RENAL ASSOCIATES
of West Michigan, P.C.

RAMANDEEP S. BANGA, M.D.
MARK R. BOELKINS, M.D.
SCOTT B. BUCHOWSKI, M.D.
PAUL A. DELYRIA, M.D.
KSENIYA V. FILIPPOVA, M.D.
SAURABH K. GOEL, M.D.
R. MICHAEL HOFMANN, M.D., FASN
DANIEL J. LEGAULT, M.D., FASN
BONITA A. MOHAMED, M.D.
BRETT W. PLATTNER, M.D.
SRIVILLIPUTTUR G. SANTHANAKRISHNAN, M.D.
BYRON T. SLATON, M.D.
MICHAEL J. UNRUH, M.D.
JAMES A. VISSER, M.D.
J. MICHELE BOWERMAN-TORRES, FNP-BC
ERIKA S. GEILE, RD
KRISTINA L. OOSTERHOUSE, PA-C
GINA R. PETERSON, PA-C
JOAN M. TOBAR, AGACNP-BC

330 East Beltline N.E., Suite 100
Grand Rapids, Michigan 49506
Phone (616) 752-6235 Fax (616) 752-6324
Toll Free 1-888-752-RAWM (7296)

KIDNEY DISEASE
ACUTE AND CHRONIC DIALYSIS
TRANSPLANT MEDICINE
HYPERTENSION

AMELIA K. KLOCKE, B.S.
PRACTICE ADMINISTRATOR

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician_____

Under the Health Insurance Portability and Accountability Act (HIPAA) Renal Associates of West Michigan, P.C. will use and disclose your protected health information for 1.) Treatment of your medical condition and maintaining the continuity of your care. 2.) Payment for medical services provided to you, and 3.) Routine health care operations including quality assurance accreditation or educational purposes.

Renal Associates of West Michigan, P.C. Notice of Privacy was posted in a clear and prominent location in the waiting area, where I was able to view it. I understand that if I would like to have a more detailed account of Renal Associates policies and procedures concerning the privacy of my health information that I can retrieve a copy before I sign this form.

PERMITTED USE OF PROTECTED HEALTH INFORMATION

While you are a patient of Renal Associates of West Michigan, P.C. we may notify your documented emergency contact of your location and condition in the event of an emergency or disaster.
If you understand and agree to the notice of privacy practices, the use of your protected health information and how it will be used, sign your name below.

X_____ _____

Signature of Patient or Legal Representative **Date**

LIMITED USE OF PROTECTED HEALTH INFORMATION

If you wish to limit our use of your protected health information please list the people who may be given information about your care, payment arrangements, or location and condition in the event of an emergency.
Do not include physicians, or insurance companies, only family/ friends.

_____

_____

X_____ _____

Signature of Patient or Legal Representative **Date**

For office use only:
If an acknowledgment is not obtained from the patient or representative, document below the provider's good faith effort to obtain why the acknowledgment was not obtained:

X_____ _____

Staff Team Member Date

Reason acknowledgment was not obtained: _____