NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

Physicians
Prince M. Aryeetey, MD
Nathan E. Chamberlain, MD PLLC
Lindsay C. Crawford, MD PLLC
Douglas Franz, DO
Claude M. Galphin, MD PLLC
Stuart G. Ginther, MD PLLC
Cameron Golightly, DO
Mandeep S . Grewal, MD MBA
Brant G. Holt, MD PLLC
Aamir Iqbal, MD
Kenneth J. Kokko, MD
John D. McCarley, MD PLLC
Christopher L. Meshberger, MD
Nilesh C. Patel, MD PLLC
Christopher V. Poole, MD PLLC
Adam Price, MD
Mohammad J. Shafi, MD
Ralph W. Stafford, Jr., MD PLLC
Hans E. Yehnert, MD, PLLC

NPs/PAs/Dietitian
Ashleigh Cates, NP
Kent Hulvey, FNP-BC
Caroline Lundy, PA-C
J. Aislinn McMahan, MSN, NP-C
Shannon McShan, MSN NP-C
Elaine Ogden, FNP-BC
Misty Day, FNP-C
Stephanie Gaston, RD, CDCES

Chattanooga Office
251 N. Lyerly Street, Suite 100
Chattanooga, TN 37404
(423) 826-8000
fax (423) 826-8005

Glenwood Office
2300-B Third Street
Chattanooga, TN 37404
(423) 826-8000
fax (423) 826-8005

Cleveland Office
2253 Chambliss Ave. NW, Suite 200
Cleveland, TN 37311
(423) 339-2889
fax (423) 339-2855

Ooltewah Office
5243 Little Debbie Pkwy Ste. 117
Ooltewah, TN. 37363
(423) 269-6455
fax (423) 602-5685

Southeast Renal Research Institute
2300 -B Third Street
Chattanooga, TN 37404
(423) 826-8003
fax (423) 648-7697

Date: _____

Dear _____,

We have been asked to participate in your care, because your referring physician has concerns regarding the health and function of your kidneys. Your kidneys are a vital organ and we are here to assist you in prolonging their proper function and your quality of life. We have scheduled an appointment for you. Our physician has reserved this appointment to make sure you have plenty of time to address any questions regarding your treatment Plan.

Please bring the following with you for your scheduled appointment:

1) Completed Paperwork
2) All current insurance cards
3) All medications, herbs and supplements (original containers) that you are currently taking

Your appointment is scheduled for:

Doctor: _____

Date: _____

Time: _____ ☐ AM ☐ PM

Location: _____

Please arrive 15 minutes early for your appointment.

We have enclosed directions to the office in which you are scheduled. You can also visit our website at **www.nephassociates.com**. Because this time has been set aside just for you, we respectfully request that you notify us as least 24 hours prior to your scheduled appointment should you not be able to keep it. If there is a need to cancel or reschedule, it is not likely we will be able to confirm another appointment during the same week or same month.

Thank you,

New Patient Coordinator

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PATIENT INFORMATION FORM

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	Cell 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 #	Effective Date
Address of Insurance Company	Copayment	Deductible
City, State, Zip	Relationship to patient	

SECONDARY INSURANCE (if applicable)

Name of Insurance Company		Policy #	
Name of Insured	SS#	Birthdate	Group #
Address of Insurance Company		Copayment	Deductible
City, State, Zip			
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:** _____

Patient Name: _____ Date of Birth: _____

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

PATIENT INFORMATION FORM

Patient Medical History Form

DATE: _____

Medical History:

Have you ever been treated for any of the following medical conditions?

□ No Changes
□ Arthritis
□ Diabetes
□ High blood pressure
□ Kidney Disease
□ Osteoporosis
□ Cancer
□ Depression/anxiety
□ ,Heart problems
□ High cholesterol
□ Lung problems
□ Thyroid problems

Please list any additional medical conditions:
_____

Have you ever been hospitalized overnight? ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No
_____

Medications and Allergies:

Will be reviewed by clinic staff.

(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

Do you take any supplements (calcium/vitamin/fish oil/multivitamin)? ☐Yes☐ N o

_____

_____

_____

Family History: Please list any known medical problems for the relatives listed below:

(For example: diabetes, cancer, heart attacks, high blood pressure, kidney disease, etc.)

