kidney specialists, inc.

☐ **Westerville Office**
595 Copeland Mill Rd.
Suite 2D
Westerville, OH 43081
(614) 823-8500
Fax: (614) 823-8501

☐ **East Columbus Office**
Suburban Internal Medicine
6465 East Broad St, Ste. D
Columbus, OH 43213
(614) 823-8500
Fax: (614) 823-8501

☐ **Lancaster Office**
1550 Sheridan Drive
Suite 103
Lancaster, OH 43130
(740) 475-0058
Fax: (740) 475-0069

☐ **Pickerington Office**
Fresenius Dialysis Center
1310 Hill Rd N.
Pickerington, OH 43147
(740) 475-0058
Fax: (740) 475-0069

☐ **Newark Office**
1272 West Main Street
Doctors' Park, Bldg. 5
Newark, OH 43055
(740) 348-0003
Fax: (740) 348-0667

Dear Patient:

You have been scheduled for an appointment with:

Michael Falkenhain, M.D.
William A. Wilmer, M.D.
Stephanie Ladson-Wofford, M.D.
Joshua Bitter, D.O.
Vinay Mulkanoor, D.O.
Joseph Tasch, D.O.
Jordan Leshnock, C.N.P.

Your APPOINTMENT DATE AND TIME at the above marked location is:

____

Please arrive 15 minutes before your appointment. If you need to reschedule your appointment, please call us at least 48 hours prior to your scheduled appointment.

IMPORTANT INFORMATION: PLEASE READ!

Please bring the following to your appointment:

1. **Current Insurance card(s)**. It is your financial responsibility to pay all co-payments at the time of your visit. *Please note that you are responsible for knowing which facilities your insurance carrier requires you to use for laboratory, testing and hospital services as well as any referral or pre-cert requirements.
2. All **prescribed and over the counter medications** you are taking.
3. Any **medical records from other physicians** or institutions **that you have in your possession**.
4. Names and phone numbers of all physicians who are providing medical care.
5. **Completed forms which are enclosed with this mailing.**

***Please be aware that a freshly voided urine sample may be requested before you see the doctor.
Please do not void prior to your appointment.

Thank you.

Rev. 08/17

NEW PATIENT INFORMATION SHEET

Patient Information:

Patient Name:____Sex: M F
First Middle Last

Address: ____
Street City State Zip

Birth Date: ______________________ Married Single Divorced Widow(er)

Home Phone: (_____)______________________ Cell Phone: (______)______________________

Social Security #:______________________

Email (to send electronic billing statements):____

Employer: ______________________ Address:______________________

Phone: ______________________ ______________________

Spouse Information:

Name: ______________________ Birth Date: ______________________

Phone: (______)______________________

Employer: ______________________ Address:______________________

Work Phone: (_____)______________________ ______________________

Other Information:

Emergency Contact: ____
Name Phone Relationship

Referring Physician: ______________________ Phone: (______)______________________

Family Physician: ______________________ Phone: (______)______________________

Patient Authorization for Care and Treatment

I hereby authorize Kidney Specialists, Inc. to provide care and treatment under my physician's direction.

Patient Signature: ______________________________Date: ______________________

INSURANCE INFORMATION - ***Please present your Insurance card(s) to receptionist for verification.***
In order for our office to file your insurance claims, we will need the following information.

