VINAY SUNKU MD. INC
43932 15TH ST W, SUITE 101
Lancaster CA 93534
PHONE (661) 945-2299 FAX: (661) 945-2202

Kidney Diseases Transplant Follow Up Dialysis Internal Medicine

PATIENT REGISTRATION INFORMATION

Name_____DOB_____Age____Sex: M/F____
Address_____City_____Zip_____
Mailing Address_____
Home Phone#_____Work Phone_____Marital Status: M / D / W / S
Drivers Lic #:_____
Email Address:_____

Patient's Employer_____Occupation_____
Address_____Phone_____

Spouse's Name_____DOB_____AGE_____
Drivers Lic#_____

Emergency Contact_____Relation_____Phone_____
Referred by_____

Primary Insurance_____Policy #_____
Phone#_____Insured's name_____
Insured's Birthdate_____

Secondary Insurance_____Policy#_____
Phone#_____Insured's name_____
Insured's Birthdate_____

I hereby authorize payment of any medical and surgical Insurance benefits to Vinay Sunku MD Inc. I understand I am financially responsible for any charges whether or not paid by said insurance. If Co-insurance and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Vinay Sunku MD Inc and understand that these charges will not be waived. I authorize Vinay Sunku MD Inc to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original

Patient Signature: _____Date: _____

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NOTICE OF PRIVACY PRACTICES (5-2-2012)

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,

Vinay Sunku MD Ince uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you recieve. Your health information is contained in a medical record that is the physical property of Vinay Sunku MD Inc.

How May Use or Disclose Your Health Information

For Treatment: Vinay Sunku MD Inc. May use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person Providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment: Vinay Sunku MD Inc may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third party payer, such as an insurance company or health plan. The information on the bill may be sent to you or a third party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations Vinay Sunku MD Inc may use and disclose health information about you for operational purposes. For example your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate staff performance
- Assess quality of care and outcomes in your cases and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide

Appointments Vinay Sunku MD Inc may use your information to provide appointment reminders or Information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law Vinay Sunku MD Inc may use and disclose information about you as required by law, For example, Vinay Sunku MD Inc may disclose information for the following purposes;

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect, or domestic violence'
- And to assist law enforcement officials in their law enforcement duties.

Public Health Your health Information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Descendants Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties

Organ/Tissue Donation Your health Information may be used or disclosed for cadaveric organ, eye, or tissue donation purposes.

Research Vinay Sunku MD Inc. May use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure or your health information.

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Workers Compensations Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Your Health Information Rights

You have the right to

- Request a restriction on certain uses and disclosures for your information as you provided by 45 C.F.F. 164.522; however, Vinay Sunku MD Inc is not required to agree to a requested restriction
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for IN 45 C.F.R. 164.524;
- Amend your health record as provided in 45 C.F.R 164.526;
- Request in writing that communications of your health information by alternative means or at alternative locations;
    - Revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- Receive an accounting of disclosures made of your health information as provided by C.F.R. 1644.522;

Complaints

You may complain to Vinay Sunku MD Inc and to the US Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Vinay Sunku MD Inc.

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed
    - Accommodate reasonably requests you may make to communicate health information by alternative means or at alternative locations; and
    - Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Vinay Sunku MD Inc reserves the right to change its information practices and to make new provisions effective for all protected health information it maintains. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about Vinay Sunku MD Inc Privacy Practices, please contact:

Name: Our Office

Address: 43932 15th Street west Ste101 Lancaster Ca 93534

Phone: 661-9454-2299 Fax: 661-945-2202

For more information about HIPAAA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue S.W.

Washington, D.C. 20201

877-696-6775 (toll-free)

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AUTHORIZATION/RESPONSIBILITY AGREEMENT

I hereby authorize my insurance company to pay the proceeds of any benefits due me directly to:

VINAY SUNKU MD INC.

A copy of this can be considered as an original for insurance purposes.

