TEXAS ADVANCED
RENAL HEALTH

Leading The Way In Kidney Health Excellence

PATIENT REGISTRATION

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (First, M.I., Last) _____

Date of Birth _____ Age _____ Male / Female Intersex / Transgendered Marital Status: S M W D Partnered

Address _____

Phone _____ Driver License #_____

Employer _____ Phone _____

Employer Address _____

Referring Physician _____

If Student, School Name _____ Full-Time / Part-Time

Responsible Party

Name _____ Relationship to Patient _____

Address _____

Phone _____

Employer _____ Phone _____

Employer Address _____

Emergency Contact _____ Phone _____

Insurance Information

Insurance Company _____ Phone_____

Address _____

Group # _____ Certificate or ID # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Partner / Dependent

Insured's Employer _____ Phone _____

Employer Address _____

Date of Birth _____

I hereby assign, transfer, and set over to Texas Advanced Renal Health all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether they are covered by insurance or not.

Patient Signature _____ Date _____

TEXAS ADVANCED
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: (_____) _____ Email (Optional): _____

Information regarding clinician or health care entity authorized to disclose this information:
Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: (_____) _____ Fax: (_____) _____

Information regarding person or entity who can receive and use this information:
Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Phone: (_____) _____ Fax: (_____) _____

Specific information to be disclosed:
□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other clinicians.
□ Other: _____

Include: (Indicate by Initialing)	Reason for release of information: (Choose all that Apply)
_____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records (Except Psychotherapy Notes) _____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results) _____ Genetic Information (Including Genetic Test Results)	□ Treatment/Continuing Medical Care □ Personal Use □ Billing or Claims □ Insurance □ Legal Purposes □ Disability Determination □ School □ Employment □ Other (Specify): _____

I certify that I understand the privacy risks of the mail, phone calls, fax and e-mail. I hereby authorize Texas Advanced Renal Health including physicians and employees to mail, call, fax or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Texas Advanced Renal Health to that effect in writing.

I also would like to give my authorization to use or disclose my protected health information to the following individual(s) or group(s).

Please add entities

-
-
-
-

The individual signing this form agrees and acknowledges as follows:

1. Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
2. Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made
3. Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the clinician or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Special Information: This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.
5. Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:
Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

TEXAS ADVANCED
RENAL HEALTH

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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.

This Notice of Privacy Practices (the "Notice") tells you about the ways we may use and disclose your protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Texas Advanced Renal Health, including its clinicians and employees.

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law;
- Follow the terms of the version of this Notice that is currently in effect; and
- Not engage in any actions that could constitute "information blocking" under the 21st Century Cures Act and the regulations promulgated thereunder.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose

medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other clinicians, and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket, and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our clinicians.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine, email, fax and through the patient portal) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations, including disclosures that may be required under the 21st Century Cures Act.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your worker' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of clinicians, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose

your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental, or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in

writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI.

Your request must state a time period, which may not be longer than six years (or

longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other clinicians need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other clinicians of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential

communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Texas Advanced Renal Health
Attn: HIPAA Officer
7300 El Dorado Pkwy, Suite 125, McKinney, Texas, 75070
972 – 548 - 4833

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's

HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

Patient Name: _____

(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to patient: _____ _____ _____

TEXAS ADVANCED
RENAL HEALTH

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NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to the patient's guardian, next of kin, or legally authorized responsible person if the patient (a) has been adjudicated incompetent in accordance with the law, (b) is found to be medically incapable of understanding the proposed treatment or procedure, (c) is unable to communicate his, her, or their wishes regarding treatment, or (d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. Access to Care. You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, sexual orientation, gender identity, disability or handicap, or source of payment for care or services.

2. Respect and Dignity. You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

3. Privacy and Confidentiality. You have the right, within the law, to personal and informational privacy. This includes the right to:

    - Be interviewed and examined in surroundings that ensure reasonable privacy
    - Have a person of your own sex present during a physical examination or treatment
    - Not remain disrobed any longer than is required for accomplishing treatment or services
    - Request transfer to another treatment room if a visitor is unreasonably disturbing

- Expect that any discussion or consultation regarding care will be conducted discreetly

- Expect all written communications pertaining to care to be treated as confidential

- Expect medical records to be read only by individuals directly involved in care, quality-assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

4. Personal Safety. You have the right to expect reasonable safety regarding the practice's procedures and environment.

5. Identity. You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.

6. Information. You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.

7. Communication. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. Consent. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.

    - Consent discussions will include an explanation of the condition, the risks and benefits of treatment, and the consequences of no treatment.

    - Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.

    - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. Consultation. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. Charges. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

11. Rules and Regulations. You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. Keep Us Accurately Informed. You have the responsibility to provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

2. Follow Your Treatment Plan. You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.

3. Keep Your Appointments. You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.

4. Take Responsibility for Noncompliance. You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. Be Responsible for Your Financial Obligations. You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.

6. Be Considerate of Others. You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

7. Be Responsible for Lifestyle Choices. Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.

TEXAS ADVANCED
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FINANCIAL POLICY

We are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities as our patient. It is your responsibility to contact our office to notify us of any changes to your information, such as a change in address, telephone number, or insurance information.

You must complete and sign our Financial Policy before care is rendered.

- Payment is due at the time of services, including copayments, deductibles, and coinsurance as applicable. If you are uninsured or if you are not insured by a plan we do business with, payment in full is expected at time of services.
- If you are insured, You must bring your insurance information and a photo ID to every appointment to ensure correct processing of all insurance claims. If you are insured by a plan we work with but do not have your up-to-date insurance card, payment in full is required at time of services if we cannot verify your coverage.
- It is your responsibility to understand your insurance policy and benefits.
- We file insurance claims as a courtesy to our patients. Your insurance company may need you to provide certain information directly to the insurance company. You are responsible for complying with their request.
- If your insurance company denies payment because of benefit limitations or noncovered services, you will be responsible for the charges.
- If your insurance company needs any additional information, you are responsible for providing it to the insurance company.

I have read, understand, and been allowed to ask questions about this policy. I agree to comply with the policy as described.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature/Relationship Date

Printed Name _____ Date _____

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TELEHEALTH INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my health care provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

    a. I may revoke my right at any time by contacting Texas Advanced Renal Health at 972 – 548 – 4833 or email at staff@tarenal.com

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.

    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

   By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Witness Signature	Date

TEXAS ADVANCED
RENAL HEALTH

Leading The Way In Kidney Health Excellence

CONSENT TO PERFORM HIV TESTING

My health care provider has answered any questions I have regarding HIV testing and has given me written information with the following details about HIV testing:

- HIV is the virus that causes AIDS.
- The only way to know whether you have HIV is to be tested for it.
- HIV testing is important for your health, especially if you are pregnant.
- HIV testing is voluntary. You can withdraw consent at any time.
- Several testing options are available, including anonymous and confidential testing.
- State law may protect the confidentiality of test results and protects test subjects from discrimination based on their HIV status.
- If you test positive, your health care provider will talk with you about notifying any sex or needle-sharing partners of possible exposure.

I agree to a test for the diagnosis of HIV infection. If I am found to have HIV, I agree to additional testing, which may occur on the sample I provide today, to determine the best treatment for me. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time.

Patient Name_____

Date of Birth _____

Patient Signature _____Date_____
(Or signature of legally authorized representative)

If legal representative, indicate relationship to patient _____

Printed Name _____

Certification

I certify that the named person above has been given an opportunity to read written information about HIV and to ask questions, that he or she understands the issues presented, that his or her decision to undergo HIV testing is an informed and voluntary one, and that I have witnessed his or her signature.

Management/Clinician Name _____

Management/Clinician Signature _____Date _____

TEXAS ADVANCED
RENAL HEALTH

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What is patient portal?

Patient portal, Healow, is a secure and reliable method to communicating with our office. Once you register with a secure username and password, you can use the patient portal for the following:

- Use the message feature to contact the office
- Request refills, schedule appointment and communicate with your doctor.
- View your medical records, visit summaries, labs, and tests.
- Be able to access valuable educational resources that may be of importance to your visit and condition

The patient portal is not recommended to be used in case of emergencies. Please review the following

- The patient portal is offered at no additional cost.
- The patient portal may NOT be used to request refills for narcotics or controlled substances.
- The patient portal is for non – emergency requests only. We will respond to your message/request within 1-2 business days.
- The link for the patient portal is available on our website at tarenal.com
- Once you are pre-registered; we will verify your information and you can enroll by clicking the “enroll now” button on the lower left corner of the page.
- Remember to also check your Junk or spam folder to ensure the messages are there.
- Your privacy and security are our priority, we will not sell or give away any private information

By signing this form, you authorize Texas Advanced Renal Health to communicate with you using the patient portal. You agree to protect your password from any unauthorized individuals. You agree not to hold Texas Advanced Renal Health responsible for any network infractions beyond our control.

Patient Name:

Patient Date of Birth:

Patient Email Address:

Signature:

Date: