INGHAM NEPHROLOGY & HYPERTENSION, P.C.

Notice of Privacy Practices
Medical and Financial Information
Patient Responsibility Notice
Signature Form

Print Patient Name_____ **DOB**_____

By signing this form you acknowledge:

1. The Notice of Privacy Practices for INH,P.C., which provides information about how we may use and disclose your Protected Health Information.
2. That you have read and agree to abide by the policies of our Patient Responsibility Notice
3. That you authorize INH to release medical/financial information related to your care, to your insurance carrier or persons or agency responsible for payment of your bill.
4. Your signature is required to receive reimbursement for charges incurred.
5. You further agree to pay any unpaid balanced not covered by insurance.
6. Your signature below indicates that you give permission for services to be performed by the attending physician with assistance from other health professionals including medical assistants.
7. In the event that an employee or other professional is exposed to your blood or body fluids, you have been informed that an HIV antibody test may be performed on you (Public Act 488).

Patient Signature_____ **Date**_____

Emergency Contact Information

Name_____

Phone Number_____ **Relationship**_____

When contacting you, may we :

YES **NO** Leave a message on your answering machine/voice mail identifying our office?

YES **NO** Leave a message requesting a return call on your work phone?

____ **DO YOU WANT TO ENROLL INTO THE PATIENT PORTAL TO VIEW YOUR RECORDS?** Please ask for the enrollment form from the receptionist.

INGHAM NEPHROLOGY & HYPERTENSION

405 W Greenlawn Ave Suite 230 Lansing Mi 48910
Phone 517.485.8217 Fax 517.489. 4980

Release of Protected Health Information

Patient's Name_____ DOB_____

Address _____Phone No_____

City/State/Zip _____

Information Requested

___All Records ___Discharge Summary ___Emergency/UC Report

___History & Physical ___Lab/Pathology Reports ___X-ray Reports

___Operative Notes ___Consults/Letters ___Progress Notes

___ Other_____

Dates Requested From _____ to _____

From_____ To_____

_____ _____

_____ _____

Purpose 0f Disclosure

___Attorney/Legal ___Continued Care __Insurance __Personal Use

___Workers Comp ___Disability __Other_____

In compliance with Michigan Statues which require special permission to release otherwise privileged information, please release records pertaining to (initial all that apply):

___ Alcohol/Drug Abuse ___Mental Health ___Communicable Disease

I hereby authorize the release of information as requested and hold harmless the releasing party from any legal liability which might arise from such release. I further understand this authorization is valid unless revoked in by contacting this office in writing.

There may be a charge for copies of your Medical Records. There is no charge to send records to another Physicians office. INH Charges are $25.00 for the first 30 pages, .25cents per page thereafter. There may be an additional cost for postage.

Signature of Patient_____

Signature of Parent or Legal Representative (if applicable):_____

Ingham Nephrology & Hypertension

Patient Responsibility Notice

APPOINTMENTS: We see patients by appointments only. We make every effort to stay on schedule, but delays do occur and we ask that you understand the medical needs of other patients. Please arrive 10 minutes before your appointment time and have your **Photo ID and Insurance cards** ready to present at the check in window. Please report all changes in address, phone number or insurance. **We reserve the right not to treat or diagnose a patient over the phone without the benefit of a physical exam.**

NO-SHOW: This office requires a 24 hour cancellation notice for scheduled appointments, failure to do so may cause a fee of $25 to patients who have 2 missed appointments, and may be discharged from the practice after the third missed appointment.

LATE ARRIVALS: Please arrive at least 10 minutes prior to your scheduled time, late arrivals may not be seen, depending on the office flow that day.

CANCELLATIONS : INH requires a 24 hour notice if you must cancel and/or reschedule an appointment. You may call 517.485.8217 ext. 4 to reschedule or leave a message. This allows the scheduler ample time to fill your canceled appointment time with a patient who may have an urgent need to be seen.

MEDICATION REFILLS:When you need a medication refill, please call the Medical Assistant with your request. There is a 48 to 72 hour reply time for prescription refills. **Please call your Pharmacist to see when you may pick it up. There is NO need to leave more than one message for a medication refill.** If you have not had an appointment in the last 6 months you **MUST make an appointment prior to any refills.**

FEES AND CO-PAYS : Co-pays are due at the time of service. We accept cash, check, Visa, Discover and Master Card. There is a returned check fee of $35.00. Please familiarize yourself with your insurance plans coverage and co-pay. Failure to provide sufficient proof of insurance will require payment in full at the time of your appointment.

MEDICAL FORMS: Requests to complete insurance, FMLA, or disability forms are completed as time allows, and we cannot guarantee a rapid turn around time as our Provider's have varied schedules. The fee filling out the forms is $20.00, payable prior to receiving the finished forms.

MEDICAL RECORDS REQUESTS: The fee for a copy of your medical records is $25.00 for the first 30 pages and .25 cents per page thereafter, to a limit of $50.00. Requests for records are completed in the order they are received within a 30 day time frame.

MCLAREN LAB: When coming in for labs, sign in at check-in, and take a seat, the Lab Tech will be with you as soon as the Lab is available. The office is very busy Monday mornings, and should you choose to come that day, you may have a long wait, that is true during the lunch hour as well. Thank you for your patience.