C K D Cleveland Kidney Disease Associates

Andrew E. Lazar, M.D.
3619 Park East Drive, Ste 318 South
Beachwood, OH 44122
(216)896-0639 Fax: (216)896-0663
www.clevelandkidney.com

Welcome to our practice! We appreciate that you have chosen us to care for your medical needs.
The date and time of your appointment is: _____

- Please contact your PCP before your appointment **if your insurance requires a referral**.
- Please bring your **medication bottles or a list of your medications** to your appointment
- You will be asked to give a urine specimen at your visit
- Please bring your **insurance cards and picture identification** to your visit
- Please complete and sign the **enclosed forms** and **bring** them to your visit
- If you have a **copay**, your insurance company requires that you pay it at the time of your appointment. Please bring **cash, check or credit card**

If you must change your appointment date or time, kindly give us at least **24 hours notice** so that we may accommodate you and other patients who need an appointment. You may be **charged** for missed appointments.
As you have not visited with us before, we have included a review of our practice's mission and information about Dr. Lazar. Please call with any questions. Again, thank you for choosing Cleveland Kidney Disease Associates!

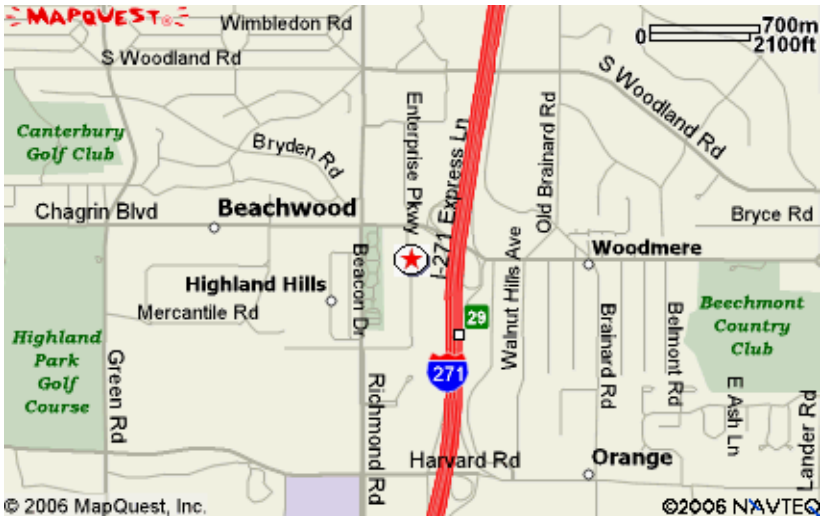
Mission Statement

Cleveland Kidney Disease Associates is devoted to delivering the highest level of nephrology care with compassion, respect, patient education, state-of-the-art practice, and the most recent medical developments. Using the latest in research, technology, and treatment options, we strive to educate the public about chronic kidney disease, and to create individualized life plans for our patients, with the uncompromising goal of providing them with the highest quality of life. By participating in medical research activities, we bridge the gap between academic medicine and community nephrology.

Dr Andrew E. Lazar has a degree in Biomedical Engineering from Boston University. He worked as a design engineer at General Motors before returning to medical school at Wayne State University in Detroit, MI. He studied Internal Medicine at the University of Virginia where he was chosen as a chief resident. Later he studied Nephrology at Case Western Reserve University. Prior to returning to Cleveland, he practiced Nephrology in Akron, OH. Please visit our website for more information regarding our practice.

Cleveland Kidney Disease Associates, LLC
Financial Policy

It is our hope that you understand that our credit and collection policies are a necessary part of assuring the financial resources required to maintain vital health care service for all of our patients. If you have health insurance, please understand that this is an agreement only between you and your insurance company. Your physician's bill is an agreement between you and your physician. Payment of your co-payment, co-insurance and deductible are required at the time of the service. We will submit your charges to your insurance company for you, if you provide us with the current and complete insurance information. It is your responsibility to be familiar with your insurance policy and what it covers. If your insurance policy requires a referral or authorization for testing or special procedures, please let us know prior to you appointment. Failure to do so may result in your full responsibility for payment of services. If you do not have insurance coverage, payment at the time of service is required. Payment of the balance can be arranged with our billing department. If unusual circumstances should make it impossible for you to meet our credit terms, we encourage you to let us know. Accounts over 120 days may be referred to an outside agency for collection, which could affect your credit rating for seven years. If your treatment is the result of an accident and a lawsuit or hearing is involved, payment for this treatment must either be processed through your health insurance or payment made at the time of service. We will assist your attorney with copies of records and billings as appropriate.



