PRINCE GEORGE'S KIDNEY CARE NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT
(Babak Razi, MD)

Name of Patient:_____ Date:_____

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law

Acknowledgement

I certify that I received a copy of Prince George's Kidney Care, P.C.'s ("Practice") Notice of Privacy Practices and that I have had an opportunity to review the Notice of Privacy Practices and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting my health information.

Date:_____ My Signature:_____

My Printed Name:_____

Date:_____ Signature of Witness:_____

I certify that I am the authorized representative of , and that I have received Practice's Notice of Privacy Practices on behalf of this individual and that the facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting health information.

Date:_____ Signature of Representative:_____

Printed Name:_____

Relationship to Individual:_____

Date:_____ Signature of Witness:_____

A copy of this document must be provided to the person to whom the Notice of Privacy Practices was provided and a copy must be filed in the patient's medical record.

FOR USE BY PRINCE GEORGE'S KIDNEY CARE ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____
_____
_____
_____

Signature of Practice representative:_____

Printed Name of Practice representative:_____

Date:_____

PRINCE GEORGE'S KIDNEY CARE (Babak Razi, MD)

7725 Bell Point Dr
Greenbelt, MD 20770

5801 Allentown Rd Ste 500
Camp Springs, MD 20746

Phone: (301) 779-1949

PATIENT CONSENT

CONSENT FOR TREATMENT

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION

By signing this form, you are granting consent to Babak Razi, M.D. to use and disclose your protected health information for the purposes of treatment, payment and health care operation. Our notice of Privacy Practice provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent; we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised notice by telephoning our office at (301) 779-1949. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under title XVII and/or Title Xl of the Social Security Act is correct. I authorize any holder or medical or other information about me, to release to Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

_____ _____

Print Patient's Name Date

_____

Patient's Signature

_____

Other Than Patient, Print Name & Relationship

_____ _____

Witness Signature Date

PRINCE GEORGE'S KIDNEY CARE (Babak Razi, MD)

Patient's Information

Name:_____ Date:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____ Height:____'____'' Weight:_____

Reason for Visit:_____ **M**_____ **F**_____

Contact Phone: (_____)_____ Cell Phone: (_____)_____ Work: (_____)_____

Date of Birth:_____ Ref by:_____ Race:_____

E-mail address:_____

Occupation: _____ Employer: _____

If under 18: Parent/Guardian_____

Emergency Contact Information:

Name:_____ Address:_____

Relationship:_____ Phone: (_____)_____

Billing Information

Responsible Person other than patient:_____ Relationship:_____

Billing Address:_____ Phone: (_____)_____

INSURANCE INFORMATION

Primary
Insurance Company:_____
Name of Insured if other than Patient:_____ Relation:_____
Identification Number:_____ Group Number:_____
Secondary
Insurance Company:_____
Name of Insured if other than Patient:_____ Relation:_____
Identification Number:_____ Group Number:_____

Assignment of Insurance Benefits - Medicare - Medicaid

I hereby authorize direct payment of medical/surgical benefits to Babak Razi, MD, for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Authorization to release information

I hereby authorize Babak Razi, MD to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

A photocopy of these assignments shall be valid as the original.

Patient Name:_____ Date:_____

Parent / Guardian:_____ Signature:_____

PRINCE GEORGE'S KIDNEY CARE (Babak Razi, MD)

Health Information
Medical History

1. **HISTORY OF DIABETES** Yes_____ No_____
   If yes, any:
   Eye problems from Diabetes Yes_____ No_____

   High Blood Pressure Yes_____ No_____
   Arthritis How Long? _____
   High Cholesterol Yes_____ No_____
   Kidney Stones Yes_____ No_____

2. **DO YOU HAVE ANY?**
   Blood in Urine Yes_____ No_____
   Difficulty Passing Urine Yes_____ No_____
   Frequent Urination Yes_____ No_____
   Bubbles in urine Yes_____ No_____
   Swelling in Legs Yes_____ No_____
   Shortness of breath when walking Yes_____ No_____
   Shortness of breath at night Yes_____ No_____
   Chest Pain Yes_____ No_____
   Nausea / Vomiting Yes_____ No_____
   Reduced Appetite Yes_____ No_____
   Weight Loss (Unintentional) Yes_____ No_____
   Muscle Cramps Yes_____ No_____
   Feeling unusually cold Yes_____ No_____
   Fatigue Yes_____ No_____
3. **DO YOU TAKE ANY?**
   Advil Yes_____ No_____
   Motrin Yes_____ No_____
   Ibuprofen Yes_____ No_____
   Indomethacin Yes_____ No_____
   Nutritional Supplements Yes_____ No_____
4. **FAMILY HISTORY OF:**
   Diabetes Yes_____ No_____
   High Blood Pressure Yes_____ No_____
   Kidney Disease Yes_____ No_____

Allergies:

PRINCE GEORGE'S KIDNEY CARE (Babak Razi, MD)

MEDICATION LIST

7725 Bell Point Dr,
Greenbelt, MD 20770

5801 Allentown Rd Ste 500,
Camp Springs, MD 20746

Name: _____ **Pharmacy Name**: _____ **Number**: **(_____)**_____

MEDICATION NAME	**STRENGTH**	**DIRECTION**					

Compliance Notes _____

_____

_____

_____

_____

_____

PRINCE GEORGE'S KIDNEY CARE (Babak Razi, MD)

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I, _____, authorize _____ to forward my complete medical records and information to:

Prince George's Kidney Care
7725 Bell Point Dr,
Greenbelt, MD 20770
Telephone: (301) 779-1949
Fax: (301) 699-1703

I understand that the information will be used for professional purposes only, and will not be released to anyone else without written permission from me, and will consist of and be limited to the following:

_____ Reports of Diagnosis, Treatments, Prognosis, and Recommendations
_____ Complete Medical Records _____ Other pertinent information

Medical care rendered from _____ to _____.

_____ _____
Patients Date of Birth Patients Soc. Security No.

_____
Patient's Address City, State Zip Code

_____ _____
Patient's Signature Date of Request