



Associated Renal & Hypertension Group, PC

Parisa Hakimzadeh, DO

M. Betsy Srichai, MD

P. Gina Obias, MD

Kobena Dadzie, MD

7 Cedar Grove Lane, Suite 31, Somerset, NJ 08873

Tel: (732) 873-1400 Fax: (732) 960-3444 www.associatedrenal.com

PATIENT INFORMATION

Patient Name: _____ Social Security Number: _____
Date of Birth: _____ Sex: M ____ F ____ Marital Status: S ____ M ____ D ____ W ____
Street Address: _____ Apt. No: _____
City: _____ State _____ Zip Code: _____
Home phone: (____) _____ Work phone: (____) _____
Cell/mobile number: (____) _____ Email Address: _____
Guardian/Parent if patient is a minor: _____
Emergency Contact: _____ Emergency Contact Phone: (____) _____
Guarantor's Name: _____ Guarantor's Social Security Number: _____
Guarantor's Date of Birth: _____ Relationship to Patient: _____
Guarantor's Address: _____ Apt. No: _____
City: _____ State _____ Zip Code: _____
Home phone: (____) _____ Cell/mobile phone: (____) _____
Employer's Name: _____ Work Phone: (____) _____
Employer's Address: _____

INSURANCE INFORMATION

Primary Insurance Company's Name: _____
Insurance Address: _____ City: _____
State _____ Zip _____ Phone Number: (____) _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____
Insurance Address: _____ City: _____
State _____ Zip _____ Phone Number: (____) _____
Name of Policy Holder: _____ Date of Birth: _____
Insurance ID Number: _____ Group Number: _____

REFERRAL INFORMATION

Referring Physician: _____ Specialty: _____
City: _____ State: _____ Zip: _____

What brings you in for today's visit: _____



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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize _____ to release my medical records.

Patient's Name _____

Patient's Address _____

Patient's Date of Birth _____ Social Security Number _____

Please forward the following records:

_____ All Records

_____ All Lab Results

_____ H&P

_____ Lab Results from:

_____ Progress Notes

_____/_____/____ until ____/____/____

_____ Consultants' Letters

_____ Radiology Reports

_____ Medication List

_____ EKG/ECHO Results

_____ Other: _____

SEND TO:

Associated Renal & Hypertension Group, P.C.

7 Cedar Grove Lane, Suite 31

Somerset, NJ 08873

Phone: (732) 873-1400

Fax: (732) 960-3444

Patient Signature: _____



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Patient's Name: _____ DOB: _____

Local Pharmacy: _____ Phone #: _____

Mail Order Pharmacy: _____

Preferred Lab: ____ LabCorp ____ Quest ____ Other _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

When we call our patients with results or appointment information:

It is OK to leave a message on my voicemail. Yes _____ No _____

I authorize you to speak to those listed below regarding my medical information:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Patient Signature: _____

I authorize ARHG to forward my medical records to the following physicians:

Primary Care Physician: _____

Other doctors involved in my care:



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REVIEW OF SYSTEMS – Please, mark X if you have had the following within the last six months:

Constitutional

- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Sweating/flushing
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

Head/Ear/Neck/Throat

- ☐ Congestion
- ☐ Dental problem
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Nosebleeds
- ☐ Postnasal drip
- ☐ Runny nose
- ☐ Sinus pain
- ☐ Sneezing
- ☐ Sore throat
- ☐ Ringing in ears/Tinnitus
- ☐ Trouble swallowing
- ☐ Voice change

Skin

- ☐ Color change
- ☐ Pale skin color
- ☐ Rash
- ☐ Wound

Eyes

- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Light sensitivity
- ☐ Visual disturbance

Respiratory

- ☐ Sleep apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Cardiovascular

- ☐ Chest pain
- ☐ Leg swelling
- ☐ Heart palpitations

Gastrointestinal

- ☐ Abdominal distension
- ☐ Abdominal pain
- ☐ Rectal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Endocrine

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Abnormal thirst
- ☐ Abnormal hunger/eating
- ☐ Urinating too much

Musculoskeletal

- ☐ Arthritis/joint pains
- ☐ Back pain
- ☐ Gait problems
- ☐ Joint swelling
- ☐ Muscle pains
- ☐ Neck pain/stiffness

Hematologic/Blood

- ☐ Enlarged lymph nodes
- ☐ Easy bruising/bleeding

Genitourinary

- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Frequent urination at night
- ☐ How often _____
- ☐ Flank pain
- ☐ Blood in urine
- ☐ Foamy urine
- ☐ Urinary incontinence
- ☐ Penile swelling
- ☐ Scrotal swelling
- ☐ Frequent urge to urinate
- ☐ Decreased urination

Neurological

- ☐ Dizziness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulties
- ☐ Fainting
- ☐ Tremors
- ☐ Weakness