Although I have requested Dr. Vinay Sunku to bill the insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

X_____ _____

Signature of Patient/responsible party Date

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ACKNOWLEDGMENT OF RECEIPT OF VINAY SUNKU MD INC NOTICE OF PRIVACY PRACTICES

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Vinay Sunku MD Inc will generally contact patients by written communication or phone calls. We will send letters or call the number that you have provided us on your patient sheet.

Home Telephone (_____) _____
[ ] Okay to leave message with detailed information
[ ] Leave message with call back number only
Cellular Telephone (_____) _____
[ ] Okay to leave message with detailed information
[ ] Leave message with call back number only
Work Telephone (_____) _____
[ ] Okay to leave message with detailed information
[ ] Leave message with call back number only
Written Communication (_____) _____
[ ] Okay to mail to my home address
[ ] Please mail to another address:_____

Record of Disclosures of Protected Health Information

I, _____ authorize the staff of Vinay Sunku MD Inc to Contact/release the following person(s) with regard to my medical information.

1._____ _____ _____
Name Relationship Telephone Number

2.._____ _____ _____
Name Relationship Telephone Number

Patient Signature: _____Date:_____
Patient Name: _____Date of Birth: _____

By signing this document, I acknowledge that I have received a copy of Vinay Sunku MD Inc Notice of Privacy Practices.

_____ _____
Patient Signature Name (Please Print)

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TO:_____

_____

_____

PATIENT: _____ DATE OF BIRTH: _____

Also Known as: _____ MED. RECORD #:_____

I HEREBY AUTHORIZE AND REQUEST THAT YOU PLEASE SEND A COPY OF MY MEDICAL RECORDS TO:

VINAY A SUNKU M.D.
43932 15TH STREET WEST SUITE 101
LANCASTER, CA 93534

I also authorize the release of records pertaining to:

_____ Laboratory

_____ Physicians Progress Notes

_____ Imaging (kidney ultrasound/ CT scans/ X-ray)

_____ _____

(WITNESS) SIGNATURE OF PATIENT/ OR GUARDIAN

_____

DATE

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ADVANCE DIRECTIVE ACKNOWLEDGEMENT
ACEPTACIÓN SOBRE DECISIONES AVANZADAS

Dr. Sunku's office and staff respect your rights to self determination in health care decision making. This facility will comply with all state and federal laws regarding the implementation of Advance Directives. All of us at Dr. Sunku's office want our patients to understand their rights to make medical decisions. Dr. Sunku's office complies with California laws and court decisions on Advance Directives. We do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an Advance Directive. We have formal policies to ensure that your wishes about treatment will be followed.

It is your responsibility to provide a copy of your Advance Directive to the hospital so that it can be kept with your records.

La oficina y el personal del Dr. Sunku respetan sus derechos de autodeterminación en la toma de decisiones de atención médica. Esta instalación cumplirá con todas las leyes estatales y federales con respecto a la implementación de Directivas anticipadas. Todos nosotros en el consultorio del Dr. Sunku queremos que nuestros pacientes comprendan sus derechos para tomar decisiones médicas. La oficina del Dr. Sunku cumple con las leyes de California y las decisiones judiciales sobre las instrucciones anticipadas. No condicionamos la provisión de atención ni discriminamos de otra manera a nadie en función de si usted ha ejecutado o no una directiva anticipada. Tenemos políticas formales para garantizar que se cumplan sus deseos sobre el tratamiento.

