CAROLINA
NEPHROLOGY, PA
Excellence in Kidney Care
Kidney Disease, Hypertension, Intervenfional Nephrology

To our patients,

On November 1, 2021, Carolina Nephrology will be converting our current electronic medical record system to EPIC. This transition will allow us to share your medical information with your other healthcare providers that are also using the EPIC platform for their electronic medical records.

As of November 1, 2021, our patient portal will change from FollowMyHealth to My Chart. Unfortunately, the information you currently see on FollowMyHealth will not transfer over to My Chart. However, you will still have access to FollowMyHealth.

As part of this transition, we will need you to bring the following items to your visit.

1) **A valid picture ID (Driver's License or Passport will be acceptable)**
2) **Current Insurance Card(s)**
3) **Signed Consent to Evaluate and Treat (Attached)**
4) **Signed Release of Information (Attached)**
5) **Signed Notice of Privacy Practices (Attached)**
6) **Signed Financial Responsibility Form (Attached)**

Please have these forms signed and ready when you come into the office to help reduce congestion at check in.

When you come in for your visit, we ask for your patience as you may experience longer wait times while our staff, providers and patients are acclimating to our new workflows.

Thank you for your understanding during this transition.

Sincerely,
The providers and staff of Carolina Nephrology.

203 Mills Avenue • Greenville, SC 29605 • PO Box 9159 • Greenville, SC 29604 • (864) 271-1844 • Fax: (864) 271-2147
www.carolinanephrology.com

CAROLINA NEPHROLOGY, PA

Consent to Evaluate and Treat

This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended treatment, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examinations, testing, and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily too its contents.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship

CAROLINA NEPHROLOGY, PA

I, _____, understand that as part of my healthcare, Carolina Nephrology PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information severs as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professional. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that Carolina Nephrology, PA is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Carolina Nephrology PA reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, should Carolina Nephrology PA change their notice, they will send a copy of any revised notice to the address I've provided (whether by US mail or, if I agree, e-mail).

I wish to have the following restrictions to the use of disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via Fax.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship

CAROLINA NEPHROLOGY, PA

Release of Medical Information

Authorization for Disclosure of Medical Information: The privacy of your medical information is important. We will discuss your medical condition with the person(s) you designate.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? (Check and complete one)

☐ **YES** – The provider may discuss my medical condition with the following family member(s) or other individual(s):

_____

_____

☐ **NO** – The provider may not discuss my medical condition with any family member or other individual.

You may revoke/cancel or modify/change the above designation, but the revocation or modification must be in writing.

NOTE: This designation does not give the above named individuals the right to make health care decisions for you. If at any time you are unable to consent to care or treatment, we will follow the procedure set forth in the South Carolina Adult Health Care Consent Act.

Communication: Please provide phone number(s) where we can reach you (by providing a number you also authorize Carolina Nephrology to leave you voicemails at the number(s) listed):

☐ Home: _____ ☐ Cell:_____ ☐Work: _____
Note: An automated appointment reminder system may call the number listed in our database.

Signature: I hereby authorize the disclosure of my medical information as described above.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Relationship

Acknowledgement of Receipt of Notice of Privacy Practices For

Carolina Nephrology, PA
Corporate Headquarters at:
203 Mills Avenue
Greenville, SC 29605

I hereby acknowledge that I have received the Notice of Privacy Practices for the above office.

_____ _____
Print: Patient's Name / Personal Representative (as defined by HIPAA) Date of Birth

_____ _____
Signature: Patient's Name / Personal Representative (as defined by HIPAA) Date

_____
Description of Personal Representation and please attach copy of documentation.

Documentation of "Good Faith" Attempt to get acknowledgement signature.

- □ Document presented to patient, but patient refused to sign acknowledgement.
- □ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to get give the Notice, and get any acknowledgement will be handled as soon as possible.
- □ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- □ The documentation was mailed to the patient but never returned to us.
- □ Other _____
  _____

Employee signature Date

_____

Notice Of Privacy Practices
for the offices of

Carolina Nephrology
Corporate Headquarter at:
203 Mills Avenue
Greenville, SC 29605
864-271-1844

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.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information
for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures

The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may,
in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe 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.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section.

Right of an individual to request a restriction of uses and disclosures

This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information

An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information

An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information

An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice

You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties

This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices will be available and posted at our office(s) and posted on our web site, if applicable.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is 9/11/2013.

CAROLINA NEPHROLOGY, PA

Acknowledgement of Financial Responsibility

As a patient of Carolina Nephrology, PA, you are responsible to pay any co-payments or deductibles that are not covered by your insurance company/companies at the time of service.

We will need to scan your insurance card, so please bring them to your appointments.

If you do not have insurance, it is your responsibility to pay for any charges incurred.

It is your responsibility to inform Carolina Nephrology of any insurance policies that we may bill for services and any changes effecting coverage of your insurance. When a new insurance card is received, please let us know so we can make to appropriate changes to help avoid a billing error.

I am voluntarily seeking medical care and treatment by Carolina Nephrology, PA and give them consent to share information concerning my care and treatment to my insurance provider so that they may seek payment for services rendered.

I acknowledge that any tests/labs sent to an outside laboratory or office will incur additional charges not set by Carolina Nephrology, PA.

I acknowledge that I am responsible for any part of my bill that is not covered by my insurance and I will be billed directly for those charges.

I certify that I have read and fully understand the above statements and consent fully and voluntarily too its contents.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship