ Never Used	

REVIEW OF SYSTEMS

Constitutional	☐ Fever	☐ Fatigue
	☐ Weight Gain	☐ Chills
	☐ Weight Loss	☐ Weakness
HEENT	☐ Vision Impaired	☐ Sinus Problems
	☐ Eye Pain	☐ Sore Throat
	☐ Redness	☐ Nose Bleeds
	☐ Color Blindness	☐ Headache
	☐ Double Vision	☐ Hoarseness
	☐ Hearing Loss	☐ Tinnitus
	☐ Ear Pain	☐ Vertigo
Respiratory	☐ Shortness of Breath	☐ Cough
	☐ At Rest	☐ Wheezing
	☐ With Activity	☐ Blood in Sputum
	☐ Pain with Breathing	☐ Night Sweats
Cardiovascular	☐ Chest Pain	☐ Orthopnea
	☐ Palpitations	☐ Edema
	☐ Claudication	☐ PND (Paroxysmal Nocturnal Dyspnea)
Gastrointestinal	☐ Abdominal Pain	☐ Constipation
	☐ Nausea	☐ Anorexia
	☐ Diarrhea	☐ Trouble Swallowing
	☐ Heartburn	☐ Indigestion
	☐ Vomiting	

Name: _____ *Last,*	_____ *First, M.I*	☐ M ☐ F	**DOB:___/___/_____**	_____ APPOINTMENT DATE

WELCOME TO CENTRAL NEPHROLOGY CLINIC

Genitourinary	☐ Urinary Urgency	☐ Urinary Hesitancy
	☐ Urinary Burning or Pain	☐ Foamy Urine
	☐ Blood in Urine	☐ Incontinence
	☐ Urinary Frequency	☐ Nocturia
Musculoskeletal	☐ Back Pain	☐ Leg Weakness
	☐ Neck Pain	☐ Left
	☐ Joint Pain	☐ Right
	☐ Muscle Pain	☐ Both
	☐ Arm Weakness	
	☐ Left	
	☐ Right	
	☐ Both	
Skin	☐ Rash	☐ Dryness
	☐ Itching	☐ Color Change
	☐ Scaling	
Neurological	☐ Numbness	☐ Tingling
	☐ Tremors	☐ Fainting
	☐ Seizures	
Psychiatric	☐ Depression	☐ Anxiety
	☐ Insomnia	
Endocrine	☐ Heat Intolerance	☐ Excessive Thirst
	☐ Cold Intolerance	☐ Excessive Urination
Hematology	☐ Bleeding Gums	☐ Easy Bruising
Immuno/Allergy	☐ Seasonal Allergies	☐ Hives

THANK YOU

Directions to Central Nephrology Clinic

THE NEW LOCATION – 102 RIVERVIEW DRIVE, FLOWOOD, MS 39232 MAY BE ACCESSED USING YOUR GPS.

COMING FROM SOUTH: Take I-55 North to the MS-25 N/Lakeland Drive, Exit 98 B - continue right off the exit. As soon as you cross the Pearl River Bridge, take a right at the traffic light onto River Bend Place, and an immediate right onto Riverview frontage road. Central Nephrology Clinic will be on your left next door to The Waffle House.

COMING FROM NORTH: Take I-55 South to the MS-25 N/Lakeland Drive exit. Turn left at the red light onto Lakeland Drive. As soon as you cross the Pearl River Bridge, turn right at the traffic light onto River Bend Place, and an immediate right onto Riverview Drive frontage road. Central Nephrology Clinic will be on your left next door to The Waffle House.

COMING FROM WEST: Take I-20 East to the Airport Road Exit. Stay on Airport Road until you get to Lakeland Drive. Turn left onto Lakeland Drive. Stay on Lakeland Drive until you reach the traffic light at River Bend Place. Turn left at the light and take the immediate right onto the frontage road (Riverview Drive), and Central Nephrology will be on your left next door to The Waffle House.

COMING FROM EAST: Take I-20 West to I-55 North to the MS-25 N/Lakeland Drive Exit 98 B, and continue right off the exit. As soon as you cross the Pearl River Bridge, take a right at the traffic light onto River Bend Place, and an immediate right onto Riverview frontage road. Central Nephrology Clinic will be on your left next door to The Waffle House.

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information
- Your privacy rights in your health information
- Our obligations concerning the use and disclosure of your health information

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Administrator & Privacy Officer Representative
Central Nephrology Clinic, PLLC
102 Riverview Dr, Suite A
Flowood, MS 39232-8908

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your health information.

1. Treatment. Our practice may use your health information to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your health information in order to write a prescription for you, or we might disclose your health information to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your health information to others who may assist in your care, such as your spouse, children or parents.

Finally, we may also disclose your health information to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your health information to bill you directly for services and items. We may disclose your health information to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your health information to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your health information to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your health information to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your health information to inform you of health-related benefits or services that may be of interest to you.

7. Disclosures Required By Law. Our practice will use and disclose your health information when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR HEALTH INFORAMTION IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your health information to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release health information if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your health information for research purposes in certain limited circumstances. We will obtain your written authorization to use your health information for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your health information for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Administrator, Central Nephrology Clinic, 102 Riverview Dr., Suite A, Flowood, MS 39232-8908, specifying the requested method of contact, or the location where you wish to be contacted. You are not required to give a specific reason for your request; however, the request must be reasonable in terms of the practices' ability to comply administratively with the request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your health information, you must make your request in writing to Administrator, Central Nephrology Clinic,102 Riverview Dr., Suite A, Flowood, MS 39232-8908. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;

(b) whether you are requesting to limit our practice's use, disclosure or both; and

(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Administrator, Central Nephrology Clinic, 102 Riverview Dr, Suite A, Flowood, MS 39232-8908, in order to inspect and/or obtain a copy of your health information. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Administrator, Central Nephrology Clinic, 102 Riverview Dr, Suite A, Flowood, MS 39232-8908. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the health information kept by or for the practice; (c) not part of the health information which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your health information for non-treatment, non-payment or non-operations purposes. Use of your health information as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Administrator, Central Nephrology Clinic, 102 Riverview Dr, Suite A, Flowood, MS 39232-8908. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact, Administrator, (601) 981-1610.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Administrator, Central Nephrology Clinic, 102 Riverview Dr, Suite A, Flowood, MS 39232-8908. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing to Administrator, Central Nephrology Clinic, 102 Riverview Dr, Suite A, Flowood, MS 39232-8908. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Administrator @ 601-981-1610.

NOTICE CONCERNING COMPLAINTS

In addition to filing a complaint with Central Nephrology Clinic, any patient may also contact:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll free: (877) 696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/