Kidney Consultants
of New Mexico, P.C.

**INTERNAL MEDICINE & NEPHROLOGY**
**2425 S. Telshor Blvd**
**Las Cruces NM 88011**
**(575)-249-2225**
**Fax (575)-249-2235**

**Rodrigo J. Alfaro, M.D.**
**Elicia Currier, MSN, AGACNP**

**Paramveer S. Saluja, M.D.**
**Selene La Marca, DNP, AGACNP**

NAME:_____ GENDER: Male AGE: _____ DOB:_____
ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____
PRIMARY PHONE#:_____ SECONDARY PHONE#: _____
SOCIAL SECURITY#:_____ MARITAL STATUS:_____
EMPLOYMENT:_____ EMPLOYMENT PHONE#:_____
INSURANCE COMPANY: _____ POLICY #:_____

NAME OF SPOUSE: _____ DOB: _____
EMPLOYMENT:_____ SOCIAL SECURITY#:_____

EMERGENCY CONTACT: _____ PHONE #:_____
REFERRED BY: _____

**PREVIOUS OR PRESENT ILLNESSES**

ANEMIA☐ ASTHMA☐ CANCER☐ DIABETES☐ UCERS☐ PNEMONIA☐
ARTHRITIS☐ HEMORRHAGE☐ EPILEPSY☐ HIGH BLOOD PRESSURE☐
MIGRANES☐ JAUNDICE☐ MENTAL DISORDERS☐ THYROID DISORDER☐
RHEUMATIC FEVER☐ HEART DISEASE☐ TUBERCULOSIS☐
CHIEF COMPLAINT:_____
DO YOU SMOKE? No IF YES HOW MUCH PER DAY?_____
DO YOU DRINK? No IF YES HOW MUCH PER DAY?_____
IF NO TO THE ABOVE DID YOU EVER SMOKE OR DRINK? No

**ALLERGIES**

(CHECK YES OR NO)

PENICILLIN YES☐ NO☐
SULFA YES☐ NO☐
ASPIRIN YES☐ NO☐
CODEINE YES☐ NO☐
MORPHINE YES☐ NO☐
OTHERS:_____
_____

**FAMILY HISTORY**

HAS ANY OF YOUR IMMEDIATE RELATIVES HAD:
ANEMIA☐ ASTHMA☐ ARTHRITIS☐ CANCER☐ DIABETES☐ ULCERS☐ HEMORRHAGE☐ EPILEPSY☐ PNEMONIA☐
TUBERCULOSIS☐ JAUNDICE☐ MIGRAINES☐ MENTAL DISORDERS☐ HIGH BLOOD PRESSURE☐ HEART DISEASE☐
RHEUMATIC FEVER☐ THYROID DISORDER☐ LUPUS☐ KIDNEY DISEASE☐
OTHER:_____

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# NOTIFICATION POLICY

I authorize Kidney Consultants of New Mexico, P.A. and/or staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them when the information changes:

☐ **YES** ☐ **NO** Home Telephone:_____
☐ **YES** ☐ **NO** Answering Machine:_____
☐ **YES** ☐ **NO** Work Telephone:_____
☐ **YES** ☐ **NO** Cell Phone:_____
☐ **YES** ☐ **NO** Voicemail:_____
☐ **YES** ☐ **NO** Fax Medical Records for Referrals to Another Entity

If you would like to have information released to someone other than yourself, please list the names of authorized individuals with whom we may leave a message:

☐ **YES** ☐ **NO** Spouse:_____
☐ **YES** ☐ **NO** Parent:_____
☐ **YES** ☐ **NO** Other:_____
☐ **YES** ☐ **NO** Other:_____
☐ **YES** ☐ **NO** Other:_____

Signature of Patient or Guardian: _____

Date: _____

**Name of Practice: Kidney Consultants of New Mexico, P.A.**

_____ _____

**Name of Patient (Please Print)** **DATE OF BIRTH**

## Acknowledgment of Notice of Privacy Practice

I hereby acknowledge that I have received Kidney Consultants of New Mexico, P.A.'s Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient Representative DATE

## Documentation of Good Faith Efforts to obtain patient's acknowledgement that they Received provider's Notice of Privacy Practices

The patient presented to the Office/Hospital on _____ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain, from the patient, a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because: _____
- The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- Other reason (describe):
  _____
  _____

_____ _____

Signature of Employee completing form DATE


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# SIGNATURE ON FILE

☐ I authorize use of this form on all my insurance submissions.
☐ I authorize release of information to all my insurance company(s).
☐ I understand that I am responsible for my bill.
☐ I authorize my doctor to act as my agent in helping me obtain payment my Insurance company(s)
☐ I authorize payment direct to my doctor
☐ I permit a copy of this authorization to be used in place of the original.

