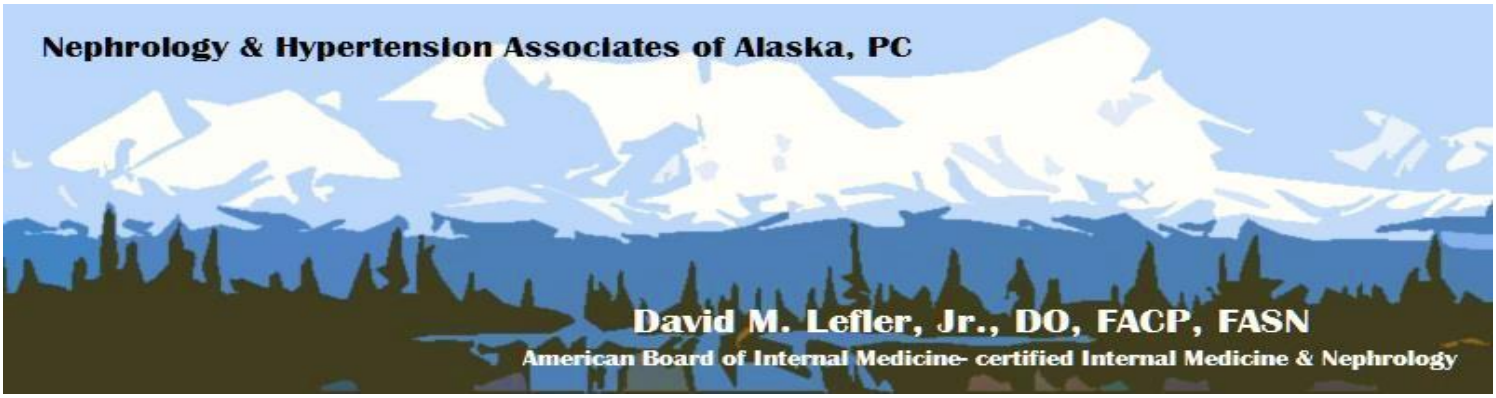


THIS DOCUMENT IS TO BE SIGNED BY THE PATIENT -OR- PERSON LEGALLY RESPONSIBLE FOR THE PATIENT'S MEDICAL DECISIONS

Notice of Privacy Practices-- Acknowledgement of Receipt

I hereby acknowledge that Nephrology & Hypertension Associates of Alaska, PC (NHA) has provided me with the below information/disclosures as it relates to health information privacy practices as federal law requires (HIPAA).

This notice describes how my medical information may be used and disclosed, and how I can access this information. I acknowledge that Nephrology and Hypertension Associates of Alaska has answered all of my questions regarding this notice.

Release of Information

I hereby authorize Nephrology & Hypertension Associates of Alaska to release and disclose to my insurance carrier(s), as applicable, any information for determining benefits or benefits payable for related services and any information for the purpose of accreditation, audits, certification, and peer or utilization reviews. I also authorize NHA to release and disclose to any healthcare provider (upon my request) any information necessary in providing medical services. If I have any questions or complaints about health information I can call the practice manager and contact HHS. NHA has a duty to protect my healthcare information when I am a patient in the practice and will release my information only at my request.

Assignment of Benefits

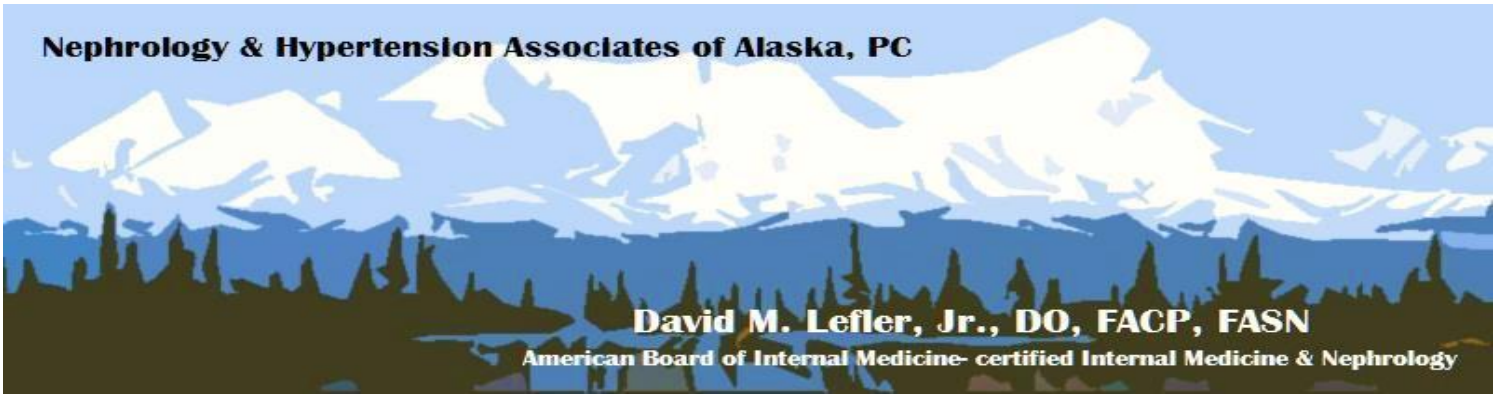
I hereby authorize that my insurance benefits payable for services provided by Nephrology & Hypertension Associates of Alaska as applicable, be paid directly to NHA. I understand that this assignment does not release me of any responsibility I may have for payment of services/ charges that are NOT covered by my insurance carrier(s), as acknowledged below.

Acknowledgment of Financial Responsibilities

There are many rules, regulations, and limitations imposed by different healthcare insurance and/or managed care companies. I acknowledge that it is my responsibility to provide NHA with accurate and complete insurance information at the time(s) services are rendered and that it is my responsibility to be aware of any limitations on coverage related to my insurance policy. I acknowledge that I am financially responsible for any co-pays and/or coinsurance amounts at the time service are rendered. I also acknowledge that I am financially responsible for all deductibles, non-covered benefits and amounts not paid by insurance as a result of my failure to provide accurate and complete insurance information at the time services are rendered. To the extent that I do not have current insurance coverage at the time services are rendered, I acknowledge that I am responsible for payment in full of such services, and that, if payment cannot be made at the time services are rendered, I will make appropriate arrangements with NHA billing department. Additionally, I acknowledge and agree that NHA may balance bill for charges that are not covered by my insurance carrier, or are over and above their usual and customary charge. My signature below acknowledges understanding of these financial responsibilities.

Office Location:
3300 Providence Drive, Suite B201—B Tower
Anchorage, AK 99508

Phone : (907)770-0412
Fax: (844) 772-0725
Website: www.nhakidney.com



*** A possible fee may be charged for any appointment not cancelled 24 hours in advance at NHA discretion. These fees are not covered by insurance and will be your responsibility. Additionally, if you miss your appointment, or are more than 15 minutes late for your scheduled appointment, your appointment may need to be rescheduled.

The undersigned patient/ patient representative acknowledge receipt of this form, and agree to the terms set forth herein.

Patient's Name

_____

Patient's Signature –or- Responsible Party

_____

Responsible Party's printed name AND relationship to patient

_____ **DATE:** _____

OFFICE USE ONLY

Document patient or responsible party was given the above information/privacy practices/receipt of notice and reason patient was unable to sign if applicable.

Given Notice: _____Yes _____No

Reason not signed by patient:_____

Staff Member:

Date:

Office Location:
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Anchorage, AK 99508

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