KIDNEY ASSOCIATES INC.

Mohan R. Kamadana, M.D. Ravindra Pawar, M.D.
Suresh Vadada, M.D. Jackson Liu, M.D.
Swapna Kamadana, M.D.

HIPAA PATIENT ACKNOWLEDGEMENT

ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement, but, in refusing, we will not be allowed to process your insurance claims

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Kidney Associates Inc. A copy of this signed, dated acknowledgement shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

_____ _____

Please print your name Please sign your name

_____ _____

Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR

HEALTHCARE INFORMATION.

(This includes spouse, children, grandchildren, sister, brother, and any care takers who can have access to this your records)

Name\	Relationship
Name	Relationship
Name	Relationship

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

- Cell phone Confirmation
- Home phone Confirmation
- Work phone Confirmation
- Email Confirmation
- U.S. Mail/Postcard

I AUTHORIZE INFORMATION ABOUT MY HEALTHCARE BE CONVEYED VIA:

- Message on cell phone
- Message on home phone
- Message on work phone
- Email message
- U.S. Mail/Postcard
- **Any of the above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS OR NEW HEALTHCARE INFO VIA:

- Phone Message
- Email
- U.S. Mail/Postcard
- **Any of the above**