Name_____ Medicare#_____
(Please Print) (If Applicable)

Signature _____ Date:_____

# HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 And 164)**

**1. Authorization**
I authorize ***Kidney Consultants of New Mexico, P.A.*** to use and disclose the protected health information described below to ***required individuals seeking the information.***

**2. Effective Period**
This authorization for release of information covers the period of healthcare from:

A. ___ _____ to _____

**OR**

B. ☐ all past, present and future periods.

**3. Extent of Authorization**

A. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse),

**OR**
B. ☐ I authorize the release of my complete health record with the exception of the following information:
   a. ☐ Mental Health Records
   b. ☐ Communicable Diseases (including HIV and AIDS)
   c. ☐ Alcohol/Drug abuse treatment
   d. ☐ Other (Please Specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law,

_____

Signature of Patient or Personal Representative

_____

Printed name of patient or personal representative and his/her relationship to the patient

_____

Date

# Telehealth Technology Patient Consent Discussion Form

Kidney Consultants of New Mexico, P.C.

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

Kidney Consultants of New Mexico, P.A. is offering the use of Telehealth Technology ("Telehealth") to communicate about your medical care and treatment. Telehealth includes communication technologies, including but not limited to audio and live video conferencing. Before Kidney Consultants of New Mexico, P.A. can communicate with you using Telehealth, we will need to discuss and affirm your understanding of the following:

**You Understand that:**

- Telehealth is not for emergency medical situations. If there is a medical emergency, you should immediately call 911 or seek help from your healthcare provider.
- You can end any Telehealth conversation at any time without affecting your right to future care and treatment
- The laws that protect privacy and the confidentiality of medical information also apply to Telehealth.
- You should take precautions to preserve the confidentiality of your communications via Telehealth, including, but not limited to, using passcodes on your devices and using headphones.
- There are potential limitations associated with the use of Telehealth. These include, but are not limited to, the risk of different, incomplete or less effective healthcare consultation and/or treatment as compared to live, in person visit as well as possible failure, interruption, or disconnection of the audio/visual connection or transmission of a video image that is not clear.
- This consent shall remain in effect for so long as you are a Kidney Consultants of New Mexico, P.A. patient. You may revoke this consent in writing at any time.

☐ I have just read a summary of Kidney Consultants of New Mexico, P.A.

Do you give your informed consent for the use of Telehealth in your medical care and treatment?

☐ Patient consents to use of Telehealth

☐ Patient does not consent to use of Telehealth

Patients Name: _____ Date:_____

Patients Signature: _____

If discussed with person authorized to provide consent on behalf of patient:

Authorized Persons Name: _____

Authorized Persons Relationship to Patient: _____

Authorized Persons Signature: _____ Date:_____

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# NOTICE OF PRIVACY PRACTICES

## 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

**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.<br>• 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.<br>• 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.<br>• 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.<br>  • We are not required to agree to your request, and we may say "no" if it would affect your care.<br>• 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.<br>  • 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.<br>• 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.<br>• 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 the back page.<br>• 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/.**<br>• 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<br>• Share information in a disaster relief situation<br>• Include your information in a hospital directory<br>*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<br>• Sale of your information<br>• 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*

## Our Uses and Disclosures

### 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:<br>  • Preventing disease<br>  • Helping with product recalls<br>  • Reporting adverse reactions to medications<br>  • Reporting suspected abuse, neglect, or domestic violence<br>  • 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:<br>  • For workers' compensation claims<br>  • For law enforcement purposes or with a law enforcement official<br>  • With health oversight agencies for activities authorized by law<br>  • 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.

**This Notice of Privacy Practices applies to the following organizations.**

*Kidney Consultants of New Mexico, P.A.*