☐No changes

Mother:_____

Father:_____

Brothers/Sisters:_____

Children:_____

Other:_____

Social History:

Are you retired? ☐ Yes ☐ No

Work Type: _____

Tobacco (chew/smoke): _____per day

Alcohol (beer/wine, etc.):_____per day

Drugs (marijuana, etc.):_____

Caffeine (coffee/tea/soda):_____per day

Any trouble sleeping? ☐ Yes ☐ No

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated

Patient Name: _____ Date of Birth: _____

NEPHROLOGY ASSOCIATES
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PATIENT INFORMATION FORM

Patient Medical History Form

DATE: _____

Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things.	☐	☐	☐	☐
2.	Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3.	Trouble falling or staying asleep or sleeping too much.	☐	☐	☐	☐
4.	Feeling tired or having little energy.	☐	☐	☐	☐
5.	Poor appetite or overeating.	☐	☐	☐	☐
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9.	Thoughts that you would be better off dead, or of hurting yourself in some way.	☐	☐	☐	☐
10.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	**Not difficult at all**	**Somew hat Difficult**	**Very Difficult**	**Extremely Difficult**
		☐	☐	☐	☐

Patient Name: _____ Date of Birth: _____

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

Notice of Privacy Policies and Practices

Your Health Information. Your Rights. Our Responsibilities.

This notice explains how your health information may be used and disclosed and how you can obtain access to it. Please review it carefully.

Our Commitment to You

Nephrology Associates is required by law to protect the privacy of your health information. We are required to follow the privacy practices described in this notice and provide you with a copy upon request.

Protected Health Information (PHI) includes information that identifies you and relates to your physical or mental health, the healthcare you receive, or payment for your healthcare services.

Your Rights

You have the right to:

Obtain a Copy of Your Medical Record

You may request to inspect or obtain a copy of your medical record, including an electronic copy. We may charge a reasonable, cost-based fee as permitted by law.

Request a Correction to Your Medical Record

You may request that we amend your medical record if you believe information is incorrect or incomplete.

Request Confidential Communications

You may ask us to communicate with you in a specific way or at a different location.

Request Restrictions on the Use or Disclosure of Your Information

You may request that we limit how we use or disclose your health information. We are not required to agree to your request, except when you have paid for a healthcare service in

full out of pocket and request that we not disclose that information to your health plan.

Receive an Accounting of Certain Disclosures
You may request a list of certain disclosures of your health information made during the previous six years, as permitted by law.

Receive a Copy of This Notice
You may request a paper copy of this notice at any time.

Revoke Your Authorization
You may revoke a written authorization at any time, except to the extent that action has already been taken in reliance on your authorization.

Our Responsibilities

We are required by law to:

- Protect the privacy and security of your health information.
- Provide you with this Notice of Privacy Practices.
- Follow the terms of this notice currently in effect.
- Notify you if a breach occurs that may have compromised the privacy or security of your health information.

We may revise this notice as laws or regulations change. Any revised notice will apply to all health information we maintain and will be available upon request.

How We May Use or Disclose Your Health Information (Without Your Authorization)

For Treatment

We may use and disclose your health information to physicians, nurses, and other healthcare professionals involved in your care.

For Payment

We may use and disclose your health information to bill and collect payment from health plans or other responsible parties.

For Healthcare Operations

We may use your health information to operate our practice, improve quality of care, train staff, conduct audits, and perform other healthcare operations.

For Public Health and Safety

We may disclose your health information as required or permitted by law, including for public health reporting, reporting abuse or neglect, health oversight activities, law enforcement purposes, court orders, and to prevent or lessen a serious threat to health or safety.

Other Permitted Uses and Disclosures

We may disclose your health information for workers' compensation, research (when permitted by law), organ and tissue donation, military and national security activities, correctional institutions, or to coroners, medical examiners, and funeral directors.

Reproductive Health Information

We provide additional privacy protections for reproductive healthcare information.

- Reproductive health information is maintained as confidential and is disclosed only as permitted or required by law.
- Written authorization is required unless the disclosure is permitted for treatment, payment, or healthcare operations.
- Only the minimum necessary information will be disclosed.
- Adolescents may receive confidential reproductive healthcare services as permitted under applicable state law.
- Electronic reproductive health records are protected, and access is limited to authorized personnel.
- We do not discriminate against or retaliate against patients for exercising their privacy rights.

Business Associates

We may share your health information with trusted service providers who assist us in operating our practice. These Business Associates are contractually required to safeguard your information and comply with applicable federal privacy and security laws.

Family Members and Others Involved in Your Care

We may share relevant health information with family members, friends, or others involved in your care unless you instruct us not to do so.

Uses and Disclosures Requiring Your Written Authorization

We will not use or disclose your health information without your written authorization for:

- Psychotherapy notes (except as permitted by law)
- Marketing communications involving financial remuneration
- The sale of Protected Health Information
- Any purpose not otherwise described in this notice

Use of Artificial Intelligence (AI) Documentation Technology

Nephrology Associates may use AI-assisted documentation (ambient scribe) technology during your visit. For details on how this technology is used, your rights, and applicable safeguards, please see our separate Notice of Privacy Practices Addendum: AI-Assisted Documentation and Ambient Scribe Technology, available upon request or at our front desk.

