WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

PATIENT REGISTRATION FORM

Patient Information

New Patient Update of information

Date of birth (MM/DD/YY:

Last First

Telephone Numbers:
Home:
Work:
Cell:
Email:

Email communication is not HIPAA secure.

Please see our EMAIL POLICY for more information.

Also Known As Name

Last First

Home Address:
Street: State:
City: Zip:

Preferred Communication Method:
Home Work Cell Email

Social Security Number:

Gender:
Male Female Nonbinary

Marital status:
Single Married Divorced Widowed

Ethnicity: Hispanic Not Hispanic or Latino Others:

Race: Asian American Indian/Alaska Native
Black or African American Pacific Islander/Native Hawaiian
White Other: Declined

Preferred Language: English Spani•h Other:

Employer Name:
Employer's Address:
Street: City: State: Zip:

School Name (If student):
School Address:
Street: City: State: Zip:

Person Financially Responsible

Person Financially Responsible (if other than patient):
Last Name First Middle

Relationship to Patient:
Spouse Child
Other:

Home Address
Street: City: State: Zip:
Telephone Number:

Insurance Information

Primary Insurance:

Insurance Company Name: Phone No:
Insurance Company Address:
Street: City: State: Zip:
Subscriber Name: Subscriber's Öææ^Á[-ÁÓãc@
Effective Date (MM/DD/YY): Policy Number:
Group Identification Number:

Secondary Insurance:

Insurance Company Name: Phone No:
Insurance Company Address:
Street: City: State: Zip:
Subscriber Name: Ù˘à•&¦ãà^¦©ÁÖææ^Á[-ÁÓãc@
Effective Date (MM/DD/YY): Policy Number:
Group Identification Number:

I authorize payment of medical benefits to be made directly to Washington Nephrology Associates, LLP. I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any informaiton necessary to process this request. Deductibles and Co-payments are due at the time of service. Please read page 2 for additional information.

Emergency Contact

Emergency Contact (who we may contact in case of an emergency):
Name: Relationship to Patient: Spouse Child Other
Street: City: State: Zip:
Telephone Number:

Patient Name: DOB:

Primary Care Physician: Name: Address: Telephone Number:	Referring Physician (if other than Primary Care Physician): Name: Address: Telephone Number:

Referrals must be presented at the time of service. If a referral is required but not obtained by the time of the appointment, the appointment may be re-scheduled.

Our office provides statements of account activity including charges and payments. Please contact our Billing Department. Patient is responsible for all co-payments, deductibles and non-covered charges by health insurance.

I am a patient of Washington Nephrology Associates, LLP and I hereby authorize the physicians and staff to discuss my medical condition with the following individuals:

Name: Relationship to Patient
Spouse Child Other:

Last *First* *Middle Initial*

Telephone Number:

Name: Relationship to Patient
Spouse Child Other:

Last *First* *Middle Initial*

Telephone Number:

Name: Relationship to Patient
Spouse Child Other:

Last *First* *Middle Initial*

Telephone Number:

Washington Nephrology Associates, LLP will apply for benefits on the patient's behalf for covered services. The payment will be made from the patient's insurance company to the company. The patient is ultimately responsible for the balance on the account.

Initials:

Restriction on Release of Information When Paying Out-of-Pocket

You may choose to tell WNA not to release certain protected health information to a health plan if you paid in full.
It is your responsibility to discuss out-of-pocket payments with the staff.

A scheduled appointment is the time that doctors and staff at WNA have reserved for your care. If you need to cancel an appointment, we request at least a 48-hour notice to avoid a missed appointment fee of $100 for a missed consultation appointment, and $60 for a missed follow-up appointment. Please note, this charge is not covered by insurance.

Initials:

Please review our **Notice of Privacy Practices** for information regarding your protected health information. In addition, please note that you may complete additional forms to restrict or amend your PHI, request confidential communication

Initials:

I have reviewed **ALL PATIENT POLICY FORMS AND DOCUMENTS.**
I agree that the information documented on this form is accurate and current to the best of my knowledge.

_ _

Signature of Patient or Legal Representative

PRINT Name of Legal Representative Relationship to Patient: Spouse Child Other:

If Legal Representative, I warrant that I am authorized to sign on behalf of the Patient.

Date (MM/DD/YY):

Patient Name: DOB (MM/DD/YY):

Pharmacy Name: Local Mail Order

Phone Number:

Pharmacy Name: Local Mail Order

Phone Number:

Allergies:

Name of Medication	Allergic Reaction	Name of Medication	Allergic Reaction

Current medications:

Name of Medication	Dosage and Frequency	Name of Medication	Dosage and Frequency

PAST MEDICAL, FAMILY AND SOCIAL HISTORY FORM

Name: *(Øã•dÊÁT ÊÃŠæ•ç)* M · F	**DOB:**

PAST MEDICAL HISTORY – COMMON DISEASES

Do you have a personal history of any of the following?

Kidney Disease	☐ CKD 1 2 3 4 5 Stage: ☐ Transplant Cadaveric Living - Related Living - Unrelated	☐ Dialysis HD PD ☐ Polycystic Kidney Disease ☐ Acute Kidney Injury ☐ Glomerulonephritis
Diabetes	Type 1 Type 2	Type Unknown
High Blood Pressure	☐ Essential ☐ Renovascular	☐ White Coat Hypertension ☐ Conn's Syndrome
Ischemic Heart Disease	☐ Heart attack ☐ Angina ☐ Angioplasty	☐ Coronary Stent ☐ CABG (Coronary Artery Bypass Graft)
Cancer	☐ Lung ☐ Breast ☐ Prostate ☐ Colon ☐ Melanoma ☐ Bladder	☐ Lymphoma ☐ Kidney ☐ Thyroid ☐ Leukemia ☐ Endometrial ☐ Pancreatic
Stroke	☐ Stroke	
Gout	☐ Gout	

PAST MEDICAL HISTORY – ADDITIONAL CONDITIONS

Do you have a personal history of any of the following?

EENT	☐ Blindness ☐ Cataracts	☐ Hearing Problems ☐ Glaucoma
Cardiovascular	☐ Atrial Fibrillation ☐ Pacemaker ☐ AICD (Cardiac Defibrillator)	☐ Valvular Heart Disease ☐ Congestive Heart Failure ☐ Mitral Valve Prolapse
Respiratory	☐ COPD ☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema	☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea

Gastrointestinal	☐ GERD (Gastric Reflux) ☐ Stomach/Bowel Ulcers ☐ Gall Bladder Disease ☐ Hepatitis	☐ Inflammatory Bowel Disease ☐ Irritable Bowel Syndrome ☐ Gluten Intolerance ☐ Lactose Intolerance
Genitourinary	☐ Enlarged Prostate ☐ Kidney Stones	☐ Frequent UTIs (Urinary Tract Infections)
OB History	☐ Preeclampsia ☐ Pregnancy Induced Hypertension	☐ Gestational Diabetes ☐ History of Complicated Pregnancy
Musculoskeletal	☐ Osteoarthritis	☐ Osteoporosis
Neurological	☐ Multiple Sclerosis ☐ Seizures	☐ Parkinson's ☐ Dementia
Psychiatric	☐ Depression	☐ Anxiety Disorder
Endocrine	☐ Hypothyroidism ☐ Hyperthyroidism	☐ Adrenal Insufficiency
Hematology	☐ Anemia ☐ Sickle Cell Disease ☐ Sickle Cell Trait	☐ Blood Transfusion ☐ Thalassemia
Immuno/Allergy	☐ HIV ☐ AIDS	☐ Rheumatoid Arthritis ☐ Lupus

PAST MEDICAL HISTORY – SURGERY HISTORY

Have any of the following surgeries been performed on you?

☐ Appendectomy	☐ Hip Replacement	☐ Renal Transplant
☐ CABG	☐ Left ☐ Bilateral	☐ Thyroidectomy
☐ Carotid Endarterectomy	☐ Right	☐ Tonsillectomy
☐ Cataract Surgery	☐ Knee Replacement	☐ Valve Replacement
☐ D & C	☐ Left ☐ Bilateral	☐ AV Fistula
☐ Gall Bladder Removal	☐ Right	☐ AV Graft
☐ Gastric Bypass	☐ Hysterectomy	☐ PD Catheter
☐ Hemorrhoidectomy	☐ Prostatectomy	☐ Other______________
☐ Hernia Repair	☐ Nephrectomy	

Other Health Problems Not Listed Above:

FAMILY HISTORY – ILLNESSES

Do the following family members have any of the following medical conditions?

