NEPHROLOGY ASSOCIATES
CHATTANOOGA & CLEVELAND, TN.

Name: (Last, First, Middle)	Social Security No.	Marital Status	Date of Birth	Sex

Local Address	Email address
City, State, Zip	Home Phone Number
Primary Employer	Secondary Phone Number
Address	Race / Ethnicity / Primary Language
City, State, Zip	Alternate Contact Person's Name
Work Phone	Alternate Contact Person's Phone Number

Primary Care Physician	Referring Physician	Contact Name	Contact Phone

RESPONSIBLE PARTY INFORMATION

Name: (Last, First, Middle)	Social Security #	Date of Birth	Sex

Local Address	Secondary Billing Address (if applicable)
City, State, Zip	City, State, Zip
Home Phone	Home/Cell phone
Relationship to Patient	

PRIMARY INSURANCE

Name of Insurance Company	Policy #
Name of Insured	Group #
Address of Insurance Company	Copayment
City, State, Zip	Deductible
Relationship to patient	Effective Date / Expiration Date

SECONDARY INSURANCE (if applicable)

Name of Insurance Company		Policy #	
Name of Insured	SS#	Birthdate	Group #
Address of Insurance Company		Copayment	
City, State, Zip		Deductible	
Relationship to patient		Effective Date	Expiration Date

Authorization: I hereby authorize you to release to third party payers and/or other health practioners any information including the diagnosis and the records.

Signature of Patient/Guardian: _____ **Date:** _____

Directions to the Chattanooga
NEPHROLOGY ASSOCIATES
251 N. Lyerly
Chattanooga, TN. 37404
Phone: (423)702-7900

Helpful driving tips:

Directions from Dunlap, Soddy Daisy, TN. Area

Take 27 S towards downtown Chattanooga, Take Exit 1C (W. 4th St.). W 4th St. becomes E. 3rd. St. Turn right onto N. Lyerly St. The office building will be on the right.

Directions from South Pittsburg, TN. Area

Take I-24 E towards Chattanooga. Take the Exit 180A (Central Ave.) toward TN-8 N. Turn slight right onto Central Ave.; Turn right onto McCallie Ave., then turn left onto N. Lyerly St. The office building will be on the left.

Directions from Hixson TN. Area

Take Hwy 153 towards Chickamauga Dam; Take the TN-319S/DuPont Parkway ramp. Take the Amnicola Hwy exit towards downtown Chattanooga. Turn slight right onto Amnicola Hwy. Amnicola Hwy becomes Riverside Dr. Turn left onto Wilcox Blvd. Turn right onto Dodson Ave. Stay straight to go onto N. Lyerly St. The office building will be on the right.

Directions from Dalton, GA. Area

Take **I-75 N** towards Chattanooga. Merge onto **I-24W** via **Exit 2** on the left toward Chattanooga/Nashville. Take **Exit 184** toward **Moore Rd**. Merge onto **North Terrace**. Take the **1st right** onto **S. Moore Rd**. Take the **3rd left** onto **Brainerd Rd**. Continue to follow **Brainerd Rd** through the **Missionary Ridge tunnel**. Turn **slight right** onto ramp; **stay straight** to go onto **McCallie Ave**. Continue to **follow McCallie Ave**. Turn **right** onto **N. Lyerly St**. **251 N. Lyerly St. will be on the left.**

Directions from Knoxville, TN. Area

Take **I40 W** toward Nashville/Chattanooga; Keep **left** to take **I-75S** via **Exit 368** towards Chattanooga. Take **Exit 184** toward **Moore Rd.** Merge onto **North Terrace**. Take the **1st right** onto **S. Moore Rd**. Take the **3rd left** onto **Brainerd Rd**. Continue to follow **Brainerd Rd** through the **Missionary Ridge tunnel**. Turn **slight right** onto ramp; **stay straight** to go onto **McCallie Ave**. Continue to **follow McCallie Ave**. Turn **right** onto **N. Lyerly St**. The office will be on the left.

