Cleveland Kidney & Hypertension Consultants, Inc.

Jeffrey H. Lautman, MD   Umesh Yalavarthy, MD   Sheru Kansal, MD
Lynda Newman, APRN Jessica Knezevich, APRN Lisa Mazzella, APRN
Timothy Ray, APRN Zoe Springstubb, PA-C
Phone: 216-261-6263 - Fax: 216-261-4964

PATIENT INFORMATION

This form must be updated yearly by every patient seen in our practice   Please Print   Today's Date: _________________

Name: ____ DOB: ___________________ SSN#: ___________________

Address: _________________________________ Apt: _____ City: ______________ State: ______ Zip: ___________

Email: _______________________________ Home phone: _______________________ Cell phone: _____________

Preferred Pharmacy: _____________________ Pharm City: _____________________ Pharmacy phone: __________

Primary Insuance : _____________________________ Secondary Insurance: ________________________________

Primary Doctor: _______________________________ Referring Doctor: ___________________________________

I am financially responsible for my account -- Yes __ No __

My Emergency contact is financially responsible for my account -- Yes __ No __

Emergency Contact Information:

Name: ____ Relationship:____________________________

Address: ___________________________________Apt. _____City: ______________State: _____Zip: _________

Home Phone: _______________________ Cell Phone: _____________________________

I have a POA (Power of Attorney) -- Yes __ No __

My POA is financially responsible for my account -- Yes __No __

POA Contact Information:

Name: ____ Relationship:____________________________

Address: ___________________________________Apt. _____City: ______________State: _____Zip: _________

Home Phone: _______________________ Cell Phone: _____________________________

<u>Agreement to pay your bills, release of medical information to/from insurance companies, and legal conduct:</u>

There are certain services that my health insurance may not cover. **I am responsible to pay in full for any and all services, tests or procedures provided or recommended by Cleveland Kidney & Hypertension Consultants, Inc. (CKHC, Inc.), that my insurance plan does not cover, for any reason. I and/or the responsible party listed above accept this responsibility.**

The undersigned hereby authorize any of CKHC Inc.'s physician and non-physicians to perform such diagnostics and treatments as they deem advisable; assents to the release of medical information to my insurers and other entities involved in my healthcare and unconditionally guarantees payment of all charges for which I may be responsible. CKHC, Inc. may provide health and billing information at its discretion to my emergency contact and/or the party responsible for this account and/or the people listed here:

Name: ____ Relationship:______________________________

Name: ____ Relationship:______________________________

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I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.
Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.
The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:
Formulary and benefit transactions-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions**--**Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.
By signing this consent form I agree that Cleveland Kidney and Hypertension Consultants, Inc. can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.
Nondiscrimination Statement:
Cleveland Kidney and Hypertension Consultants Inc. complies with applicable Federal civil right laws and does not discriminate on basis of race, color, national origin, age, disability or sex.
I understand that I am entering into a contractual relationship with Cleveland Kidney & Hypertension Consultants, Inc. for professional care. I further understand that meritless and frivolous claims for medical malpractice may have an irreparable harm to a medical provider. As additional consideration for professional care provided to me by Cleveland Kidney & Hypertension Consultants, Inc., **I** and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Cleveland Kidney & Hypertension Consultants, Inc.
Should meritorious medical malpractice case or cause of action be initiated or pursued, I **,** and /or my representative, agree to use ABMS board-certified expert medical witness (es) in the same or similar specialty as nephrology. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty society for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case.
I've read the Privacy Policy of CKHC, Inc. I understand and agree to be seen on these terms. In addition, I am aware that further extensive guidelines of my rights and rights to my information are available to me to read either in the waiting

Signature of patient or representative: ______________________________________ Date: ________________

<u>If you are the patient's representative:</u>

Print your name: ____ Phone #: ______________________

Relationship to the patient: ____

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Please be aware of our policies on phone calls, audio/ video communications and online messages and consultations.

TELEHEALTH POLICY

Consent for these services is required. By signing below, you acknowledge that you understand the risks and benefits of this type of care. You agree to provide the most accurate information available to you (or your family members) about your medical issues.

Risks include security breaches that can occur with any internet- based process including unintentional exposure of protected health information.

Benefits include access to care by phone, audio video and computer technology with flexibility in scheduling contact with our providers.

The platforms this practice uses for audio video communication, for telehealth visits, are Facetime and Doximity. When using this audio/video technology you should identify whose technology you are using, provide the practice with your location while communicating with us and identify who is with you during your encounter with us.

MYCHART MESSAGING POLICY

Our providers answer hundreds of MyChart messages each week. Sometimes, they can quickly answer and get you the information you need. Other times, it requires time to look through your medical records and provide medical advice. Messages that involve a longer amount of your provider's time for medical decision making or medication change may be billed to you and/or your insurance.
Types of messages that could get billed: Changes to your medications, new symptoms, changes to a long-term condition, check-ups on your long-term condition care, questions about lab results, etc.

This practice codes and bills the services we provide to your insurance plan based on the rules created by the AMA CPT coding board and Medicare/Medicaid. These services may be subject to co-payments, deductibles or denied as non-covered and you may be responsible for these costs.

UNSECURE TEXTING

The best way to communicate with us electronically is via your EPIC patient portal, since federal law prohibits practices from sending you texts or email which are unencrypted or "unsecure." However, some patients find it convenient to communicate by traditional text. Those modes of communication are generally not considered “secure.” Some patients appreciate the tradeoff between ease of use and/or convenience and security. At the physician's discretion, we may accommodate your preferences.

I have read, understand, and agree to the CKHC Telehealth, telephone, MyChart Messaging, and Unsecure Texting Policies

Patient Name (printed): ____

Patient Signature: ____

Date: _________________________________