PATIENT INFORMATION

PLEASE PRINT **Today's Date** _____

Name: _____ DOB: ____/____/____ SSN: _____--_____--_____

Address: _____ Apt. _____City: _____State: ____

Zip: _____ Email _____ Home Phone: _____

Cell: _____ Pharmacy_____ Pharmacy #:_____

Primary Insurance_____ Secondary Insurance: _____

Primary Doctor _____Referring Doctor:_____

☐ I'm financially responsible for my account.
☐ My emergency contact is financially responsible for my account.

Emergency Contact Name: _____Relationship _____
Address: _____
Cell: _____Home:_____Work:_____

☐ I have a POA (Power of Attorney)
☐ My POA is financially responsible for my account.

POA Name: _____ Phone #:_____
Address:_____

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

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 phone **Name relationship phone**

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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 room of this office or copies of the policy will be given to me by the receptionist if I request it.

Signature of patient or representative _____ Date ____/____/____

If you are the patient's representative:

Print your name: _____ Your phone number: (____) _____-_____

Relationship to patient: _____