Directions to the Cleveland
NEPHROLOGY ASSOCIATES
2253 Chambliss Ave NW
Cleveland, TN. 37
Phone: (423)702-7900

Helpful driving tips:

Directions from Ooltewah, TN. area

Take **I-75 N** towards Knoxville, Take **TN-60 exit 25** towards Cleveland/Dayton. Turn **left** onto **25th St. NW**. Turn right onto **Chambliss Ave. NW**.
2253 Chambliss Ave. NW will be on the right

Directions from Copperhill, TN. area

Take **Hwy 64 / US-64 / US 74W.** Continue to follow **US-64W / US-74W.** Merge onto **25th St. NE / TN 60 N towards Dayton.** Turn **left onto N Ocoee St.,** Ten turn **Right,** then turn **left** onto **Chambliss Ave NW.**
2253 Chambliss Ave. NW will be on the right

Directions from Athens, TN. area

Take **I-75 S** towards Chattanooga, Take **TN-60 exit 25** towards Cleveland/Dayton. Turn Right onto **TN60 / Georgetown Rd. NW** continue to follow **TN-60**, turn **right** onto **Chambliss Ave. NW**
2253 Chambliss Ave. NW will be on the right

Patient Name: _____
Patient DOB: _____

Notice of Privacy Practices

Effective Date: January 1, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What's Protected Heath information (PHI)?

Protected Health Information (PH I) is information that Individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances;

For Treatment. We may use PH I to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring specialist's physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Notice of Privacy Practices
Continued

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that 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 PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: 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; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; 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.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures that Require Us to Give You an Opportunity and Object and Opt Out

Individual Is Involved in Your Care or Payment for Your care. We may disclose PH I to a person who is involved in your medical care or helps pay for your care, such as a family provide a written request to this office listing the contact information of the Individual or entity who should receive your electronic PHI.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Notice of Privacy Practices

Continued

Right to Request Amendments. If you feel that PHI we have 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 or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request 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 (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) Is not Information that you would be permitted to Inspect and copy, or (2) Is accurate and complete. Lf we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement

Right to an Accounting of Disclosures, You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should Indicate in what form you would like the accounting (for example, on pa per or by e-mail), the first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI 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 agree, we will comply with your request unless we terminate our agreement or the Information is needed to provide you with emergency treatment.

Right to Request Confidential -Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work.

Patient Name: _____
Patient DOB: _____

ACKNOWLEDGEMENT OF RECEIPT

I, (Patient Name) _____, have reviewed the Notice of Privacy Practices for Nephrology Associates.

_____ _____
Patient/Guardian Signature Date

Patient Name: _____
Patient DOB: _____

Patient Authorization for Disclosure of Protected Health Information

Notice to Patients: In compliance with HIPM regulations, this letter authorizes Nephrology Associates, P.C. to release medical records concerning you to the entity specified below. We must have this form to authorize our release of your protected health information to entities other than covered providers (for example, insurance companies, attorneys, education programs, etc.)

Patient Name: _____

Purpose of Request: I authorize Nephrology Associates to disclose or provide protected health information, about me, to: (please list person or persons below, example family or friends by first name last name and relationship)

_____

Description of Information to be Disclosed: I authorize Nephrology Associates, P.C. to disclose the following protected health information about me to the person identified above (please provide a written description of the information to be disclosed).

_____

Purpose of Disclosure (please list the purpose of the disclosure).

_____

Expirations or termination of authorization - This authorization will expire one year (365 days) from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date. (Please list earlier expiration, if less than one year)
Right to Revoke or Terminate - As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person, or by mailing a request to

Nephrology Associates
251 N. Lyerly
Chattanooga, TN. 37404
ATTN: Clinical Manager

Redisclosure - We have no control over the person(s) you have listed to receive your protected health information.

Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Nephrology Associates.

_____ _____
Patient/Guardian Signature Date

Patient Name: _____
Patient DOB: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
MEDICAL RECORD RELEASE

NOTICE TO PATIENTS: In compliance with HIPAA Regulations, this letter authorizes Nephrology Associates, to obtain medical records concerning you from other providers.

Patient Name: _____

Purpose of Request: - I request and authorize the disclosure or release of my protected health information (as identified below) to the following provider:

NEPHROLOGYASSOCIATES **(To be filled out by the provider)**

Name of Provider _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Description of Information to be disclosed - I authorize the disclosure of the following protected health information about me to the person(s) identified above.

