NANI
Nephrology Associates of
Northern Illinois and Indiana

Patient Forms

Patient Name: _____

Date of Birth: _____

Joint Consent for Treatment

I consent to any or all medical examinations, testing, and treatment considered necessary by the physicians, non-physician providers (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), registered nurses, and other healthcare professionals of Nephrology Associates of Northern Illinois and Indiana (NANI) and/or their patient care partners from Strive Health.

I understand I have the right to revoke this consent in writing at any time, except to the extent that the healthcare providers or medical group have acted in reliance of this consent. This consent will remain fully effective until it is revoked in writing.

My signature at the bottom of this form indicates that this consent is continuing in nature even after a specified diagnosis has been made and treatment recommended. I consent to treatment in this office or any other satellite office under common ownership.

If more invasive or interventional testing or procedures are recommended, I understand that I may be asked to read and sign additional consent forms prior to the test(s) and/or procedure(s).

Notice of Privacy Practices

All NANI locations maintain a current Notice of Privacy Practices (“Notice”). The Notice provides information about how NANI may use and disclose your protected health information. A hard copy will be provided to you at your appointment for review. You can also visit our website to view the Notice at any time.

Patient Rights and Responsibilities

NANI is committed to providing patients with high quality medical services and wants patients to know they have rights and responsibilities. A hard copy of these rights and responsibilities will be provided to you at your appointment for review. You can also visit our website to view the Notice at any time.

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Consent to Financial Responsibility

I understand it is my responsibility and obligation to understand my health insurance policy benefits. This includes my financial obligations for services provided by the participating healthcare provider, and to obtain prior authorization when necessary. My signature at the bottom of this form indicates that I acknowledge that I have read and understand the financial policy of NANI and accept fiscal responsibility for professional services and understand that I will be responsible for any unpaid balance on my account.

A hard copy of NANI's Financial Responsibility Policy will be provided to you at your appointment for review. You can also visit our website to view this Policy at any time.

For your convenience, our billing office is staffed Monday through Friday from 9:00 AM – 4:00 PM. The billing office can be reached at 866-785-3627. Our knowledgeable staff will be happy to address any questions or concerns you may have regarding our financial policy or your account.

Patient Communication Consent Form

I agree to allow NANI to contact me using the following methods regarding my personal health information, evaluation, and treatment. I authorize/do not authorize NANI to leave messages for me when I am unavailable as indicated below:

Check to Confirm Approval Method	Method	Number/Address	Leave Messages (Circle)
❑	Home Phone		**Y or N**
❑	Cell Phone		**Y or N**
❑	Work Phone		**Y or N**
❑	Alternate Phone		**Y or N**
❑	Unencrypted E-Mail*		**Y or N**
❑	Unencrypted Text Message*		**Y or N**
❑	Communication-Based Technology Services *(MyChart)*		**Y or N**

***Please note:** *Sending or receiving PHI (Protected Health Information) via unencrypted e-mail or text message is not considered secure. Your signature attests that you understand this and assume and risks associated.*

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I authorize NANI to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number	Information Allow to be Discussed (Circle)
			Routine Sensitive Financial
			Routine Sensitive Financial

Emergency Contact(s) Information

Name	Relationship to Patient	Phone Number

You may update this consent at any time by contacting your healthcare provider's office.

Signature to Patient Forms

Patient Name _____

Date of Birth of Patient _____

_____

Signature of Patient (or Legal Representative)

_____

If signed by a Legal Representative, please print name/relationship

_____

Date

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Request to Release Patient Medical Information To NANI

It is important for your healthcare Providers to review your past medical information so they can provide you with the best level of care. This form allows other healthcare Providers to share information with NANI.

I hereby direct my healthcare provider(s) to release my medical information to NANI via electronic fax.
I understand I have the right to access my complete medical records maintained by my health care providers based on federal HIPAA law.

I understand that I may be asked to verify my identity when records are released to NANI.

Type of information I wish to be released to NANI:

____ My entire medical record
____ Physicians notes only
____ Diagnostic testing only
____ Other (specify):

Type of information <u>not</u> to be released to NANI:

Confidential information protected by state/federal law:
___ Drug or alcohol abuse diagnosis/treatment
___ Mental health diagnosis/treatment
___ Sexually transmitted diseases or AIDS/HIV diagnosis/treatment/counseling
___ Other (specify):

Signature to Release Information

Patient Name _____

Date of Birth of Patient _____

_____
Signature of Patient (or Legal Representative)

_____
If signed by a Legal Representative, please print name/relationship

_____
Date