FROM THE SOUTH : Take I-271 North (local lanes) and exit at Chagrin Blvd. At light turn left on Chagrin. Go to next intersection (second light) which is Park East Drive, make a left. Parkway Medical Center is on left side of street.

FROM THE WEST: Take I-480East to I-271 North (local lanes) and exit at Chagrin Blvd. At light turn left on Chagrin. Go to next intersection (second light) which is Park East Drive, make a left. Parkway Medical Center is on left side of street.

FROM THE NORTH: Take I-271 South and exit at Chagrin Blvd. At light turn right. At next light (Park East Drive) turn left. Parkway Medical Center is on the left.

FROM THE EAST: Take I-480 West to I-271 North (local lanes) and exit at Chagrin Blvd. At light turn left on Chagrin. Go to next intersection (second light) which is Park East Drive, make a left. Parkway Medical Center is on left side of street.

Cleveland Kidney Disease Associates **Andrew E. Lazar, M.D.**

Patient Information Date_____/_____/_____

Patient Name_____
Last First MI

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____

Date of Birth_____ Sex (circle) M F SS#_____

Employer _____ Work Phone_____

Primary Care Physician_____ Physician Sending You Here_____

Emergency Contact_____
Name Relationship Phone number

Responsible Party (person responsible for payment) – Usually this is the Policy Holder
(If different than patient)

Name_____
Last First MI

Address_____
Street City State Zip

Home Phone_____ Work Phone_____

Date of Birth_____ Sex (circle) M F SS#_____

Employer _____ Relation to patient (circle) Spouse Father Mother Father Guardian Other____

Insurance Information

Primary Insurance Company_____ Secondary Insurance_____

Does your insurance company require a referral for office visits? _____Y_____N

Does your insurance company restrict which hospital system you can use?_____

Have you recently been hospitalized? _____Y (date ___/___/___) _____N

Hospital Name_____ Admitting Physician_____

PLEASE GIVE YOUR INSURANCE CARD(S) TO RECEPTIONIST FOR COPYING.

PLEASE COMPLETE OTHER SIDE

NOTICE OF PRIVACY PRACTICES AND PERMISSION TO SHARE HEALTH INFORMATION

By signing below, I am acknowledging that I have received a copy of the CKD Associates Notice of Privacy Practices.

Patient Signature_____ Date_____/____/_____

Authorized Representative_____ Date_____/_____/_____

Relationship to patient?_____

Refusal to sign_____ Date_____/_____/_____

If you would like to authorize disclosure of your personal health information to parties other than your referring physician and primary care physician, you will need to complete a HIPPA Supplemental Disclosure Form. Please ask the receptionist for this form.

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician of CKD Associates and authorize payment directly to the physician (CDC-PO) of the Medical and/or Surgical benefits, if any, otherwise payable to me by Medicare or any other insurance company, for his services, and I assume responsibility for any unpaid balance including not covered services except as limited by law. I also hereby authorize the physician to release any information to my referring physician and/or primary care physician, Health Care Financing Agency, or its agents, to third party payors and anyone assisting the provider in obtaining payment including billing, coding and collection agents, provider's attorney, consultants, and to my insurance company as acquired in the course of my examination or treatment. This authorization will remain in effect until revoked by me in writing.

CKD Associates' financial policy is displayed in the reception area.

I have reviewed and accepted the Financial Policy and Authorization, Assignment and Information Release.

_____/_____/_____

Signature of Patient or Responsible Party Date

Cleveland Kidney Disease Associates

Date _____

Name _____ DOB _____ Age _____
Referring Physician _____ Primary Care Physician _____
Reason for Referral _____
Occupation _____ Marital Status _____ Phone Number _____

Medical History

List any past illnesses _____
_____
_____

List any past surgical procedures (include date/yr if known) _____
_____
_____

Check any of the following you have experienced

_____ Heart problems (including heart failure, attack, murmurs)
_____Cancer
_____ Lung problems (including emphysema, asthma)
_____Liver problems (including hepatitis, jaundice, gall bladder disease)
_____ Thyroid problems
_____ Kidney problems (blood or protein in your urine, stones, frequent infections)
_____ High blood pressure
_____ Arthritis
_____ Stroke, mini-stroke
____ Diabetes (sugar)

Do you smoke?_____ How much per day? _____ How many years? _____ When did you _____ quit? (now or in the past)

Do you use drugs? _____Marijuana _____ Cocaine _____ Heroin _____Other _____ (now or in the past)

Do you drink alcohol?_____ How much per week? _____

Do you follow any specific diet? _____ If yes, explain _____
_____

Allergies to medications _____
(including reactions, if known)_____

Current medications _____
_____
_____

Family Medical History (include high blood pressure, cancer, heart, kidney or lung disease, stroke, diabetes and inherited diseases)

