KSM

KIDNEY SPECIALISTS OF MINNESOTA

Patient Registration and Consent Form

Patient Name: Date of Birth:

PLEASE CHECK BOXES AND SIGN BELOW:

- ☐ RECORDS RELEASE: I hereby authorize KSM to release and obtain my medical records including protected health information and billing information, ("Information") to my primary care, referring physicians and other providers involved in my care, Medicare, payer network organizations, health plans (including accountable care organizations) and their contractors, and third-party administrators as needed for treatment, payment, and healthcare operations. I also authorize each of them to share my Information obtained from KSM with health information exchanges, accountable care organizations in which my provider participates, and with the contractors and third-party administrators of these parties as needed for treatment, payment, and health care operations. I agree that this authorization shall continue for a period of ten years from the date of this authorization.

- ☐ EMR RELEASES: I hereby authorize KSM to share my Information obtained from KSM with healthcare providers other than KSM who utilize the same electronic medical record ("EMR") system subject to the requirements of and to the extent authorized under such EMR system. I agree that this authorization shall continue for a period of ten years from the date of this authorization.

- ☐ SOCIAL WORK RECORDS: I understand that to the extent I receive services from a KSM social worker, my social worker will generate client information including without limitation my medications and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, the results of clinical tests, and any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. All such information will be included in the definition of Information under this Consent Form. I hereby provide my informed consent and authorization for KSM to use and disclose such social work Information as provided above under the general Records Release and to include such Information in the EMR utilized by KSM from time to time. I agree that this authorization shall continue for a period of ten years from the date of this authorization.

- ☐ ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to KSM for services rendered to myself and/or dependents in addition to authorizing KSM or my insurance company to release any of my Information required to process my claim.

☐ MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to Kidney Specialist of MN for services furnished to me by a physician/clinic/supervisor of KSM. I authorize any holder of hospital or medical information about me to release to the Center for Medicare and Medicaid Services and its agents any of my Information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization to be used in place of the original.

☐ MEDIGAP: I request that authorized MEDIGAP benefits be made on my behalf for services rendered to me. I authorize any holder of my Information to release to the applicable MEDIGAP carrier any of my Information needed to determine these benefits payable for related services.

☐ CONSENT TO TREATMENT: I authorize KSM, its physicians, and any employee working under the direction of the physician, or providers working with KSM, to provide medical care to me. This medical care may include services and supplies related to my health and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling assessment of review of mental status/functions of the body, and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professions for care and treatment as well as a consent to communication and treatment through telemedicine.

☐ VERIFIED FACESHEET: I have reviewed the patient face sheet and verified my demographic and coverage information is correct. I agree to contact KSM if this information changes.

☐ VOICEMAIL: I authorize KSM to leave a voicemail at the locations designated below (check all that apply, or "none"). I understand the subject matter of a voicemail may contain my Information and KSM will not be responsible for who may obtain access to the voicemail message.

☐ HOME ☐ CELL ☐ WORK ☐ NONE

In the above-detailed voicemail, can test results be communicated? (Please select one)

☐ YES ☐ NO

MARKETING AUTHORIZATION: Kidney Specialists of Minnesota ("KSM") values you as a patient and respects the privacy of your personal and medical information that is disclosed to us in the course of our treatment relationship with you. Generally speaking, the law permits KSM to communicate with you about descriptions of its own health-related products or services, your treatment, and your case management or care coordination. Communications that occur in a face-to-face encounter or communications that involve a promotional gift of nominal value are also permitted under the law. All of

these communications are a normal and valuable part of our provider-patient relationship and authorization is not required. Certain types of communications, however, cannot be sent to you unless you provide written authorization to receive them, including communications about a product or service that encourages you to purchase or use the product or service in addition to communications that are sponsored or reimbursed by a third party whose products or services are promoted in the communication. You have a choice whether to receive these communications. The purpose of This Marketing Authorization grants KSM permission to use or disclose your name, phone number, mailing address, and/or email address to send you marketing communications that promote products and services, for which KSM may receive direct or indirect payment from a third party. KSM will never sell your information to third parties. Information disclosed pursuant to this Marketing Authorization may be re-disclosed by a recipient without additional authorization.

CHECK ONLY ONE:

- ☐ YES, I authorize KSM to make the marketing communications described.
- ☐ NO, I DO NOT authorize KSM to make the marketing communications described.

☐ I permit a copy of the authorization to be used in place of the original. I agree that the authorizations and consents provided above shall be effective for a duration of ten years unless earlier terminated by written notice to:

Kidney Specialists of Minnesota, P.A.
Corporate Office
6200 Shingle Creek Pkwy, Suite 260
Minneapolis, MN 55430

A copy of this verbal consent or signed document will be viewable on your MyChart and can be printed upon request.

☐ VERBAL CONSENT OBTAINED By:_____

_____ _____
Patient Signature Date