Psychiatric

- ☐ Agitation
- ☐ Behavior Problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Depression
- ☐ Hallucinations
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal thoughts



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PAST MEDICAL HISTORY

- | | | |
|---|---|--|
| ☐ Kidney Disease | ☐ Cancer (type) | ☐ High Cholesterol |
| ☐ Chronic kidney disease | ☐ Gout | ☐ Lung) |
| ☐ Protein in urine | ☐ Heart Disease | ☐ COPD |
| ☐ Blood in urine | ☐ Bypass surgery | ☐ Asthma |
| ☐ Kidney stones | ☐ Heart Attacks | ☐ Sleep Apnea |
| ☐ Urinary tract infections | ☐ Coronary stents | ☐ Gastrointestinal |
| ☐ Urinary incontinence | ☐ Congestive heart failure | ☐ GERD (gastric reflux) |
| ☐ Anemia | ☐ Atrial fibrillation | ☐ Stomach/bowel ulcers |
| ☐ Blood Clots | ☐ Hepatitis (A/B/C) | ☐ COVID-19 |
| ☐ Other Medical History: _____ | | |

PAST SURGICAL HISTORY

- | | |
|--|---|
| ☐ Appendectomy | ☐ Intestinal Surgery |
| ☐ CABG (Coronary artery bypass graft) | ☐ Kidney transplant |
| ☐ Carotid Endarterectomy | ☐ Knee Replacement (L/R/bilateral) |
| ☐ Cataract Surgery | ☐ Nephrectomy |
| ☐ Gallbladder removal (cholecystectomy) | ☐ Pacemaker/defibrillator |
| ☐ Hernia repair | ☐ Thyroidectomy |
| ☐ Hip Replacement (L/R/bilateral) | ☐ Tonsillectomy |
| ☐ Hysterectomy | ☐ Valve replacement |
| ☐ Other Surgical History: _____ | |

SUBSTANCE USE

Tobacco

- | | |
|--|------------------------------------|
| ☐ Never | ☐ Former |
| ☐ Every Day | ☐ Some Days |
| ☐ Cigarettes | |
| ☐ Smokeless tobacco | |
| ☐ Vaping | |
| ☐ How much: _____ | |
| ☐ Quit: _____ | |

Alcohol

- | | | |
|---|------------------------------|------------------------------|
| ☐ No | ☐ Yes | ☐ Occ |
| ☐ Wine | | |
| ☐ Beer | | |
| ☐ Hard liquor | | |
| ☐ Other | | |
| ☐ How much: _____ | | |
| ☐ How often: _____ | | |

Illicit Drugs

- | | | |
|---|------------------------------|------------------------------|
| ☐ No | ☐ Yes | ☐ Occ |
| ☐ "Crack" cocaine | | |
| ☐ Marijuana | | |
| ☐ Opioids | | |
| ☐ Other | | |
| ☐ How much: _____ | | |
| ☐ How often: _____ | | |

SOCIAL HISTORY

Occupation History: _____

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married
☐ Other ☐ Significant Other ☐ Single ☐ Widowed

Spouse/Significant Other Name: _____

Number of Children: _____

Preferred Language: _____ Ethnicity: _____

FAMILY HISTORY

Do any of your family members have any of the following medical conditions.

☐ Kidney Disease _____ ☐ High Blood Pressure _____

☐ Diabetes ☐ Stroke

☐ Cancer ☐ Gout

☐ Heart Disease _____ ☐ Kidney Disease _____

Mother: Alive/Deceased Age Heath Conditions: _____

Father: Alive/Deceased Age _____ Health Conditions: _____

Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____

Siblings: M/F Alive/Deceased Age _____ Health Conditions: _____

Siblings: M/F Alive/Deceased Age ____ Health Conditions: _____

Siblings: M/F Alive/Deceased Age _____ Health Conditions: _____

Siblings: M/F Alive/Deceased Age Health Conditions:

Children: M/F Alive/Deceased Age Health Conditions:

Children:	M/F	Alive/Deceased	Age	Health Conditions:

Children:	M/F	Alive/Deceased	Age	Health Conditions:

Children:	M/F	Alive/Deceased	Age	Health Conditions:

CURRENT MEDICATIONS

Allergies: _____

[illegible]



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that Associated Renal & Hypertension Group, PC has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Associated Renal & Hypertension Group, PC has given me the opportunity to ask any questions about this notice, and all my questions have been answered.

Patient's Name Printed

Patient or Guardian Signature

Date Signed

Provider Use Only

If the patient was not able to sign due to an emergency, or did not want to sign, please document if the patient was given the notice and the reason why the patient did not sign.

Patient was given this notice: ____ Yes ____ No

Reason signature was not obtained:

Staff Signature

Date

Associated Renal & Hypertension Group

7 Cedar Grove Lane, Suite 31 Somerset, NJ 08873
Tel 732-873-1400 Fax 732-960-3444

Dr. Parisa Hakimzadeh
Dr. P. Gina Obias



Dr. M. Betsy Srichai
Dr. Kobena Dadzie

Payment Policy

1. **Insurance** – We participate in many insurance plans, including Medicare, Horizon BCBS, Aetna, Cigna, Oscar, and **United Healthcare (Dr. Hakimzadeh and Dr. Srichai only)**; however, it is **your responsibility** to call your insurance company to verify that our physicians are in-network with your plan. We do not accept any Medicaid plans, most D-SNP plans, or Charity Care.
If ARHG physicians are uncovered or out-of-network with your insurance, you will be billed the balance of any insurance payments received and our Self-Pay rates.
2. **Self-Pay** – If you are not insured by a plan we participate with, payment at our Self-Pay rates is expected at each visit. **Self-Pay rates are as follows:**
 - \$200 for New Patient/Initial in-office Visit
 - \$100 for Follow-up Visits.
3. **Insurance Cards** – If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit may be required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
4. **Referrals** – If your insurance requires a referral please make sure to have your referral at the time of the visit. We are not responsible for non-payment from insurance companies. If a referral is required and you do not have one at the time of your visit, you will be responsible for payment for that visit:
5. **Co-payments and deductibles** – All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
6. **Claims submission** – We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **Missed appointments** – Patients will be charged a \$50 fee for no-shows and or cancellations less than 24 hours prior to your scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. If you are unable to make your scheduled appointment, please contact our office as soon as possible to reschedule.

Thank you for choosing Associated Renal & Hypertension Group as your care provider. Please let us know if you have any questions or concerns about this payment policy.

I have read and understand the payment policy and agree to abide by its guidelines, including assuming full responsibility for payment as required:

Signature of patient or responsible party

Date



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IMPORTANT OFFICE POLICIES

RELEASE OF MEDICAL INFORMATION

I authorize *Associated Renal & Hypertension Group, P.C.* to release the medical records concerning the above patient to any physician, hospital, or agency involved in the care of this patient.

PAYMENT POLICY

It is your responsibility to confirm your individual healthcare plan is in-network with our physicians. Co-payments are to be collected at the time services are received. We accept cash, checks, or credit card payments. All medical services provided are directly charged to the patient or responsible party. You will be responsible for any balance deemed: patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 24 hours prior to the appointment. We reserve the right to charge \$50.00 for a "no show" appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date: _____

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all medical benefits, if applicable, to *Associated Renal & Hypertension Group, P.C.* I also authorize release of medical information necessary to process all medical insurance claims. I hereby authorize my insurance benefits to be paid directly to *Associated Renal & Hypertension Group, P.C.* I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: _____ Date: _____

ASSOCIATED RENAL & HYPERTENSION GROUP, PC

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NOTICE OF PRIVACY PRACTICES

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.

Effective Date: April 14, 2003

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal, and are committed to protecting your medical information. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or received by us.

We are required by law to:

- Make sure that medical information that identifies you is kept private, and will be used or disclosed only as described by this Notice or applicable law;
- Make this Notice available to you; and
- Follow the terms of the Notice that is currently in effect.

2. 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 medical information we already have about you as well as any information we receive in the future. We will have copies of this notice available in our offices and on our website: www.associatedrenal.com.

3. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose your medical information. For each category of uses or disclosures, we will give some examples. Not every use or disclosure in a category will be listed.

- a. For Treatment. We will use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other office personnel who are involved in taking care of you. For example, we would disclose your health information, as necessary, to a home health agency that provides care to you. We also may disclose medical information about you to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- b. For Payment. We will use and disclose medical information about you so that the treatment and services we provide may be billed to and payment may be collected from you, an insurance company, a governmental entity such as Medicare or Medicaid, or a third party. For example, we may need to give your health plan information about treatment we provide so your health plan will pay us or reimburse you for the treatment. 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 or hospital admission. We may also have to send your information to more than one health plan in circumstances where it is not clear which health plan has the responsibility to pay for your care.
- c. For Healthcare Operations. We will use and disclose medical information about you for our operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and

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whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other office personnel for review and learning purposes. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you.

d. **Treatment Alternatives.** We may/will use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

e. **Health-Related Benefits and Services.** We may/will use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

f. **Reminders.** We may/will use and disclose medical information about you to contact you in an effort to provide appointment reminders for medical care.

g. **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, your clinical lab values may be used for clinical research. Research projects may be conducted with de-identified patient information, with your written authorization, or with the approval of a Privacy Board or Institutional Review Board. De-identified patient information has numerous items removed (i.e., your name, address, phone number, etc.) so that the information may not be used to identify you.

h. **Business Associates.** We contract with business associates to provide some services. Examples may include medical billing and transcription services. When these services are contracted, we may/will disclose your health information to our business associate so that they may perform the job we have asked them to do. To protect your health information however, we require the business associate to appropriately safeguard your information.

i. **As Required By Law.** We will disclose medical information about you when required to do so by federal, state, or local law.

j. **To Avert a Serious Threat to Health or Safety.** We will use and disclose 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.

k. **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. *Except in emergency situations, you may object to the uses and disclosures described in this Section k, either in general or to any specific person or persons to whom your medical information might otherwise be disclosed.*

l. **Special Situations.** We will use and disclose medical information about you:

➤ To facilitate organ and tissue donation.

