Dr. Lorraine Wilson, Dr. Radhika Medipalli, Dr. Kaelin Merveldt, and Dr. Celeste Boeckman
****

Welcome to Oklahoma Kidney Care, the office of Dr. Lorraine Wilson, Dr. Radhika Medipalli, Dr. Kaelin Merveldt, and Dr. Celeste Boeckman. We are Board Certified Nephrologists specializing in the care of your kidneys and difficult to treat cases of hypertension. As your Nephrologists our goal is to offer you the best care and patient experience available in Oklahoma City and surrounding areas.

Oklahoma Kidney Care's main campus is located at 13901 McAuley Blvd. Suite #303, Oklahoma City, OK 73134. Our office phone number is (405) 748-5800 and our fax is (405) 748-5806. We also have satellite clinics located in Yukon. Each of these clinics require an appointment.
The office hours for our main campus are Monday through Thursday 8:00 AM to 4:00 PM. Should you find the need to schedule your appointments at our satellite office please inform our staff when scheduling your appointment.

As you are aware there have been many changes in the structure of Healthcare. One change has been to offer the patient a way to communicate with their physician and/or staff via a "Patient Portal" which is a secure email process given to you during your clinic visit. If you are interested please inform our Receptionist to begin this process for you. She will simply need your current email address. Please know your information will be kept secure by all of the standard HIPPA laws.
Another change is the specific type of medical information we must gather. Due to this change we have made adjustments to our patient forms to ensure we capture all pertinent information to allow for the best quality of care. This may take a few extra moments of your time, but it is necessary, so we thank you for your patience.

APPOINTMENTS:

In order to benefit each patient by extending excellent care with professional efficiency we require each patient to schedule an appointment. We ask that all **New Patients be 20-30 minutes early to allow proper time for paperwork** and to please bring all medication bottles with them to their first visit. Please note that your first appointment will take at least one hour. If you cannot keep your appointment a 24 hour advance notice is required to cancel or reschedule.

Please note: If you are a new patient and you do not call the office to reschedule (24 hours prior to your appointment) or fail to show for you appointment there will be a charge of $50.00 applied to your account. (One hour has been held for your time with the physician and considerable time expended in the preparation of your electronic record before coming to the appointment). If you do not fully understand the reason for your appointment, we encourage you to contact the referring physician.

BILLING/INSURANCE

For the convenience of our patients we will file their office visits with their insurance carrier. Please bring all current insurance cards with you when you come to your appointment. Please inform the receptionist of any update is needed on your address, phone number or insurance coverage and/or benefits.

It is the policy of this office to collect all co-pays at time of service. It is also the policy of this office to collect any portion that is considered patient balance by insurance, (i.e. co-insurance percentage and deductibles). Should you need special assistance with an outstanding balance please contact our Billing Manager.

Thank you for choosing Oklahoma Kidney Care.

Oklahoma Kidney Care
Dr. Lorraine Wilson, Dr. Radhika Medipalli, Dr. Kaelin Merveldt, and Dr. Celeste Boeckman

---

Acknowledgement of Review of Notice of Privacy Practices

Patient Name:________________________________ **Date of Birth:**_________________________

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

If there are any restrictions/limitations you would like to place on the sharing of your private healthcare information please list:
____
____
____

***The following individuals are permitted to obtain/review/assist me with my:

______appointment information ______medical records ______Billing records

___________________________ (relationship) ___________________________ (relationship)
___________________________ (relationship) ___________________________ (relationship)

In compliance with this Notice of Privacy Practices I authorize the release of any normal and/or abnormal test results in the following manner: (please check all that apply)

___Yes ___No - Permission to leave recorded message on home phone

___Yes ___No - Permission to speak with my spouse

___Yes ___No - Permission to speak with my child/children

___Yes ___No - Permission to speak with my parents

___Yes ___No - Permission to notify me in writing

___Yes ___No - Other_______________________________________

____________________________________ ______________________________
Patient Signature Date

____________________________________ ______________________________
Guardian Signature (if different from patient) Date

Revised 2/8/2023

Oklahoma Kidney Care

Lorraine Wilson, M.D. | Radhika Medipalli, M.D. | Kaelin Merveldt, M.D. | Celeste Boeckman, D.O.

Past Medical History

Check boxes if you have been treated for the following. NAME______________________________

Date_________________________ DOB__________________________

Medical History

Kidney disease	☐Chronic Kidney Disease ☐Transplant ☐Dialysis ☐Polycystic kidney disease ☐Acute kidney injury ☐Glomerulonephritis
Diabetes	☐Type1 ☐Type 2
High blood pressure	☐
Ischemic heart disease	☐Heart attack ☐Angina ☐Angioplasty ☐Coronary stent ☐CABG ☐Stroke/TIA
Cancer	☐Lung ☐Breast ☐Prostate ☐Colon ☐Melanoma ☐Bladder ☐Lymphoma ☐Kidney ☐Thyroid ☐Leukemia ☐ Pancreatic
EENT	☐Blindness ☐Hearing problems
Cardiovascular	☐Atrial fibrillation ☐Pacemaker ☐High cholesterol ☐AICD (defibrillator) ☐Valvular heart disease ☐Congestive heart failure ☐Aneurysm
Respiratory	☐COPD ☐Chronic bronchitis ☐Pneumonia ☐Tuberculosis ☐Sleep apnea ☐Asthma ☐Emphysema
Gastrointestinal	☐GERD ☐Stomach/Bowel ulcers ☐Gall bladder disease ☐Hepatitis ☐Inflammatory bowel disease
Genitourinary	☐Enlarged prostate ☐Kidney stones ☐Frequent UTIs
Musculoskeletal	☐Osteoarthritis ☐Osteoporosis
Neurological	☐Seizures ☐Parkinson's ☐Dementia ☐Stroke/TIA
Psychiatric	☐Depression ☐Anxiety disorder
Endocrine	☐Hypothyroidism ☐Hyperparathyroidism ☐Hyperthyroidism ☐Adrenal insufficiency
Hematology	☐Anemia ☐Sickle cell disease ☐Sickle cell trait ☐Blood transfusion
Immuno/Allergy	☐HIV ☐AIDS ☐Rheumatoid arthritis ☐Lupus
Other	☐______________________________________

Surgery History - ☐Yes ☐No

☐ Appendectomy	☐Valve replacement	☐Prostatectomy	☐Hip replacement
☐Cataract surgery	☐PD catheter	☐Thyroidectomy	☐Nephrectomy (Kidney removal)
☐Hemorrhoidectomy	☐CABG	☐AV fistula	☐Tonsillectomy
☐Knee replacement	☐Gall bladder removal	☐Carotid endarterectomy	☐AV graft
☐Renal transplant	☐Hernia repair	☐Gastric bypass	☐Other_____________________

Family History

Kidney disease	☐Father	☐Mother	☐Sibling	☐Child	☐None
Diabetes	☐Father	☐Mother	☐Sibling	☐Child	☐None
High blood pressure	☐Father	☐Mother	☐Sibling	☐Child	☐None
Cancer	☐Father	☐Mother	☐Sibling	☐Child	☐None

Status:						
	Father	☐Living	☐Deceased	☐Unknown	Age_______	Cause____________
	Mother	☐Living	☐Deceased	☐Unknown	Age_______	Cause____________

Social History

Current Marital Status	☐Married ☐Single ☐Divorced ☐Separated ☐Widowed
Living arrangement	☐Alone ☐Spouse ☐Significant other ☐Family member ☐In-home caregiver ☐Assisted living facility
Occupation	☐Retired ☐Employed ☐Unemployed ☐Student
Profession	______________________________
Level of Education	______________________________

Habits

Tobacco use	☐Current user ☐Former user ☐Never used Amount______________
Alcohol use	☐Current user ☐Former user ☐Never used Amount______________
Recreational drug use	☐Current user ☐Former user ☐Never used
Are you taking NSAIDS?	☐Ibuprofen ☐Aleve ☐Advil ☐Naproxen ☐Motrin ☐Celebrex ☐Mobic ☐None
Immuno	☐Pneumococcal ☐Influenza ☐Shingles (Zostivx)

Review of Systems

Constitutional	☐Fever ☐Weight gain ☐Weight loss ☐Fatigue ☐Chills ☐Weakness
HEENT	☐Vision impaired ☐Eye pain ☐Double vision ☐Hearing loss ☐Sinus problems ☐Sore throat ☐Nose bleeds ☐Headache
Respiratory	☐Shortness of breath ☐Shortness of breath at rest ☐Shortness of breath with activity ☐Cough ☐Wheezing ☐Blood in sputum ☐Pain with breathing ☐Night sweats
Cardiovascular	☐Chest pain ☐Palpitations ☐Claudication (leg pain w/walking) ☐Orthopnea (trouble lying flat) ☐Edema (swelling) ☐PND (sleep on more than 2 pillows)
Gastrointestinal	☐Abdominal pain ☐Nausea ☐Diarrhea ☐Heartburn ☐Vomiting ☐Constipation ☐Anorexia (loss of appetite) ☐Trouble swallowing ☐Indigestion
Genitourinary	☐Urinary urgency ☐Urinary burning or pain ☐Blood in urine ☐Urinary frequency ☐Urinary hesitancy ☐Foamy urine ☐Incontinency ☐Nocturia (Urinate more than 1 time per night)
Musculoskeletal	☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Arm weakness ☐Leg weakness
Skin	☐Rash ☐Itching ☐Dryness ☐Color change
Neurological	☐Numbness ☐Tremors ☐Seizures ☐Tingling ☐Fainting
Psychiatric	☐Depression ☐Anxiety ☐Insomnia
Endocrine	☐Heat intolerance ☐Excessive thirst ☐Cold intolerance ☐Excessive urination
Hematology	☐Bleeding gums ☐Easy bruising
Immuno/Allergy	☐Seasonal allergies ☐Hives

OKLAHOMA KIDNEY CARE

AMERICAN BOARD OF INTERNAL MEDICINE
NEPHROLOGY
DIALYSIS AND TRANSPLANTATION
HYPERTENSION

PATIENT INFORMATION
(PLEASE PRINT)

Name: ______________________________ Date: ______________________

Address: ______________________________ City: ________________ Zip: ________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________ Sex: ☐ M ☐ F

Email Address: (for patient portal) ______________________________

Date of Birth: __________ Age: ____ SSN: ____________ Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ SEP

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Other Race

Language: ______________

Referred By: ______________________ Primary Care Physician: ______________________

Patient's Employer: ______________________ Position: ______________________

Business Address: ____

Spouse's Name: ______________________ Spouse's Employer: ______________________

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

Name: ______________________________ Relationship: ______________________

Address (If other than above): ______________________________ Phone: ____________

Employer: ______________________________ Position: ______________________

Business Address: ______________________________ Phone: ______________________

INSURANCE INFORMATION

Name of Policy Holder: ______________________________ SSN of Policy Holder: ____________

Primary Insurance: ______________________ Group #: ____________ Policy #: ____________

Address: ____ Phone: ____________

Secondary Insurance: ______________________ Group #: ____________ Policy #: ____________

Address: ____ Phone: ____________

Tertiary Insurance: ______________________ Group #: ____________ Policy #: ____________

Address: ____ Phone: ____________

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

Name: ______________________________ Relationship: ______________________

Address: ____ Phone: ____________

Employer: ____________________ Position: ____________________ Phone: ____________

Pharmacy: ______________________ Location: ______________________________

Allergies: ____

AUTHORIZATIONS

Financial Responsibility and Benefits to Physician:

I understand that I am financially responsible for services rendered by the physician and his/her staff, unless a contract exists between the physician and my insurance company that super cedes my financial obligation or in the case of authorized Worker's Compensation. I authorize my insurance company to pay benefits directly to the physician.

______________________ ______________________________________

Date Insured Signature

Release of Information:

I hereby authorize the release of any and all information from Oklahoma Kidney Care for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then Oklahoma Kidney Care may disclose any or all of the patient's information to that party to verify charges. Oklahoma Kidney Care may disclose any or all of the patient's information to the patient's attending physician, consulting physician(s) and other health care provider who have a legitimate need for such information in the care and treatment of the patient. **The information released may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).**

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

______________________ ______________________________________

Date Insured Signature

Acknowledgement of Receipt of Patient Privacy Notice:

I acknowledge I have been provided with a Patient Privacy Notice that provides a description of information uses and disclosures.

______________________ ______________________________________

Date Patient Signature

HIPAA PATIENT PRIVACY NOTICE

Effective Date: 2/1/11

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.

If you have any questions about this notice, please contact our office at 405-748-5800.

WHO WILL FOLLOW THIS NOTICE:
This notice describes our office's practices and that of any heath care professional authorized to enter information into your file or record and all employees, staff and other personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:
We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use of disclosure of medical information. We are required by law to: make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to protected medical information about you and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:
The following categories describe different ways that we use and disclose protected medical information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use protected information about you to provide you with medical treatment or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists or other personnel who are involved in taking care of you. We also may disclose protected medical information about you to people outside the practice who may be involved in your care (i.e.: family members). We may disclose protected medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We may also disclose your protected medical information to others we use to provide services that are a part of your care, such as outside billing companies and transcription services.
For Payment: We may use and disclose protected medical information about you so that the treatment and services you receive any be billed to and payment any be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We also may use and disclose your information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your information to bill you directly for services and items.
Appointment Reminders: We may use and disclose protected medical information to contact you as a reminder that you have an appointment for treatment or medical care. Messages may be left on answering machines, voice mails, or with the person answering the phone.
Treatment Alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
Health-Related Benefits and Services: We may use and disclose protected medical information to tell you about health-related benefits or services that may be of interest to you.
Research: Under certain circumstances, we may use and disclose protected medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are the subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care in our practice.
As Required by Law: We will disclose protected medical information about you when required to do so by federal, state or local law.
To Avert a Serious Threat to Health or Safety: We may use and disclose protected medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release protected medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Military and Veterans: If you are a member of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority, if you are in their service.
Workers Compensation: We may release protected medical information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness. Release of such information is controlled by state and or federal law.
Public Health Risks: We may disclose protected medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report a known or suspected crime;
- To report child abuse or neglect;
- To report vulnerable adult abuse;
- To report reactions to medications or problems with products;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities by law. These oversight activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement: We may release protected medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct involving our practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Medical Examiners and Funeral Directors: We may release protected medical information about you to a medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release protected medical information about patients to funeral directors as necessary to carry out their duties.
National Security and Intelligence Activities: We may release protected medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
Protective Services for the President and Others: We may disclose protected information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected medical information about you to the correctional institutions or law enforcement official. This release would be necessary (1) for this practice to provide you with health care; (2) to protect your health and safety or health and safety of others; (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:
You have the following rights regarding protected medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes.

To inspect and/or copy your medical information you must submit your request to the office manager in our office in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. (By statue in Oklahoma we may charge you $1.00 for the first page, $.50 for each additional page for copies, plus our postage costs. If your record contains any item that requires a photographic process to copy, such as an x-ray or photograph, we may charge you up to $5.00 per image).
Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our practice.

To request an amendment, your request must be made in writing and submitted to our office. In addition, you must provide a reason that supports your amendment request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- In our judgment is accurate and complete as it appears or as it was at the time it was originally captured and recorded.

Right to an Accounting of Disclosures: You have the right to request and “accounting of disclosures”. This is a list of the disclosures we have made of your medical information.

To request this list of accounting of disclosures, you must submit your request in writing to our office. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want this list (for example, on paper or electronically [i.e. on a disk]). The first list you request within each 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.
Right to Request Restrictions: You have the right to request a restriction or limitation on the protected medical information we use or disclose about you for treatment, payment or health care operations. However, we must receive your restrictions in writing before we have made such disclosures. Also, of you restrict our right to use your protected medical information for treatment, payment or health operations, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship.

You also have the right to request a limit on the protected medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery to your family.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our office. In your request for restrictions, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (i.e.: disclosures to your spouse).
Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain locations. For example, you can ask that we only contact you at work, or at home, or by mail or by phone.

To request confidential communications, you must make your request in writing to our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Copy of This Notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, you may ask for a current copy of this notice at any time.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office at 405-748-5800. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION:
Other uses and disclosures of protected medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

OKLAHOMA KIDNEY CARE
13901 MCAULEY BLVD, SUITE 303
OKLAHOMA CITY, OK 74134
405-748-5800 OFFICE
405-748-5806 FAX