Questions or Complaints

If you believe your privacy rights have been violated, you may file a complaint. You will not be retaliated against for filing a complaint.

Privacy Officer
Sharon Grayson
Phone: **423-826-8000**
Email: **compliance@nephassociates.com**

You may also file a complaint with the **U.S. Department of Health and Human Services, Office for Civil Rights (OCR).**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of **[Nephrology Associates]** (the "Practice"). The Notice of Privacy Practices provides information about how the Practice may be used and disclose my protected health information.

*I acknowledge receipt of the Notice of Privacy Practices of **[Nephrology Associates]***.

Signature: _____

Date: _____

(patient/parent/conservator/guardian)

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

PATIENT INFORMATION FORM

Patient Authorization for Disclosure of Protected Health Information

Notice to Patients: In compliance with HIPAA regulations, this letter authorizes Nephrology Associates 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 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

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

PATIENT INFORMATION FORM

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: _____

Date of Birth: _____

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

NEPHROLOGY ASSOCIATES (**To be filled out by the provider**)

Name of Provider: _____

Address: _____

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:

_____

Please fax records to fax number: _____

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

_____ _____

Patient/Guardian Signature Date



PATIENT INFORMATION FORM

Patient Financial Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. The following is a statement of our payment policy. This payment policy applies to all services provided by Nephrology Associates, regardless of the location.

Insurance Coverage – We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to services being rendered. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Copays – We have a contractual obligation (with your insurance company) to collect your copay. We will collect it at the time of service. **Our office does not bill copays. Copays are the patient's responsibility and are due at the time of service.** We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service. We cannot waive copays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

Referrals – If your insurance plan requires a referral, it is your responsibility to obtain one from your primary care physician. A referral should be requested from your primary care physician's office at least 48-72 hours prior to your appointment.

For our patients with no Medical Insurance Benefits – If you do not have group or individual medical insurance, payment or arrangement for all services is expected at the time of your visits. If you pay the charges in full on the day of service, we will offer a prompt pay discount.

Account Balances – Please let us know if you are having difficulty paying your account. Nephrology Associates may be able to help by setting up a payment plan based on your financial needs. Our billing office is available Monday – Friday from 8:00 a.m. to 4:30 p.m. to assist you in satisfying your financial obligation. Please contact our billing department directly at 423-702-7903 to discuss payment plans, patient financial evaluations and discounts available.

Unpaid Accounts – In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

Returned Check Fee – It is the policy of Nephrology Associates to charge $35 to patients who checks are returned by our bank for non-sufficient funds or Account Closed. After two check returns, no checks will be accepted from that point on the account.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made on my behalf to Nephrology Associates for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to my insurance carrier, any information needed to determine these benefits or benefits payable for related services.

_____ _____

Patient/Guardian Signature Date

I have read, understand, and agree to the above financial policy and I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

Patient Name: _____ Date of Birth: _____

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

PATIENT INFORMATION FORM

Consent to Voicemail/Text for appointment reminders and other Healthcare Communications:

Patients in our practice may be contacted via voicemail and/or Text 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 Voicemail from the practice to receive communications as stated above. I understand that this request to receive voicemail will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

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

_____
Cell Phone Number:

_____ (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 voicemail messages.

____ (Patient initials) ○ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via Text 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: _____ Date of Birth: _____

We Continue to Search for a Cure for Kidney Disease…..

If you have any of the following…

- Diabetes
- FSGS
- IGA
- Chronic Kidney Disease
- Proteinuria

Please ask your kidney doctor if you would benefit from a research study.

Would you help us find a cure?

Call 423-826-8003 for more information.

Southeast Renal Research Institute

Is a Department of

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

NEPHROLOGY ASSOCIATES
SPECIALISTS IN KIDNEY HEALTH

Nutrition & Dietitian Services

Understanding how food impacts chronic kidney disease is an important step in slowing the progression of the disease and prevent complications. Nutrition counseling and support may contribute to better outcomes.

Dietitian services include not only teaching you ***what*** foods are best for chronic kidney disease, but ***how*** to make those foods fit into your life. If you have diabetes, glycemic control is imperative to preserving kidney function. Our dietitian, Stephanie Gaston, is also a Certified Diabetes Care and Education Specialist. She can create a plan that will help you balance nutrition for CKD and diabetes.

Consultations are covered by Medicare and most major insurance plans.

Would you be interested in this consultation? Yes No

If so, please provide us with the best method to reach you if you qualify for a consultation with Stephanie Gaston, RDN, CDCES.

Name: (Please print) _____

Phone: _____

Email address: _____

Patient Name: _____ Date of Birth: _____