Prana Health

Ad Vitam - For Life

Dear Patient,

Welcome to Prana Healthcare. In Sanskrit, the word Prana refers to the cosmic energy that flows through all of us and is commonly thought to be associated with the breath. I know that having trust in your doctor to care for some of your most important health concerns is an act of faith. At Prana, we encourage a feeling of comfort, relief, and patient satisfaction. I want you to know that my first and foremost priority is to ensure that you receive the very best care. I would like to help you not only understand your health journey but further how to cope with any problems that you may be facing. It is my mission to not only better manage your condition but improve your quality of life as well.

At Prana Healthcare, we treat both children and adults with chronic and acute pulmonary disorders, sleep disorders, as well as obesity medicine. In my years of practice, I have found that obesity, pulmonary disorders, and sleep often intersect. Patients will see separate specialists for each disorder resulting in a lowered quality of care. At Prana, it is my goal to bring these facets of your health together as one. I do this with hopes of helping patients achieve a healthier and happier lifestyle no matter what stage of life.

In my almost 30 years of practicing medicine, I have been trained in six different specialties including sleep medicine, pulmonary medicine, internal medicine, critical care medicine, obesity medicine, and anesthesiology. I enjoy teaching medical students and residents in our offices and I am involved in some collaborative research with my colleagues across the country. I offer consulting services for the Agency of Healthcare Administration with the state of Florida. In the past I served as Chief of Pulmonary Medicine, Director of many sleep centers and held academic positions at the University of Florida and the University of Michigan. I have served on the steering committee for the American Academy of Sleep Medicine, holding an emphasis in sleep-related breathing disorders.

At Prana Healthcare I hope to help you find balanced health in sleep, body, and breath. Thank you for the opportunity to take part in your journey.

Sincerely,

Rahul Kakkar

Rahul K. Kakkar, MD, FCCP, FAASM
Board Certified in Internal Medicine, Pulmonary Disease, Critical Care and Sleep Medicine and Anxiety Medicine
200 Forsythe St. Fayetteville, NC 28303 Phone (910) 824-7619 Fax (910) 824-7754
1212 Central Dr. Ste. 103, Sanford, NC 27330 Phone (910) 824-7619 Fax (910) 824-7754
120 NE Maynard, NC 27513 Phone (910) 824-7619 Fax (910) 824-7754

Patient Introduction **Today's Date:** ___________________

Name: ____________ ____________ ____________ __________ ____________
First Middle Last DOB SSN:

Home Phone: __________________________ Cell Phone: ___________________________

Home Address:____

City: _____________ State: _________ Zip: ________ Business Name: _____________

Work Phone: __________________________________ _________________________

Race: □ White □ Black African American □ Hispanic / Latin □ Multiracial □ Other: _________

Ethnicity: □ Hispanic □ Non-Hispanic

(Required) Email: __________________________________

Health Insurance Information

Primary Insurance Company Name: ____

ID#: ____ Group #: ____________________________

Company Address:____

Secondary Insurance Company Name: ____

ID#: ____ Group #: ____________________________

Company Address: ____

Assignment of benefits: I hereby authorize the payment to be made directly to Prana Health PLLC of benefits due for my services. I understand I am financially responsible for charges not covered by my Health Insurance Company.

Date: ________________ Signature: ____

Emergency Contact

In case of an emergency please notify: ____

Phone #: ________________________________ Relationship: ____________________________

Pharmacy Information

Pharmacy Name: ____

Address: __________________________ City: _________________________________

State: ____________________________ Zip: __________________________________

Phone # _____________________________ Fax # _________________________________

General Consent and Authorization Form

ADMINISTRATION OF TREATMENT

I hereby consent to the administration of treatment deemed necessary by my physician(s) and other physicians who my attend me, their associates and assistants, healthcare, professionals responsible for my care, Prana Health PLLC, and any of its affiliates (Hereinafter referred to as "Prana Health"), the Prana Health's house of staff and employees to provide medical care, tests, procedures, drugs or drug products, services, and supplies considered advisable by Prana Health.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures, or examinations, while in the care of Prana Health. I am aware that, except in limited situations (such as in a medical emergency), I am required to sign separate consent forms should I need to undergo surgery or other invasive procedures. I understand I have a right to refuse any procedure or medical treatment.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by Prana Health PLLC. (Hereinafter referred to as "Prana Health"), Prana Health physicians and Prana Health employees, I hereby authorize direct payment to Prana Health and physicians, of all insurance benefits applicable (including Medicare and/or medical benefits), which are not or which shall become due and payable to me. In addition, I hereby authorized direct payment to Prana Health of all insurance benefits applicable to medical and/or surgical services rendered by physicians for whom Prana Health is authorized to charge and bill. If my attending physician and/or other physicians or physician extenders associated with him/her or whom he/she may designate accept insurance assignment, then I hereby authorize my insurance benefits to be paid directly to those physicians or physician extenders.

____

Legal Representative/Patient Signature

____

Print Patient Name

____

Date

FINANCIAL POLICIES

1. Payment is expected at the time of service. (This includes co-pays and insurance deductibles).
   A credit card must be held on file for fees that are not collected at the time of service.
   These may include: (please initial each item)
   A.) Copay: ______________
   B.) Deductible: ______________
   C.) Past due balance: ______________
   D.) No show fees: ________________

Credit cards are held with a third-party company, to ensure the safety of your personal financial information. I authorize Prana Health to charge my credit card for balance due.

Signature: ____________________________ Date: ____________________

2. If you are unable to keep your appointment, you must notify us at least 24 business hours prior to your appointment. You WILL charged a $50 no call/no show fee for a clinic appointment and $200 for a sleep study, if you fail to notify us in a timely manner.
3. Some insurance requires that your labs be performed in a different location other than your doctor's office. If you choose to have the test performed at your physician's office, you will be expected to pay the necessary fee for this service. Your insurance cannot be billed in those instances.
4. Similarly, if your insurance does not authorize a procedure or test and you choose to have the procedure or test done anyway, you will need to pay for the service upfront. Your insurance cannot be billed in those instances.
5. A fee of $5 per page is charged for filling out forms for a job, prior authorization for prescriptions not covered by your insurance carrier, or other miscellaneous forms, and is payable at the time of service.
6. For a printed copy of medical records, you may incur a flat fee of $35.
7. For Disability forms, a flat fee of $30 is charged

FINANCIAL AGREEMENT

As a courtesy to our patients, we are happy to file insurance forms and will accept assignment of insurance benefits. After 90 days, if no payments have been received and no extended payment plans have been made, necessary collection proceedings will begin.

1 UNDERSTAND, FULLY ACCEPT, AND ACKNOWLEDGE THE RESPONSIBILITY FOR PAYMENT OF ALL FEES.

SIGNATURE: ____________________________ DATE: ____________________

APPOINTMENT NON-CONFIRMATION POLICY

PLEASE READ CAREFULLY

1. Patients will receive reminders from our office in one or more forms, which include phone calls, e-mails, text reminders or letters.

2. PLEASE CONFIRM YOUR APPOINTMENT BY RESPONDING TO TEXT, E-MAIL OR PHONE CALL. YOUR APPOINTMENT WILL BE CONFIRMED ONLY WHEN WE GET A CONFIRMATION FROM YOU OR YOUR LEGAL REPRESENTATIVE.

3. IF WE DO NOT RECEIVE YOUR CONFIRMATION ONE BUSINESS DAY PRIOR TO YOUR APPOINTMENT, WE RESERVE THE RIGHT TO GIVE THAT APPOINTMENT SLOT TO ANOTHER PATIENT. IN THE EVENT YOU SHOW UP FOR YOUR APPOINTMENT, WE WILL STILL SEE YOU, BUT IT WILL DELAY THE WAIT TIME.

4. IF YOUR APPOINTMENT WAS FOR A SLEEP STUDY AND WE DO NOT RECEIVE CONFIRMATION, THE SLEEP STUDY SLOT WLL BE ASSIGNED TO ANOTHER PATIENT AND YOUR SLEEP STUDY WILL BE CANCELLED.

I UNDERSTAND THE ABOVE POLICY

____

SIGNATURE DATE

Notice of Privacy Practice

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You have the right to:

- Get a copy of your paper or electronic medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. We will say "yes" to all reasonable requests.
- Correct your paper or electronic medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit the information we share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that.
- Request confidential communication: You can ask us to contact you in a specific way for example: home or office phone or to send mail to ask for information for the purpose of payment, or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared your information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you believe your privacy rights have been violated: U.S. Department of Health and Human Services Office for Civil Rights

    Address: 200 Independence Avenue, S.W., Washington, D.C. 20201
    Phone #: 1 (877) 696-6775 Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
  We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures

How do we typically use or share your health information?

- Treat you: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your service.

How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- To use or share your information for health research purposes

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when death occurs.
- Address workers' compensation, law enforcement, and other government requests
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of this Notice: 06/25/2019

If you need to contact concerning this notice or your privacy you may reach out to:

Prana Health, PLLC
200 Forsythe St.
Fayetteville, NC 28303
Phone: (910) 824-7619
Fax: (910) 824-7754

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICE

Notice to Patient:

We are required by law to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this form if you wish.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICE

____

PLEASE CLEARLY PRINT NAME

____

SIGNATURE

____

DATE

Please list any family members whom we may release any of your medical information to: (lab results, x-ray results, etc.)

____

____

____

Authorization for Release of Medical Records

Patient Name: ____
Date of Birth: __________________ Phone: _____________________________
Address: ____
City: ______________________________ State: _____________________ Zip:______________

I authorize the use or disclosure of the above-named individual's health information.

The following individual or organization is authorized to make the disclosure:

Provider Name: ____
Address: ____
City: ___________________________ State: _______________________ Zip: ______________

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_______ Complete health records _________ Lab results/X-ray reports/CT scan
_______ Physical exam _________ Echocardiogram
_______ Pulmonary Function Test/ABG _________ Sleep Studies
_______ Other: please specify: ____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization.

Name: PRANA HEALTH, PLLC
Address: 200 Forsythe St.
Fayetteville, NC 28303
Phone #: 910-824-7619
Fax #: 910-824-7754

For the Purpose of Evaluation and Treatment:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If fail to specify an expiration date, event or condition, this authorization will expire in 1 calendar year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.

____

Legal Representative or Patient Signature

____

Date