Please read and circle your answer

Por favor lea y circule sus respuestas

1. I have executed an Advance Directive.....YES/NO
   Yo he ejecutado decisiones avanzadas.....Sí/NO
2. I have been given written materials about my rights.....YES/NO
   Yo he recibido información escrita sobre mis derechos.....Sí/NO
3. I would like to receive additional information regarding Advance Directives.....YES/NO
   Me gustaría recibir información adicional sobre las decisiones avanzadas.....Sí/NO
4. I have received the additional information regarding Advance Directives.....YES/NO
   Yo he recibido información adicional sobre las decisiones avanzadas.....Sí/NO

Patient Signature_____ Date_____

Firma del Paciente_____ Date_____

Comments/Comentarios_____

_____

Patient Name:_____ DOB:_____

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Surgeries/Circugías

Previous Operation/Procedures	Year	Surgeon	Place/Hospital OR City	Complication/Problem

Hospitalizations/Hospitalizaciones

Reason for other hospitalizations (Non-Surgical Admissions)	YEAR	Physician	Place (Hospital/City)

What are your diagnosis/Tu Diagnóstico Medico

PLEASE LIST ANY OTHER MEDICAL ILLNESS, ANY HISTORY OF CANCER OR CHRONIC CONDITIONS	HOW LONG HAVE YOU HAD THIS?

Allergies to any medication _____ Reaction: _____

Cualquier Alergia a la medicación _____ Reacción: _____

LIST YOUR MEDICATION	DOSAGE	DIRECTION

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NEW PATIENT QUESTIONS PLEASE PUT A CHECK MARK IF YOU HAVE HAD ANY OF THE FOLLOWING

Patient Name: Date:

General/Constitutional
_ Change in Appetite
_ Chills/Fever
_ Fatigue
_ Weight loss
_ Weight gain
_ Night Sweats

Eye
_ Dry eye
_ Diminished Visual Activity
_ Visual Changes
_ Double Vision
_ Blurred Vision

Integumentary/Breast
_ Breast lump/Discharge
_ Breast Pain
_ Breast soreness

Allergy/Immunology
_Congestion
_ Itching
_ Rash
_ Sneezing
_ Watery eyes
_Wheezing

ENT
_Ear discharge
_Hearing Problems

Respiratory
_Chest Pain
_Cough
_Pain with inspiration
_Wheezing
_Sputum
_Shortness of breath w/activity

Cardiovascular
_Chest Pain
_Fluid accumulation in legs
_Difficulty lying flat
_Pain/Irregular Heartbeat

Gastrointestinal
_Abdominal Pain
_Blood in stool
_Chainge in bowel habits
_Constipation
_ Diarrhea
_Heartburn
_Nausea/Vomit/Vomit blood
_Indigestion
_Bloating/ Gas

Hematology
_Easy bruising
_Recent blood transfusion
_Anemia
_Cancer

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_Ringing in the ears
_Nasal Discharge/Stuffy nose
_Sinus problems

ENT
_ Difficulty Swallowing
_ Throat Pain
_ Dizziness
_ Ear Pain
_ Nosebleed

Endocrine
_ Excessive thirst
_ Frequent urination
_ Mood swings
_ Sweating

Genitourinary
_Difficulty initiating a stream
_Dribbling after urination
_Incontinence
_Vaginal pain/Discharge/Sores
_Penile pain/Discharge/Sores
_Missed periods
_Kidney stones
_Bladder Infection
_Kidney Disease
_Waking up at night to urinate

Musculoskeletal
_Painful joints
_Swollen joints
_Leg cramps
_Joint stiffness
_Decreased range of motion

Skin
_Itching
_Rash

Neurologic
_Headache
_Seizures
_Tingling/Numbness
_Tremor
_Weakness
_Back Pain

Psychiatric
_Difficulty Sleeping
_Depression
_Anxiety

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The office of Vinay Sunku MD Inc. Is committed to providing all of our patients with exceptional care. When a patient Cancels or Reschedules without giving enough notice or No Shows, they prevent another patient from being seen.

Please call us at (661) 945-2299 by 12:00pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00pm on Friday. If prior notification is not given, you will be charged $25.00 for the missed appointment, which is not covered by insurances. It is a patient responsibility.

Patient Signature:_____ Date:_____

Patient received copy:_____ Date:_____

Witness Signature:_____ Date:_____