➤ For specialized governmental functions, including the military and veterans, national security, criminal corrections and public benefit purposes.

➤ For Workers' Compensation or similar programs, as permitted by law.

➤ For public health activities.

➤ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

➤ For health oversight activities including, for example, audits, investigations, inspections, and licensure.

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➤ For lawsuits and disputes, we will disclose medical information about you in response to a valid court or administrative order or in the course of defending ourselves.

➤ For law enforcement purposes when asked to do so by a law enforcement official.

➤ To coroners, medical examiners, and funeral directors as necessary to assist them to carry out their duties.

➤ To correctional institutions or law enforcement officials with respect to inmates.

m. Written Authorization. Except as described above, we will disclose your medical information only with your prior written authorization. You may revoke that authorization, in writing, at any time, unless we have taken action relying on your prior authorization or if you signed the authorization as a condition of obtaining insurance coverage.

4. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

a. 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. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records under certain circumstances.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. 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.

We may deny your request to inspect and copy medical information in certain very limited circumstances, including requests by an inmate at a correctional institution, requests for information we obtained from someone else subject to certain confidentiality agreements, and some requests concerning ongoing research projects. If you are denied access to medical information for any other reason, you may request that the denial be reviewed. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

b. Request to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, please submit a written request to our Privacy Officer with a reason that supports your 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 us;

➤ Is not part of the information which you would be permitted to inspect and copy; or

➤ Is accurate and complete.

If we deny your request, you may submit a written statement disagreeing with the denial. We will keep your statement on file and distribute it with all future disclosures of the information to which it relates.

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c. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures of medical information about you, with exceptions. We do not need to account for disclosures made: (i) to you; (ii) pursuant to your written authorization; (iii) for the purpose of carrying out treatment, payment or operations; (iv) to persons involved in your care, or to notify your family or friends about your whereabouts; (v) that are incidental to another permissible use or disclosure; (vi) for national security or intelligence purposes; (vii) who had you in custody at the time of the disclosure; (viii) as part of a limited data set; (ix) to a health oversight agency or law enforcement official if they so request. The accounting will include the date of each disclosure, the name of the entity or person to whom the disclosure was made and that person's address (if known), and a brief description of the information disclosed together with the purpose of the disclosure.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that 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 the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you. 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.

d. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

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 us. In your request, 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, for example, disclosures to your spouse.

e. Right to Confidential Communications. You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. All reasonable requests will be granted. Contact our Privacy Officer if you require such confidential communications.

f. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice by requesting a paper copy from our Privacy Officer in writing.

5. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact us:

Associated Renal & Hypertension Group, P.C.
7 Cedar Grove Lane, Suite 31
Somerset, NJ 08873
(732) 873-1400

All complaints must be submitted in writing. You will not be penalized for filing a complaint.



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DIRECTIONS TO OUR OFFICE

FROM NEWARK AIRPORT

- New Jersey Turnpike South to Exit 9 NEW BRUNSWICK
- Bear right after toll booth
- Get into the two LEFT lanes
- Follow signs for ROUTE 18 NORTH/ NEW BRUNSWICK
- Follow directions below from ROUTE 18

FROM ROUTE 18

- Route 18 NORTH through New Brunswick
- Take exit for EASTON AVE/S. BOUND BROOK
- Follow road to traffic light, make LEFT onto LANDING LANE
- At next light, make RIGHT onto EASTON AVE, travel approx. 3.1 miles
- Stay in LEFT lane, at traffic light for CEDAR GROVE LANE, make LEFT
- Make RIGHT turn into Mandell's Plaza

FROM ROUTE 287

- Route 287 to Exit 10 NEW BRUNSWICK/EASTON AVE
- At first traffic light, make RIGHT onto CEDAR GROVE LANE
- Make RIGHT turn into Mandell's Plaza

FROM PRINCETON

- Route 27 NORTH, make LEFT onto SOUTH MIDDLEBUSH ROAD (Route 615) Turn LEFT on Amwell Road
- Turn RIGHT onto CEDAR GROVE LANE
- Approx 3 miles, office will be on LEFT (Mandell's Plaza)

Any Questions? Please call our office for assistance.
(732) 873-1400