PRIMARY INSURANCE

Insurance Name: ______________________ Address: ______________________

Name of Insured: ______________________ Birth Date: ______________________

Policy/ID #: ______________________ Social Security #: ______________________

Group #: ______________________ Effective Date: ______________________

Insured's Relationship to Patient: Self ☐ Spouse ☐ Other ☐ ______________

SECONDARY INSURANCE

Insurance Name: ______________________ Address: ______________________

Name of Insured: ______________________ Birth Date: ______________________

Policy/ID #: ______________________ Social Security #: ______________________

Group #: ______________________ Effective Date: ______________________

Insured's Relationship to Patient: Self ☐ Spouse ☐ Other ☐ ______________

TERTIARY INSURANCE

Insurance Name: ______________________ Address: ______________________

Name of Insured: ______________________ Birth Date: ______________________

Policy/ID #: ______________________ Social Security #: ______________________

Group #: ______________________ Effective Date: ______________________

Insured's Relationship to Patient: Self ☐ Spouse ☐ Other ☐ ______________

Insurance Billing Authorization: I authorize Kidney Specialists, Inc. to submit a claim to my insurance carrier(s) or it's intermediaries for all services rendered and authorize and direct my insurance carrier or it's intermediaries to issue payment directly to Kidney Specialists, Inc. I hereby authorize Kidney Specialists, Inc. to release of medical information as may be necessary to the insurance carrier for the completion of my medical claims.
Medicare and Medicaid Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, or it's intermediaries or carriers any and all information needed for this. I authorize and request that payment be made directly to Kidney Specialists, Inc.
Guarantee of Payment: I understand that filing a claim with my insurance carrier or third party payor does not relieve me from my responsibility for payment of all charges. I understand that I am personally responsible for the payment of the services rendered if not fully covered by health insurance benefits. I also accept responsibility for knowing and understanding the restrictions, if any, of my insurance carrier regarding outpatient testing, laboratories, hospitals, and obtaining any necessary referrals.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient Signature: ______________________________ Date: ______________

Responsible Party Signature (If applicable): ______________________ Date: ______________

Print Responsible Party Name: ______________________ **Relationship:** ______________

ADULT PATIENT HISTORY FORM

Welcome to our practice! As a new patient, we ask that you complete this form and all areas to the best of your knowledge. This will help us get to know you better and target any issues or concerns that you may have. Periodically, as an existing patient, we may ask you to complete this form again, to help us update your history with any changes that may have occurred. Please bring this with you to your appointment.

Name:______________________________________ Date of Birth:________________________
Email address to be used for preventive reminders:_____________________________________
Date of upcoming appointment: __________________________

Personal and Social History:

Ethnicity: ○ Hispanic/Latino ○ Non-Hispanic/Latino ○ Decline to Specify
Race: ○ White ○ African American ○ Asian ○Decline to Specify ○ Other:_______________
Sleep(usual hrs): **Aids to sleep:**
Exercise:
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
Tobacco Use: Current User ○Former User Year Quit: ________ ○Never Used
Type: ☐ Cigarettes ☐ Pipes ☐ Chewing Tobacco ☐ Snuff
Alcohol Use: ○Current User ○Former User Year Quit: _______ ○Never Used
Amount: ☐ Social Drink ☐1-2 drinks a day ☐3 or more a day
Recreational Drug Use:
○Current User ○Former User Year Quit: _______ ○Never Used
☐Marijuana ☐Heroin ☐Cocaine ☐Amphetamines ☐Ectasy ☐Barbiturates
☐LSD ☐Opium ☐Other ____________________

Surgery History ○**Yes** ○**No**

If yes please list:____

Medical History and Surgeries

Please list any medical conditions you are being treated for: (use back if more room needed

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

If you have diabetes, approximately what year where you diagnosed:______________

Do you have eye disease or nerve damage due to diabetes? Y/N

If you have high blood pressure, approximately what year where you diagnosed:

____

Do you use NSAID medications (ibuprofen, naproxyn, motrin, aleve, celebrex etc):

________________________ **if yes, how often: rarely, frequently, daily**

Do you have history of kidney stones:

_________________________ **if yes, one time or multiple times and type if known**

Do you have history of kidney or bladder or prostate surgery:

__________________________ **if yes describe**

Have you been told you have blood or protein in your urine?

____

Have you been told you have electrolyte abnormalities in past? (Abnormal sodium, potassium, calcium or magnesium levels?) Y/N

If yes describe to best of your knowledge (please include any dietary restrictions or supplements given due to abnormality)

____

Medications and Allergies

Please list all medications you are taking, including over the counter medications and herbal supplements. Include dose and frequency. **Bring the pill bottles to the appointment for review by the physician**. Attach another sheet if necessary.

1.	4.
2.	5.
3.	6.
7.	8.
9.	10.
11.	12.

Please list all medications you are allergic to and what occurs.
Check this box if you have no known allergies: ☐

1.	3.
2.	4.

Immunizations: Please list the date of your most recent immunizations.
Shingles _______ Hepatitis B______ Flu Shot_______ Pneumonia_______

Family History

Kidney Disease: ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None **Sickle Cell Anemia** ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Diabetes: : ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
High Blood Pressure: : ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Heart Disease: ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Cancer: ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Stroke: ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Gout: ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Kidney Stones ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None **Blood in Urine** ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
Dementia: ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None
High Cholesterol ◻Father ◻Mother ◻Sibling __________ ◻Child ◻None **Other**____
Father: ○Living ○Deceased Age: ___ Cause Of Death: ______ ○Unknown
Mother: ○Living ○Deceased Age: ___ Cause Of Death: ______ ○Unknown

Review of Symptoms

(Symptoms you have had within the last 6 months)
Constitutional: ◻Fever ◻Weight Gain ◻Weight Loss ◻Fatigue ◻Chills ◻Weakness
HEENT: ◻Vision Impaired ◻Eye Pain ◻Redness ◻Color Blind ◻Double Vision ◻Hearing Loss ◻Ear Pain ◻Sinus Problems ◻Sore Throat ◻Nose Bleeds ◻Headache ◻Hoarseness ◻Tinnitus ◻Vertigo
Respiratory: ◻Shortness of Breath (at rest or with activity) ◻Pain with Breathing ◻Cough ◻Wheezing ◻Blood in sputum ◻Night sweats
Cardiovascular: ◻Chest Pain ◻Palpitations ◻Trouble Breathing when you lie flat ◻Swelling ◻Trouble breathing at night
Gastrointestinal: ◻Abdominal Pain ◻Nausea ◻Diarrhea ◻Heartburn ◻Vomiting ◻Constipation ◻Little to no appetite. Why?__________ ◻Trouble Swallowing ◻Indigestion
Genitourinary: ◻Urinary Urgency ◻Burning or pain ◻Blood in urine ◻Frequency ◻Hesitancy ◻Foamy urine ◻Trouble holding urine. When does it occur?_______ ◻Urinating more than 3 times at night ◻Erectile dysfunction/ prostate issues
Musculoskeletal: ◻Back pain ◻Neck Pain ◻Joint Pain ◻Muscle pain ◻Arm weakness ◻Leg Weakness
Skin: ◻Rash ◻Itching ◻Scaling ◻Dryness ◻Color Change ◻ Bruise easily
Neurological: ◻Numbness ◻Tremors ◻Seizures ◻Tingling ◻Fainting ◻Memory loss ◻Cramping
Endocrine: ◻Heat intolerance ◻Cold Intolerance ◻Excessive Thirst ◻Excessive urination
Hematology: ◻Bleeding gums ◻Easy bruising ◻anemia
Immuno/allergy: ◻Seasonal allergies ◻Hives
OB/GYN ◻ Toxemia (Early delivery due to high blood pressure and severe swelling ◻Do you still have menstrual periods ◻Osteoporosis or bone loss

Patient Signature:________________________________**Date:**_____________

Standard Consent / Authorization for Use and Disclosure of Protected Health Information

I understand that it is important for the healthcare system and my doctors to maintain health records about me. Information may be disclosed to Health Care Providers with direct or indirect treatment and billing related services the patient has had or will receive from Kidney Specialists, Inc. Examples include: hospitals, physicians, pharmacies, urgent care centers, radiologist, and/or laboratories. You have the right to revoke this authorization by submitting a written request to the Privacy officer.

Expiration: This authorization is effective one year through the date signed below unless terminated by the patient or their representative.

INFORMATION COVERED BY THIS AUTHORIZATION:

1. Please specify where we are allowed to contact you (please circle):

   HOME: YES NO Specify Number: ___________________________

   WORK: YES NO Specify Number: ___________________________

   CELL PHONE: YES NO Specify Number: ___________________________

2. Are we permitted to give lab, diagnostic, or any other testing results, information regarding healthcare services and any billing issues to family or other parties?

   YES NO If YES, please list names here:

   ____________________________________ ____

   ____________________________________ ____

3. Are we permitted to leave detailed messages on an answering machine, answering service, or voicemail concerning lab results, diagnostic, or any other testing results, appointment confirmations, or answers to messages left with our office?

   YES NO If YES, please verify the number you would like us to list: ______________________

4. By signing this consent, I acknowledge and agree that Kidney Specialists, Inc. may use and disclose my personal health information for the purpose of carrying out treatment, payment, and healthcare operations for me, or on my behalf. This information may also be needed and used, to secure payment on any outstanding claims, or to give the same type of information to billing departments for the sole purpose of collecting payments. Examples include but are not limited to personal address and phone number, insurance information, test results, or medical records from any of the following sources: primary care doctor, specialist, laboratory services, radiology group, or hospital. This Information will only be used to secure payment.

5. I understand that Kidney Specialists, Inc. may bill me if this information cannot be obtained and/or my insurance company denies my claim(s) because protected health information could not be obtained or shared.

Patient Name (please print): ____

Patient Signature: _____________________________________ Date: ___________________________

THIS PAGE MUST BE COMPLETED, SIGNED AND RETURNED

kidney specialists, inc.

Joshua E. Bitter, D.O.
Michael Falkenhain, M.D.
Stephanie Ladson-Wofford, M.D.
Vinay Mulkanoor, D.O.
William A. Wilmer, M.D.
Peg Barrows, CNP
Jordan R. Dodge, CNP

ABIM certified in Nephrology
AANP certified FNP

KSI Columbus/Westerville Administrative Office
595 Copeland Mill Rd., Suite 2D
Westerville, Ohio 43081
614-823-8500
FAX: 614-823-8501

KSI Lancaster
1550 Sheridan Drive, Suite 103
Lancaster, Ohio 43130
740-475-0058
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KSI Newark
1272 West Main Street
Doctors' Park, Building #5
Newark, Ohio 43055
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FAX: 740-348-0667

KSI Columbus/East
6465 East Broad St., Suite D
Columbus, Ohio 43222
614-823-8500
FAX: 614-823-8501

KSI Pickerington
1310 Hill Rd N.
Pickerington, OH 43147
740-475-0058

Dialysis Center Directorships:

Lancaster Hocking Hills Dialysis
Westerville Dialysis Center
Central Ohio North Dialysis
Central Ohio East Dialysis
DaVita Premiere Kidney Center
Pickerington Dialysis Center

Hospital Affiliations:

Mount Carmel St Ann's Hospital
Mount Carmel East Hospital
Fairfield Medical Center
Licking Memorial Hospital
Select Specialty Hospital
Ohio State University East

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations can cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some who are quite ill.

A "no show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time.

After the first no-show appointment you will receive a phone call to remind you of the missed appointment and to reschedule your appt. If a subsequent no-show occurs, it will be the physician's discretion as to whether a discharge letter will be sent out disengaging you from the practice and giving you 30 days to enroll with a new physician.

**** PLEASE READ ****

In preparation of your visit to KSI, our physicians will review the medical record provided by your primary care provider.

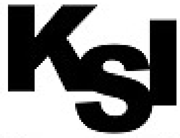
It is often necessary for our physicians to also review medical records from hospitalizations, including hospital bloodwork, urine studies, and radiology studies. These efforts are made to facilitate your visit with us and to develop a complete record regarding the reason you were referred to us.

If our review of that information is in excess of 30 minutes, in preparation of your visit, we may charge a non-face-to-face review code reflecting the time spent on that preparation. <u>Please note that such a charge may be billed even if you do not show for your visit.</u>

Therefore, please make every effort to show for your appointment and if you need to reschedule or cancel, please alert us as soon as possible.

Thank you.

Patient Signature/Date: ____



Kidney Specialists Inc.
595 Copeland Mill Rd. Ste 2D Westerville, OH 43081
Main: 740-653-2739

Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider.

3. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

4. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information as required for these payment methods. I am responsible for any returned ACH or paper check fees.

5. I understand that my signature and payment information will be maintained on file digitally for future use by the practice according to my payment arrangement. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan.

6. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account as I agree in payment arrangement for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.

7. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.

8. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

9. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I may not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

AUTHORIZED SIGNATURE____ DATE__________________________

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Doctors' Park, Bldg. 5
Newark, OH 43055
(740) 348-0003
Fax: (740) 348-0667

CONSENT FOR MEDICAL RECORDS

Patient Name: ____
First *Middle* *Last*

Birth Date: ____________________ Social Security No: ____________________

I hereby authorize Kidney Specialists, Inc. to:

☐ **RELEASE** MEDICAL RECORDS* **TO**:

1) Physician or Facility Name:______________________Phone#:______________
Address:______________________Fax#:______________

2) Physician or Facility Name:______________________Phone#:______________
Address:______________________Fax#:______________

3) Physician or Facility Name:______________________Phone#:______________
Address:______________________Fax#:______________

☐ **OBTAIN** MEDICAL RECORDS* **FROM**:

1) Physician or Facility Name:______________________Phone#:______________
Address:______________________Fax#:______________

2) Physician or Facility Name:______________________Phone#:______________
Address:______________________Fax#:______________

3) Physician or Facility Name:______________________Phone#:______________
Address:______________________Fax#:______________

***Records requested include**: ☐ All within chart ☐ Dates from__________to__________

I authorize Kidney Specialists, Inc. to obtain/release medical record information to either verify services rendered in order to process a claim for benefits, to provide continuity of my care, or at the request of a facility or an individual. **I understand that this authorization extends to all or any part of my records which may include treatment for physical and mental illness and/or alcohol/drug abuse, and/or AIDS (Acquired Immune Deficiency Syndrome), and/or may include the results of an HIV test or the fact that an HIV test was performed.** I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization will remain in effect from the date of my signature below unless I withdraw this request in writing or note an expiration date here:__________. A photocopy of this consent shall be as valid as the original.

Patient or Authorized Representative Signature: ______________________________
Relationship, if not patient: ____________________ **Date**: ____________________

Notice of Privacy Practices

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>

Patient Name: ______________________________________ D.O.B.: __________________________

☐ I have received a copy of Kidney Specialist's, Inc. Notice of Privacy Practices.

☐ I was offered a copy of Kidney Specialist's, Inc. Notice of Privacy Practices, but declined it.

Patient Signature: ___________________________________ Date: ____________________________

Signature of Representative: ___________________________Date:____________________________
(only used if the patient is a minor or an adult who is unable to sign)

Print Representative's Name: ____

A good faith effort was made to provide a copy of Kidney Specialist's, Inc. Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same.

Patient ☐ accepted ☐ declined the Notice and refused to sign this acknowledgement for the following

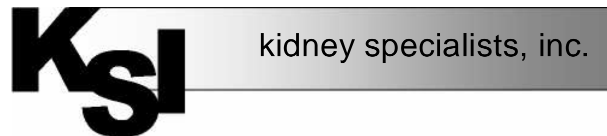
reason:____

____

Kidney Specialist's Inc. Representative: ____

Signature: ____Date:_______________________________

THIS PAGE MUST BE COMPLETE, SIGNED AND RETURNED



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. The effective date of this policy is April 14, 2003.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices informing you of our legal duties and our privacy practices regarding your PHI. We are required to abide by the terms of our Notice of Privacy Practices. We will notify you if a breach occurs that may have compromised the privacy or security of your information.

Uses and Disclosures

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment Your health information may be used by Kidney Specialists, Inc. and the staff members, or your information may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Kidney Specialists, Inc. may use your health information to seek payment from your health Insurance plans, or for other sources of coverage, for example: workers' compensation, automobile insurers, and any third party liability coverage. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated, which we are required to provide in order to obtain payment for services. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

NOTICE: If Kidney Specialists, Inc. cannot obtain needed documentation from you, a treating physician, lab, or hospital to obtain payment from your Insurance carrier we will request payment from you.

Healthcare Operations Kidney Specialists, Inc. may use your health information as necessary to support the day-to-day operations, activities and management of Kidney Specialists, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information; to the extent that the, use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Health Information Exchange: We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Privacy & Security Officer.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Appointment / prescription reminders, billing and collection notices: Your health information will be used by our staff to send you appointment reminders, prescription refill notices, billing statements, and collection notices.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information. As permitted by state and federal law, we may charge you a reasonable copy fee for your records. Federal law restricts the inspection and copying of certain types of records. Please contact our Privacy Office for these restrictions.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Kidney Specialists, Inc. - Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required by law to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices.

Requests and Complaints

You may complain to us or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated by us. To file a complaint with the Secretary of the United States Department of Health and Human Services, send a letter to: Secretary, United States Department of Health and Human Service, 200 Independence Avenue, S.W., Washington, D.D. 20201. All complaints to the Secretary must be submitted in writing and must be received within 180 days of the incident or event. You will not be penalized for filing a complaint. You may contact our Privacy Office to submit a comment or complaint about our privacy practices by sending a letter outlining your concerns to:

Privacy & Security Officer
595 Copeland Mill Rd. Ste. 2D
Westerville, OH 43081