Relationship	Age	Health problems	Cause of death
Father			
Mother			
Brothers			
Sisters			
Children			

General Health Review

Please check any of the following you are experiencing

General
___Decreased appetite
___Food tastes strange/different
___Weight loss in past 6 months
___Weight gain in past 6 months
___More easily fatigued
___Fevers
___Sweating at night
___Hair loss
___Change in your skin
___New/changing/bleeding moles
___Rash
___Depression

Head
___Headaches
___Blurred vision
___Double vision
___Decreased hearing
___Ringing in your ears
___Frequent nosebleeds
___Trouble swallowing foods
___Mouth sores

Heart and Lungs
___Chest pain or heaviness
___Racing heart/skipped beats/palpitations
___Short of breath at rest
___Short of breath lying flat
___Wake up and have to sit up to breathe
___Have to sleep propped up
___Loud snoring
___Cough with mucous and/or blood
___Swelling or edema
___Pain in legs when walking

Gastrointestinal
___Nausea
___Vomiting
___Pain in abdomen
___Frequent constipation
___Frequent diarrhea
___Blood in your stool
___Black stools

Urinary System and Genital Tract
___Frequent urination
___Bladder doesn't empty completely
___Burning or pain with urination
___Blood in urine
___Foamy urine
___Need to wake up to urinate
___Change in force of urine stream
___Trouble starting or stopping urinating
___Dribbling after urination
___Losing urine spontaneously
___Losing urine after coughing/sneezing
___Impotence
___Change in your periods
___Bleeding after menopause
___Bleeding between periods

Muscles, Joints, Nervous System
___Muscle aching or cramps
___Joint pains
___Joint swelling
___Arthritis
___Fainting
___Seizures
___Numbness or tingling anywhere
___Weakness anywhere
___Paralysis anywhere
___Trouble speaking/making words
___Discoloration of hands and/or feet

Physician/Provider to Complete Reviewed with patient on: _____/_____
DD/MM/YY Provider initials

CLEVELAND
KIDNEY
DISEASE ASSOCIATES

ANDREW E LAZAR M D
3619 PARK EAST DRIVE
STE 318 SOUTH
BEACHWOOD OH 44122
216 896 0639 FAX
216 896 0663
WWW CLEVELANDKIDNEY COM

Authorization to Disclose Personal Health Information

HIPPA Supplement Form

I, _____, hereby authorize CKD Associates to disclose my
Patient Name
Health information to the following parties (family, next of kin):

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

/ /

Patient Signature Date

/ /

Representative Signature Date

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Authorization for Release of Protected Health Information (PHI)

I hereby request/authorize Cleveland Kidney Disease Associates to use, disclose and/or release my individually identifiable health information as described below. I understand that this authorization to release my individually identifiable health information is voluntary and that I may revoke the authorization in writing addressed to CKD Associates at 3619 Park East Drive, Suite 318 South, Beachwood, OH 44122. This authorization may not be revoked where CKD Associates has reasonably acted in reliance on this authorization. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name (print): _____
Maiden/Previous Name (print): _____ Date Of Birth: _____
Social Security Number: _____ Approx. Date Last Seen: _____

Request for release of individually identifiable health information to the following facility/physician/person:

Name: _____
Address: _____
_____
Phone: _____ **Fax:** _____

Description of information being disclosed:

□ **Progress Notes**	□ **Operative Reports**	□ **Discharge Summaries**	□ **Pathology Reports**
□ **Renal Ultrasounds**	□ **Renal Artery Duplex**	□ **Renal Arteriograms**	□ **MRI/MRA Reports**
□ **CT Scans**	□ **Echocardiograms**	□ **Chest X-ray**	□ **Billing Records**

□ **All Laboratory Studies (i.e. Renal Panel, CBC, U/A, 24 Hour Urine)**
□ **Other:** _____

Purpose of Disclosure: At the request of the patient.

This authorization expires (choose only one):
[ ] 90 days from the date in which I, or my legal representative, signs this authorization
[ ] upon the happening of the following event: _____
Treatment or payment may not be conditioned on the execution of this Agreement, except for research-related treatment and treatment solely for the purpose of disclosure to a third party based on this release.

Patient/Representative Signature: _____
Patient/Representative (print): _____
Legal Authority of Representative to sign on behalf of the patient : _____
Representative verified by: _____ Date: _____

Additional information can be found in the CKD Associates Privacy Practices. You will be given a copy of this Authorization with a copy filed in your medical record.