William H. Cleveland, M.D.
Michel D. Brathwaite, M.D.
Tanjela M.Jackson, M.D.
Evelyn C. Lewis, M.D.
Sammy M. Mugambi, M.D.

121 Linden Avenue Ste 102
ATLANTA, GA 30331-3711
Phone: (404) 905-2828 Fax: (404) 905-2829

Dear New Patient,

Hello and welcome to Atlanta Kidney Center!

Please arrive at the office 30 minutes prior to your first visit so we can ensure all the appropriate information is updated in our state of the art Electronic Health Records.

For your convenience, we have enclosed an informational packet. We request that you complete all enclosed forms and bring with you to your upcoming appointment, along with your insurance card(s) and a form of picture identification.

On your behalf, we will request your medical information from the referring physician with your permission. Please follow up with your physician's office to have these released.

Our policy is to collect co-payments and co-insurance at the time of service. If you are unable to make payment at the time of service, please contact our office prior to your appointment to make financial arrangements. For your convenience, we accept cash, check, Visa, Mastercard, and American Express.

To summarize the information above:

- Complete the enclosed forms (double-sided)
- Arrive 30 minutes before your scheduled appointment;
- Bring all completed forms along with insurance cards and a form of photo identification;
- Bring a medication list and/or all your medications;
- Be prepared to give a urine specimen when you arrive in the office;
- Be prepared to make any necessary co-payments and/or co-insurance at the time of your visit.

We would like to thank you for this opportunity to provide very good service and look forward to meeting you soon. If you have any questions or need directions to our office, please contact us directly or visit our website at www.atlkidneycenter.com.

Sincerely,

Atlanta Kidney Center

Patient Registration Form
Please print, complete in full, and make any necessary corrections

USE BLACK or BLUE INK

Patient Information

Date: _____

Last Name: _____ First Name: _____

MI: _____

Social Security Number:_____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile/Pager: _____

Email Address: _____

Sex (circle) Female Male

Marital Status (circle) Married Widowed Divorced Separated Single Race

(circle) African American Caucasian Hispanic Asian Native American

Driver's License #: _____

Patient Employer Information

Status (circle) Employed Retired Disabled Student Other

Employer's Name _____

Employer's Phone _____

Occupation _____

Emergency Contacts

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

_____

Responsible Party Other than Patient

Responsible Party Information _____

Name_____

Address_____

City and State _____ Zip _____

Employer _____

Home Phone _____ Work Phone _____

Social Security # _____ Date of Birth _____

Relationship to Patient _____

Primary Care Physician and Referring Physician

Primary Care Physician _____

Phone _____

Referring Physician (if different from PCP) _____

Phone _____

Insurance Information

Primary Insurance Name _____

ID# _____ Group # _____

Subscriber's Name _____

Subscriber's Phone# _____ Relationship to Patient _____

Subscriber's Employer _____

Subscriber's Date of Birth _____ Subscriber's SS# _____

Secondary Insurance Name _____

ID# _____ Group # _____

Subscriber's Name _____

Subscriber's Phone# _____ Relationship to Patient _____

Subscriber's Employer _____

Subscriber's Date of Birth _____ Subscriber's SS# _____

Pharmacy Information

Pharmacy Name:

_____

Pharmacy Address:

_____

Pharmacy Phone:

_____

Pharmacy Fax:

_____

Patient:
Patient DOB:

Medication List

Name of Medication	Strength	Directions (i.e. 1 per day, 2 every 6 hours)

Have you ever taken any anti-inflammatory medications such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.? Yes____ No ____. If YES, please list medications:

_____

_____

_____

_____

Medication allergies:

_____

_____

_____

_____

Patient:
Patient DOB:

Health History

Have you ever had the following? Please circle all that apply.