Condition			
Kidney Disease	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
Diabetes	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
High Blood Pressure	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
Ischemic Heart Disease	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
Cancer	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
Stroke	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
Gout	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
ADPKD	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child
Dementia	☐ Father ☐ Mother	☐ Ó¦[c@¦ ☐ Ùã c^¦	Child

FAMILY HISTORY – STATUS

Father	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:__________ ☐ Cause of Death:__________
Mother	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:__________ ☐ Cause of Death:__________

Other Family History Not Listed Above:

SOCIAL HISTORY – GENERAL

Current Marital Status	☐ Married ☐ Separated ☐ Single	☐ Widowed ☐ Divorced
Living Arrangement	☐ Alone ☐ Family Member ☐ Spouse	☐ In Home Caregiver ☐ Significant Other ☐ Assisted Living Facility
Occupation	☐ Retired ☐ Unemployed ☐ Employed ☐ Full - time ☐ Part - time ☐ Student List your Current or Former Occupation:_______________	
Deficits	☐ Hearing Loss ☐ Limited Mobility	☐ Poor Vision or Blindness ☐ Transportation Challenges

SOCIAL HISTORY – HABITS

Tobacco Use	☐ Current or Former User ☐ Cigarettes ☐ Chewing Tobacco ☐ Pipes ☐ Snuff ☐ Cigars If a current or former user, what year did you start? _____________ If a former user, what year did you quit? _____________	☐ Never Used ☐ Unknown

<table>
<tr><td></td><td>Complete the following section if you are a current or former cigarette user:

How often do you currently smoke or how often did you smoke before you quit?

☐ Every Day ☐ Some Days ☐ Unknown

How many packs per day do you currently smoke or how many packs per day did you smoke before you quit?

____
How many total years have you used cigarettes?

____________</td></tr>
<tr><td>Alcohol Use</td><td>☐ Current or Former User ☐ Never Used
☐ Occasional
☐ 1-2 per Day
☐ 3 or more per Day

If a former user, what year did you quit?

____________</td></tr>
<tr><td>Recreational Drug Use</td><td>☐ Current or Former User
☐ Marijuana
☐ Amphetamines
☐ LSD
☐ Heroin
☐ Ecstasy
☐ Opium
☐ Cocaine
☐ Barbiturates
☐ Other ____________
☐ Never Used

If a former user, what year did you quit?

____________</td></tr>
</table>

Other Social History Not Listed Above:

WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

PRIVACY NOTICE

This Privacy 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.

A. Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us that we can in writing. If you tell us we can, you may change your mind at any time, and you will be required to notify us in writing.
We share a single patient record with other practices that use our electronic medical record system (Acumen 2.0), in compliance with state and federal laws, and in accordance with Acumen 2.0 rules which are available at
https://acumenmd.com/wp-content/uploads/2020/01/Acumen-Data-Sharing-Rules-ofthe-Road.pdf. Our medical group's ability to access your records for treatment and related purposes is critical to maintaining continuity of patient care and improving the quality and efficiency of health care, all of which benefit the individual patient. Each practice is responsible for obtaining your consent or authorization required by state and federal laws applicable to that practice before accessing, using or disclosing information in your record.
We can change the terms of this notice and the changes will apply to all the information we have about you. The new notice will be available at the time of any changes.
Our Uses and Disclosures
1. Treatment: We can use your health information and share it with other professionals who are treating you. For example, your information may be disclosed to your primary care physician or to another specialist who referred you to WNA for treatment.
2. Healthcare Operations: \'(/ e can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, your information may be used and disclosed by WNA to engage in case management, coordinate your care, schedule your appointments and inform you of your lab results. We may contact you to give you information about treatment alternatives or other health benefits and services that may be of interest to you.
3. Payment: We ca n use and share your health information to bill and get payment from health plans or other entities. For example, your information may be used and disclosed to submit claims to your insurer and/ or to obtain payment for services provided.

B. Your Choices: Uses and Disclosures with Your Verbal Consent

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please tell us what you want us to do.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in your care.
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts- We may contact you for fundraising, but you can tell us not to

contact you again for fundraising.
Please note: If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission: For marketing
For the sale of your information
For most sharing of psychotherapy notes

C. Other Uses and Disclosures without your consent.

We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
Public Health and Safety
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Research
We can use or share your information for health research.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner or funeral director when an individual die.
Address worker’s compensation. law enforcement and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official with health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

D. Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. Get a copy of your medical record. You can ask to see or get a copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We will charge a reasonable, cost-based fee.
2. Ask us to correct your medical record. You can ask us to correct health information about you if you think it is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Please note that email is not always secure. We will do our best to protect your health information, but we do not guarantee privacy through email.
4. Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
5. Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date yo1,1 ask, who we shared

it with and why. We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

6. Get a copy of this Privacy Notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
7. Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that a person has this authority and can act for you before we take action. We will require an executed medical power of attorney form for our records.
8. File a complaint. If you feel your rights have been violated, you can contact us at:
   Barbara Rotter, Privacy Officer
   Administration
   Washington Nephrology Associates, LLP
   1201 Seven Locks Rd, Suite 200,
   Rockville, MD 20854
   You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to
   200 Independence Ave, SW
   Washington, DC 20201
   1-877-696-6775
   www.hhs.gov/ocr/privacy/hipaa/complaints/
   We will not retaliate against you for filing a complaint.

Missed/Canceled Appointment Policy

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments. A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 48-hour notice. Please remember we reserved appointment times especially for you. Therefore, we request at least a 48-hour notice in order to cancel and reschedule your appointment. This will allow us the opportunity to better serve our patients and ensure we can accommodate everyone by offering your canceled time to others.

WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

If you are unable to keep your scheduled appointment time, please call our office at least 48-hours in advance in order to avoid a missed appointment fee of $100 for a consultation visit or $60 fee for a follow-up visit. This charge is not covered by your insurance carrier.

Release and Use of Health Information

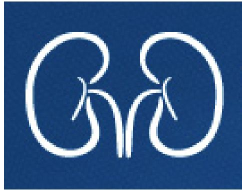
PATIENT AUTHORIZATION WAIVER FOR DISCLOSURE OF INFORMATION TO ANY WASHINGTON NEPHROLOGY ASSOCIATES ADMINISTRATIVE STAFF EMPLOYEE TO DISCUSS ANY MEDICAL CONDITION (S) WITH FAMILY MEMBERS OR DESIGNATED PERSON (S)

I am a patient of Washington Nephrology Associates, L.L.P. (WNA) and hereby authorize the support staff. I.e. secretaries, medical assistants, nurses, etc. to discuss my medical condition with the members of my family listed in the Registration Form.
The patient or the patient's legal representative must read the following statements:
A. I understand that the provision of health care and the payment of health care will not be affected if this form is not signed.
B. I understand that I may revoke this authorization at any time by notifying Washington Nephrology Associates in writing, but it will not affect any actions taken by Washington Nephrology Associates prior to receiving the revocation.
Please initial and sign on Registration Form

Patient Consent to the Use and Disclosure of Information

Washington Nephrology Associates, L.L.P. ("WNA") obtains and maintains health information relating to my past, present or future physical or mental condition, and provision of health care or payment for health care, referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by WNA for purposes of treatment, payment or health care operations, including, but not limited to:

- Planning for my care and treatment
- Calling me with appointment reminders and lab results
- Submitting a claim to my insurer or health plan
- Assessing the quality of care provided to me



WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

WNA'S Notice of Privacy Practices contains a more complete description of how my Protected Health Information may be used or disclosed and how I can obtain access to this information. I understand WNA reserves the right to change its Notice and practices and I can request a copy of its current Notice.
I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by WNA. WNA is not required to agree to my request but if WNA does agree, the requested restrictions will be binding on WNA.
I further understand that, at any time, I may revoke this consent in writing, except to the extent that WNA has already taken action in reliance on it.