_____ Complete Medical Record Or _____ Only the following information (listed below)

_____

Purpose of Disclosure - This protected health information ls being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

_____

Expiration or termination of authorization - This authorization will expire one year (365 days) from the date of my signature below:

_____ _____
Patient/Guardian Signature Date

NEPHROLOGY ASSOCIATES
CHATTANOOGA & CLEVELAND, TN.

Patient Name: _____
Patient DOB: _____

Patient Responsibility Disclosure Statement

Deductibles and Co-Pays:

I understand that all charges for services rendered at Nephrology Associates are due and payable at the time of services; to include unmet deductible; amounts, co-pays and co-insurance percentages for in-network or out of network coverage.

Non-Insured Patients:

There are programs available for patients whom are uninsured or underinsured. Please contact the Patient Account Specialist at our Business Office (423) 702-7900 for more information.

Medical Insurance:

We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible for the charges if your insurance company declines to pay for any reason as well as:

- Informing Nephrology Associates of the current address and phone number for the patient and the responsible party.
- Presenting all current insurance cards prior to each office visit.
- Verifying at each visit that your patient information is current by speaking to the front receptionist and completing a new demographic at the beginning of each New Year. Paying any additional amount owed within 30 days of receiving a statement from our office. When Nephrology Associates receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.

Authorization/Referral Policy:

I understand that it is my responsibility to obtain an authorization and/or referral though my primary care physician's office, if required by my insurance company. Failure to do so may result in charges being billed directly to me or my appointment being cancelled and rescheduled once I obtained the appropriate authorization and/or referral.

Return Check Policy:

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF) or Account Closed, the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $20.00 service charge. After two check returns, no checks will be accepted from that point on the account.

By signing below, I acknowledge that I have read, understand and agree to abide by the above payment and other office policies.

Patient/Guardian Signature	Date
Print Patient/Guardian Name	Guardian's Relationship

NEPHROLOGY ASSOCIATES
CHATTANOOGA & CLEVELAND, TN.

Patient Name: _____
Patient DOB: _____

Consent to Email or Voicemail for appointment reminders and other Healthcare Communications:

Patients in our practice may be contacted via email and/or voicemail to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email at which I may be contacted, I consent to receiving appointment reminders and other healthcare communication information at that email or voicemail from the Practice.

_____ (Patient Initials) ○ I consent to receive Emails and/or Voicemails from the practice to receive communications as stated above. I understand that this request tore receive emails and voicemail will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

_____ (Patient Initials) ○ The email address that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is:

_____
Email Address:

_____ (Patient Initials) ○ I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recording. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Revocation
I hereby revoke my request for future communications via email and/or voicemail.

_____ (Patient initials) ○ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

_____ (Patient initials) ○ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via voicemail messages.

_____ (Patient initials) ○ I DO NOT consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g. quality improvement activities).

NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____
Patient/Patient Representative signature: _____
Date: _____ Time: _____

Patient Name (Printed) _____ DOB: _____

Patient Signature _____ Date: _____

NEPHROLOGY ASSOCIATES
CHATTANOOGA & CLEVELAND, TN.

Patient Name: _____
Patient DOB: _____

Southeast Renal Research Institute

Southeast Renal Research Institute (SERRI) is the Research Department of Nephrology Associates. We study new medications and devices to help improve and slow the progression of kidney disease and associated conditions.

Would you like to join SERRI in helping to find a cure?

Please check one of the following:

Would you be interested in participating in a clinical trial? ☐ **Yes** ☐ **No**

If yes, do you have any of the following?

Hypertension (High Blood Pressure)**?** ☐ **Yes** ☐ **No**

Diabetes? ☐ **Yes** ☐ **No**

Kidney Stones? ☐ **Yes** ☐ **No**

Lupus or Other Autoimmune conditions? ☐ **Yes** ☐ **No**

Please provide us the best method to reach you if you qualify for a clinical trial here at SERRI:

Name: (Please Print) _____

Phone: _____

Cell Phone: _____

Email Address: _____

SERRI Contact Info:

45 East Main St, Suite A, Chattanooga, TN 37408
Phone: 423-826-8003 Fax: 423-648-7697
Email: research@nephassociates.com