	NO	YES		NO	YES
Anemia	N	Y	Hyperlipidemia	N	Y
Arthritis	N	Y	Hyperparathyroidism	N	Y
Asthma/COPD	N	Y	Hypertension	N	Y
Atrial Fibrillation(AFIB)	N	Y	Kidney Cyst	N	Y
Congestive Heart Failure(CHF)	N	Y	Kidney Failure	N	Y
Cancer	N	Y	Kidney Stones	N	Y
Cancer within Last 5 Years	N	Y	Lupus	N	Y
Coronary Artery Disease	N	Y	Polycystic Kidney Disease	N	Y
Diabetes Type 2	N	Y	Protein in Urine - Proteinuria	N	Y
Diabetes Type 1	N	Y	Recurrent Urinary Tract Infections	N	Y
Blood in Urine - Hematuria	N	Y	Stroke	N	Y
Hepatitis A	N	Y	Thyroid Disorder	N	Y
Hepatitis B	N	Y	Transplant	N	Y
Hepatitis C	N	Y	Vitamin D Deficiency	N	Y

Other

_____

Previous Hospitalizations and Surgeries (Please include dates)

_____

_____

_____

_____

Family Medical History

Has anyone in your family had any of the following:

Kidney disease Yes___ No___ If yes, list family member(s):_____

Protein in urine Yes___ No___ If yes, list family member(s):_____

Blood in urine Yes___ No___ If yes, list family member(s):_____

Dialysis Yes___ No___ If yes, list family member(s):_____

Diabetes Type 1 Yes___ No___ If yes, list family member(s):_____

Diabetes Type 2 Yes___ No___ If yes, list family member(s):_____

Hypertension Yes___ No___ If yes, list family member(s):_____

SLE Yes___ No___ If yes, list family member(s):_____

Kidney Stones Yes___ No___ If yes, list family member(s):_____

Polycystic Kidney Disease Yes___ No___ If yes, list family member(s):_____

Cancer Yes___ No___ If yes, list family member(s):_____

Deafness Yes___ No___ If yes, list family member(s):_____

Other? Yes___ No___

If yes, please specify illness and family member(s): _____

Current Social History (circle)

Alcohol intake: None Occasionally Moderate Heavy _____

Chewing Tobacco: None 1 per day 2-4 per day 5+ per day _____

Tobacco - years of use: _____

Smoking Status: Never Smoker | Former Smoker | Current every day smoker | Current some day smoker | Smoker - current status unknown | Unknown if ever smoked

Smoking - How much?: None 1 PPW 2 PPW 1/4 PPD 1/2 PPD 1 PPD 1 1/2 PPD 2 PPD 3+ PPD

Has smoked since age: _____

Illicit drugs: _____

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner

Occupation: _____

Patient:
Patient DOB:

REVIEW OF SYSTEMS

Please circle and describe how you are feeling today

Constitutional: Fever Fatigue Weight gain (_____ lbs) Weight loss (_____ lbs)

Eyes: Dry eyes Vision change

Nose: Frequent nosebleeds

Mouth/Throat: Sore throat Snoring Dry mouth

Cardiovascular: Chest pain on exertion Shortness of breath when walking Palpitations

Known heart murmur Light-headed on standing Swelling in the extremities

Respiratory: Cough Wheezing Shortness of breath Coughing up blood Sleep apnea

Gastrointestinal: Abdominal pain Vomiting Change in appetite Frequent diarrhea Nausea

Genitourinary: Urinary loss of control Difficulty urinating Increased urinary frequency Blood in urine

Musculoskeletal: Muscle aches Arthralgias/joint pain Back pain

Skin: Jaundice Rash Itching

Psychiatric Depression Restless sleep

Endocrine: Increased thirst Heat intolerance Cold intolerance

Hematologic/Lymphatic: Swollen glands Easy bruising Excessive bleeding

Allergy/Immunologic: Runny nose Itching Hives

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Patient:

Patient DOB:

Consent for Release of Information and Test Results

I, _____, give my consent and authorization to the staff of ATLANTA KIDNEY CENTER to relay medical information to the following persons. This information may include but is not limited to scheduled appointments and/or surgeries, lab, radiology testing and medications.

Please check and complete the following:

Contacts: Phone: Relationship to patient:

_____

_____

_____

_____

OK to leave messages/fax:

YES **NO**

___ ___ Answering Machine at Home _____

___ ___ Mobile Phone#_____

___ ___ Fax Machine#_____

Date_____ Signature_____

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Patient:

Financial Policy

Welcome to ATLANTA KIDNEY CENTER. We are dedicated to quality healthcare. We have experienced staff that understands your need for confidentiality and compassion. We are required to have you provide information to our office in order to file your insurance. Please be sure you have given us the correct insurance card as we will need to copy both front and back of the card. We also will ask that you provide us with a picture ID for your chart (i.e. driver's license, etc.). Co-payments are due at the time of service. We ask that any balance owing be paid promptly.

