We require you to be an active participant in your healthcare. We ask that you read and sign the following policies for our office. It is important that you are aware and understand our policies on how we do business so that we can provide you with outstanding healthcare services. Communication is important and we ask that you notify us if any issues arise. We will make every effort to resolve your issue in a timely and efficient manner.

HOURS OF OPERATION: Our main offices are open Monday – Friday from 9:00am – 4:30pm.
These offices will be closed on Saturdays, Sundays & most major holidays. A physician will be on call 24 hours a day, 7 days a week, for emergencies only.

IF YOU HAVE AN EMERGENCY REQUIRING IMMEDIATE CARE, PLEASE CONTACT 911 OR GO TO THE APPROPRIATE EMERGENCY CARE FACILITY.

SCHEDULED APPOINTMENTS: New, routine and same-day appointments can be scheduled with our office during regular hours. The schedule is usually full and same-day appointments will be given on a case-by-case basis. Please make sure to have an approved authorization or referral **prior to** scheduling your appointment. If you are unsure if your insurance requires a referral please call the member services telephone number on the back of your insurance card. Medicare does not require a referral.

PATIENT INFORMATION: You will be required to complete and sign our patient information sheet annually. It is your responsibility to notify the office of any changes to your address, telephone number(s), and/or insurance information. Incorrect insurance information can increase your financial responsibility unnecessarily. We will ask to see your insurance cards each time you visit.

REFERRAL FORMS: If you are covered by an insurance company that requires referrals, it is **imperative** for **you** to contact your Primary Care Physician (PCP) and have their office make a referral to us **prior to** your appointment. If your plan requires a referral to obtain **your full benefits** and you incur an out-of-pocket penalty by not supplying one, you will be responsible for the non-covered amounts connected to that visit. Seeing a specialist without a proper referral can increase your financial responsibility.

PAYMENTS: Co-payments, any outstanding balance or financial arrangements made prior to your appointment are due when you check-in for your visit. For your convenience, we accept Cash, Checks, Money Orders, Visa, MasterCard, American Express & Discover credit and debit cards. Our knowledgeable billing office associates are available to you to discuss insurance related question &/or your account @ (440) 799-4224.

PRESCRIPTION REFILLS: Please ask your pharmacist to send us a fax for medication refill requests. All prescription refills will be processed during regular office hours. Please call our office for a new or written prescription requests. These may require a scheduled appointment with your physician. Please DO NOT ALLOW your medication(s) to run out before requesting a refill. We would appreciate at least a weeks notice for prescription refill request as time is required to verify your patient information and medical need for the refill.

CANCELLED APPOINTMENTS: If you are unable to keep your scheduled appointment please give our office 24-hour notice of the cancellation. The scheduled appointment is important to your medical care but if you are unable to make it then it is possible that another patient that needs immediate care can be seen.

CONFIRMATION OF APPOINTMENTS: May we leave medical appointment information on your home answering machine or voicemail? ☐ **YES** ☐ **NO** _____

SIGNATURE **DATE**

MEDICAL INFORMATION: May we leave medical information on your home answering machine or voicemail?

☐ **YES** ☐ **NO** _____

SIGNATURE **DATE**

CONSENT TO CARE AND TREATMENT: To provide you with the appropriate medical care you must consent to care and treatment by the Americare Kidney Institute, LLC. Without your consent, we cannot provide you with any medical services. To consent to medical care and treatment, please read and sign the following statement:

I, the undersigned, do hereby agree and give my consent for the Americare Kidney Institute, LLC to furnish medical care and treatment to myself:

_____*, and/or my dependent,*

_____*,as considered medically necessary and proper in the diagnosing or treating his/her physical and/or mental condition.*

SIGNATURE	**RELATION**	**DATE**

PRIVACY OF INFORMATION: Confidentiality of patient protected health information is vital to our processes here at Americare Kidney Institute, LLC. We will only release information to someone other than the patient or guardian for the purposes of proper medical care, HIPAA compliance, and assignment of benefits or court-ordered requests. If, however, you would like to have your or your dependents information released to any other individual please provide us with that/those person(s) name, relation, contact information:

NAME	RELATION	TP#'S
NAME	RELATION	TP#'S
NAME	RELATION	TP#'S

The importance of understanding and following these policies for both the patient and the office is apart of providing a good service. You have the right and we encourage you to ask for any clarification of any of these policies. Please feel free to ask the front office staff if you have any questions or concerns.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND POLICIES AND ASKED FOR CLARIFICATION WHERE NECESSARY. I UNDERSTAND MY RIGHT TO PRIVACY.

PRINT PATIENT NAME

PRINT GUARDIAN/RESPONSIBLE PARTY NAME

PATIENT SIGNATURE **DATE**

SIGNATURE OF GUARDIAN/RESPONSIBLE PARTY **DATE**

RELATIONSHIP TO THE PATIENT

OFFICE REPRESENTATIVE/WITNESS **DATE**