



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (PLEASE READ SIGN AND FAX BACK TO US)

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES", revision date of April 27-2018.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

___ I wish to file a "Request for Restriction" of my Protected Health Information.

___ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

___ I wish to object to the following in the "Notice of Privacy Practices":

I understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original or previous version(s).

Signature: _____ Date signed _____ Printed Name: _____

CONSENT (PLEASE READ, SIGN AND FAX TO US)

I give The Virtual Nephrologist, Inc. and A. O. Rifai, MD my consent to use my Protected Health Information to carry out my Virtual consultation and to obtain payment from me via PayPal or direct e-mail billing to my e-mail of record.

I understand for any medical emergencies I should call 911 or go to the nearest ER.

I understand for any "time sensitive matter", I should not use the internet. I understand that e-mails and Skype, Vsee may not be HIPAA compliant.

I understand that Dr. Rifai is not my treating physician and for my ultimate decision and medications and direct patient care, I should see my primary care physician and any consultant I follow with, including Nephrologist.

Signature: _____ Date signed _____ Printed Name: _____

DO NOT WRITE BELOW THIS LINE _____

For Office Use Only: received by: _____ Date: _____

<https://thevirtualnephrologist.com/>

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