Please read and sign the following so that we may file your insurance.

I, _____ authorize ATLANTA KIDNEY CENTER to release information regarding my health to my insurance company. I understand that my insurance company may request records from my physician in order to pay the claims submitted. I give permission to ATLANTA KIDNEY CENTER to send any records necessary to obtain payment for the claims submitted. I assign all insurance benefits to ATLANTA KIDNEY CENTER. I understand that I am fully responsible for any/and all unpaid charges and agree to pay any balance unpaid by my insurance company. This authorization will remain in effect from this date until revoked by me in writing.

_____ _____

Patient Signature Date

_____ _____

Witness Date

ATLANTA KIDNEY CENTER
A DIVISION OF SOUTHWEST ATLANTA NEPHROLOGY

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Patient:
Patient DOB:

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. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice please contact our privacy officer.

ATLANTA KIDNEY CENTER (the "Practice") is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed. Company will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

Company may use your individually identifiable health information for the following purposes without your authorization:

1. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition.
   In this regard, we disclose patient data to the CommonWell network as part of a query-based data exchange for permissible treatment purposes.
2. Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. Health Care Operations: We may use and disclose health information in order to support the business activities of your physician's practice. For example, your health information may be used to evaluate the quality of care we provide, for state licensing or to identify you by name when you visit the office.
   You understand and acknowledge that we will disclose information in accordance with HIPAA laws to our affiliates (namely, Renal Care Organization, LLC and RCO Analytics, LLC) for the purposes of creating a population health care delivery model with goals of improving quality of health care and outcome, reducing costs of health care, and increasing savings to patients.
4. Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.
5. Treatment Options: We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as afterhour’s telephone answering, billing or quality assurance. Our Business Associates agree to protect the privacy of your health information.
7. Research: We may use your information in conjunction with agents of the Practice who may be required to review your files, just as our employees are so permitted, in order to determine whether you are qualified for a research project. If you are asked to join a research project, you will be asked first to execute an authorization, granting the Practice or a research organization the right to use your protected health information.

Company may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- Food and Drug Administration.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- If you are an inmate of a correctional facility.
- To health oversight agencies.
- To your employer if we provide health care services to you at the request of the employer, whereupon we shall provide you written

notice of release so such information.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner or funeral director.
- For the facilitation of organ, eye or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- In order to follow various mandates for clinical quality metric reporting, benchmarking, and related matters
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.
- Sign in sheet.

Unless you object, company may also disclose your information to family members and/or other persons involved in your care or payment for your care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death.

Company may leave messages for you at work or home about your visits. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Company will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential Communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Company if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. Accounting of Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Company has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

Complaints:
You may complain to us or to the Secretary of Health and Human Services (Office for Civil Rights/U.S. Department of Health & Human Services) on-line at HHS.gov if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (404) 905-2828 for further information about the complaint process.

If you have any questions about this notice, please contact Practice’s Privacy Office; (404) 905-2828

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Patient:
Patient DOB:

Acknowledgement of Receipt of
Notice of Privacy Practices

I acknowledge that I have received a copy of this officeâ€™s Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed and protected.

Patient Name: _____

_____
Name/Relationship if signed by individual other that patient

_____ _____
Patient Signature Date

_____ _____
Witness Date

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for providers to send electronically, an accurate, error free, and understandable prescription from the provider's office to the pharmacy. This program also includes:

- Medication History Transactions: provides the healthcare provider with information about your current and past prescriptions. This allows your providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy reactions, adverse drug reactions, and duplicative therapy.

The medication history information would include medications prescribed by your healthcare provider at ATLANTA KIDNEY CENTER as well as other healthcare providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease, and HIV/AIDS. As part of this consent form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form, you are agreeing that your provider at ATLANTA KIDNEY CENTER may request and use your prescription medication history from other healthcare providers and/or third party benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to receive medical care, payment for your medical care, or your medical care benefits. You also have the right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke your consent at any time in writing. Please note, this revocation will not have an effect on any actions taken prior to receipt of the revocation.

Understanding all of the above, I hereby provide informed consent to ATLANTA KIDNEY CENTER to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____
Signature of Individual (or Legal Representative):

_____
Individual's Name (Print):

_____
Name of Legal Representative, if applicable (Print):

_____
Relationship:

_____
Date: