NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This Notice of Privacy Practices explains how Optima Kidney Care may use and disclose your protected health information (PHI) and your rights regarding that information. We are required by law to maintain the privacy and security of your health information and to provide you with this notice.

Your Rights

1. Get a copy of your medical record: You may request to view or receive a copy of your medical record within 30 days. Fees may apply.

2. Request corrections: If you believe your record is incorrect, you may request a correction.

3. Request confidential communications: You may ask us to contact you in a specific way or at a different address.

4. Ask us to limit what we use or share: You may request limits on how we use or disclose information.

5. Get a list of disclosures: You may request an accounting of disclosures from the past six years.

6. Obtain a copy of this Notice: Available electronically or in office.

7. Choose someone to act for you: Your representative may exercise your rights.

8. File a complaint: With Optima Kidney Care or HHS. You will not be penalized.

Your Choices

You may choose how we share information with family, caregivers, or during emergencies.

How We Use and Disclose Your Information

1. Treat you: We share information as needed for your care.

2. Bill for services: We use information to obtain payment.

3. Run our practice: We use PHI for operations and quality improvement.

Other Disclosures: Public health reporting, abuse/neglect, oversight, law enforcement, court orders, organ donation, workers ' compensation, reducing health threats.

Telehealth Services: We use encrypted, HIPAA-compliant systems but no system is risk-free.

Our Responsibilities: Maintain privacy, notify you of breaches, follow this Notice, and update it as needed.

Effective Date: January 1, 2025

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received and reviewed Optima Kidney Care ' s Notice of Privacy Practices.

_____

Patient Signature

Date

OPTIMA KIDNEY CARE – NEW PATIENT INFORMATION FORM

Patient Information

Full Name

Date of Birth

Phone Number

Email

Physical Address

Insurance Information

Primary Insurance

Member ID

Group Number

Secondary Insurance (if applicable)

Medical History

Preferred Pharmacy

Medication List (include dose & frequency)

Past Medical History

Family History

Social History

Alcohol Use

Smoking / Tobacco Use

Consent Acknowledgments

Consent to Treat

By signing below, I consent to medical evaluation and treatment by Optima Kidney Care, including examinations, diagnostics, and ongoing management of my kidney health.

Signature: _____ Date: _____

Consent to Release Information

I authorize Optima Kidney Care to request, receive, and release my medical information for the purposes of treatment, care coordination, and billing, in accordance with HIPAA regulations.

Signature: _____ Date: _____

Telemedicine Consent

I understand that telemedicine involves the use of electronic communication technologies and consent to receive care via telehealth, acknowledging the risks and benefits explained to me.

Signature: _____ Date: _____

No-Show Policy

We require a minimum of 48 hours' notice for appointment cancellations or rescheduling. Failure to provide sufficient notice will be considered a no-show. No-shows are subject to the following fees: First no-show: $25 charge. Second no-show: $50 charge. Third no-show: dismissal from the clinic.

Patient Initials: _____