USE OF TELEHEALTH FOR PHYSICIAN AND/OR CARE TEAM VISITS

By providing my consent, I agree to participate in telehealth visits with members of Washington Nephrology Associates team, including my physician and members of my physician's practice group, and if applies, members of dialysis unit (Care Team) during the term of the national/state (i.e. COVID-19 pandemic). I understand certain steps are being taken to reduce the risk of potential exposure and spread of the virus, including the option to receive health care services via telehealth visits when appropriate. Some portions of my care may be reasonably provided via telehealth instead of an in-person visit when my Care Team determines telehealth visits are appropriate for me. Reduced frequency of in-person visits may reduce my risk of potential exposure to the virus and may also help protect others. My Care Team will inform me if and when it is necessary to conduct an in-person visit. In such cases, my care team will follow all relevant policies, procedures, and infection control practices to reduce my risk of potential exposure I understand using telehealth services involves some increased risk that an unauthorized person may see, access, copy, or interrupt my personal information. I also understand there is some risk unencrypted electronic communications could be intercepted in transmission or misdirected to a third party not authorized to receive the information. I understand my Care Team may need to end, delay, or pause my telehealth session. I agree to cooperate with these interruptions and with directions given by my Care Team. I understand telehealth services are subject to the laws protecting the confidentiality of my medical information and my right to access that information. My Care Team will not share information obtained through telehealth if prohibited by federal or state law. I understand this consent will be effective until I am notified that this consent is no longer in effect because of resolution of the national and/or applicable state pandemic emergency. I may withdraw or revoke it at any time. I understand I have a right to receive a copy of this consent. I understand it is my choice to use telehealth visits and my decision to use, or not use, telehealth visits will not affect my right to future dialysis treatments. I understand my health benefits plan may not cover telehealth services and I may need to pay for telehealth visits, including copayments, co-insurance, or deductibles. I understand I am encouraged to discuss my telehealth service coverage with my health benefits plan.

WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

Medical Release Authorization and Insurance Assignment

I hereby authorize Washington Nephrology Associates to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above-named provider. I understand and agree that, regarding my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.
I request that payment of authorized Medicare benefits be made to Washington Nephrology Associates for any services rendered. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.
I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. I may revoke this authorization at any time in writing.
I authorize Washington Nephrology to release and/or send medical information regarding my case to other consulting and/or referring physicians.

Financial Responsibility Agreement

I understand that my insurance is a contract between me and the insurance carrier, and not between the insurance carrier and Washington Nephrology Associates, and that I am still fully responsible for all fees. Should timely payments of this account not be made, I authorize Washington Nephrology Associates to retain the services of an attorney and/or collection agency to assist with the collection of only outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility.

Email Disclaimer

WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

Washington Nephrology Associates (WNA) will use reasonable means to protect the privacy of your health information sent by email. However, because of the risks outlined below WNA cannot guarantee that email communications will be confidential. Additionally, WNA will not be liable if you or anyone else inappropriately uses your email. WNA will not be liable for improper disclosure of your health information that is not caused by WNA's intentional misconduct.

Email risks and your responsibility

At the discretion of the WNA, its staff, physicians and agents (WNA) and upon your agreement to the terms outlined within this consent form, you may use email to communicate with WNA. These emails may contain your personal health information. If you decide to use email to communicate with WNA, you should be aware of the following risks and/or your responsibilities:

1. As the Internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify email you send or are sent by WNA.
2. You must protect your email account, password and computer against access by unauthorized people.
3. Since email can be used to spread viruses, some which cause email messages to be sent to people who you do not intend to send email messages to, you should install and maintain virus protection software on your computer.
4. Since emails can be copied, printed and forwarded by people to whom you send emails, you should be careful regarding whom you send emails.
5. As your employer may claim ownership of, or the right to access, the email account issued to you by our email, you should avoid using an employer issued email account to communicate with WNA.

Conditions for the use of email

By consenting to the use of email with WNA, you agree that:
WNA may forward emails as appropriate for diagnosis, treatment, reimbursement, and other related reasons. As such, WNA staff members, other than the recipient, may have access to emails that you send. Such access will only be to such persons who have a right to access your email to provide services to you. Otherwise, WNA will not, otherwise, forward emails to independent third parties without your prior written consent, except as authorized or required by law.

1. Although WNA will try to read and respond promptly to your emails, WNA staff may not read your email immediately. Therefore, you should not use email to communicate with WNA if there is an emergency or where you require an answer in a short period of time.
2. If your email requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with WNA.

WASHINGTON NEPHROLOGY ASSOCIATES

Founded in 1984

3. You should carefully consider the risk of using email for the communication of sensitive medical
4. Information, such as, but not limited to, information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
5. You should carefully word your email messages, so the information provided clearly, yet briefly,
6. Describes the information you intend to convey. You should avoid writing long "chatty" emails.
7. You are responsible for correcting any unclear or incorrect information.
8. WNA reserves the right to save your email and include your email or information contained within your email in your medical record.
9. It is the patient's responsibility to follow up and/or schedule an appointment if warranted or recommended by WNA.
10. Emails may not be the only form of communication that WNA will use to communicate with you.
11. Additionally, WNA may decide that it is not in your best interest to continue to communicate with you by email. In such case, WNA will notify that it no longer intends to communicate with you by email.