Start Your Personalized Health Plan Today.

East Bay Nephrology Medical Group

Schedule Your Annual Health Assessment

It's easy. You can even speak to a nurse from the comfort of your home.

Medicare allows you to get an annual comprehensive health evaluation. And, it is no additional cost to you.

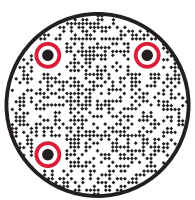
With flexible scheduling options, your nurse practitioner will perform an assessment designed for you to review your health and well-being goals. We will:

- Talk about your health conditions and needs
- Identify health problems and timely solutions
- Answer your health questions

Your nurse will share findings with your doctors to help you reach your goals. Keeping your health information confidential is a priority.

Don't wait. Schedule your health assessment today!
Call: 800-767-0063 (TTY 711), 7 a.m.–7 p.m., ET, Monday–Friday.

If we don't hear from you, we will call you to schedule. To learn more about VillageHealth, visit **www.VillageHealth.com**.



Consent Forms

East Bay Nephrology Medical Group

You make all your health decisions. We are here for support.

Keeping your personal health information confidential is a priority for Nightingale Clinical Care.

To start helping you, we need your consent to:

- Work closely with you and your doctors.
- Communicate with you by email or text.
- Access your medical records and share information with your other health care providers.

To fill out the form, you can either:

1. Use the paper form in this packet. Sign where you see the green arrows. Then mail it back (within 30 days) using the prepaid envelope.
2. Use the QR code to sign digitally.
3. To use the QR code:
   - Make sure your smartphone is connected to the internet.
   - Open the camera on your smartphone.
   - Select the rear-facing camera in Photo or Camera mode.
   - Hold your phone up to the QR code and keep it steady for a couple of seconds.
   - Tap the box that pops up to open the link.

Questions?

Call your kidney doctor or us at: 800-767-0063 (TTY 711), 7 a.m. - 7 p.m., Monday- Friday. These times are EST, or Eastern Standard Time.

QR code

Nightingale Clinical Care Consent Selections

Please complete the form and return to us. Questions? Call us at 1-800-767-0063

The following documentation details the permissions granted to Nightingale Clinical Care*. Please review the attached documents prior to completing this form if you have not done so already. Additional information regarding these consent selections can be found in the attached documents. You may change these selections and/or revoke your consent by speaking with your care team and requesting a new form to complete. Otherwise, these permissions will remain in place for the duration of your treatment, unless otherwise noted.

Digital Communication – You can make your selections for digital communication preferences below. You are responsible for the security of your personal email account and phone. You agree to notify Nightingale Clinical Care as soon as possible of any changes to your contact information. Please note that digital communications are not guaranteed secure. They are easier to intercept than standard mail and you should make yourself familiar with the associated risks before making these selections.

Email Address: _____

Phone: _____ **Mobile:** _____

By checking the boxes below, you agree to periodic communications from Nightingale Clinical Care via the methods selected.

- ☐ **Detailed Voicemails**
  (Detailed voicemails may include sensitive health information)
- ☐ **General Text Message Communications**
  (Appointment Reminders; General Updates; Educational Materials; Etc.)
- ☐ **Marketing Text Message Communications**
- ☐ **General Email Communications**
  (Appointment Reminders; General Updates; Educational Materials; Etc.)
- ☐ **Marketing Email Communications**

Notice of Privacy Practices – By signing below you acknowledge that you have received our Notice of Privacy Practices detailing our use, access, and storage of your personal health information. By signing below, you attest that you have reviewed the terms and conditions set out in the corresponding documents and give your informed consent to the terms and conditions as they relate to your health information and communication preferences.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Personal Representative Signature Date

☐ I am signing this form on behalf of a patient. I represent that I am the legal parent/guardian/personal representative of the patient named above. (Proof of legal representation is required if you are acting as a personal representative or court appointed guardian).

Nightingale Clinical Care is a California-based health care provider. Nightingale Clinical Care operates as a professional corporation in California that employs nurse practitioners. Nightingale Clinical Care is engaged with your insurance provider to provide you with dedicated care services. As the Management Service Organization for NCC, VillageHealth DM, LLC, dba: DaVita Integrated Kidney Care, assists NCC with administrative activities. By providing your consent to the terms in this documentation you also provide your consent to Nightingale Clinical Care's affiliated entities, including but not limited to, VillageHealth.

Authorization to Obtain Protected Health Information

Please complete the form and return to us. Questions? Call us at 1-800-767-0063

1. **PATIENT NAME (Last, First, MI)**:_____ DOB: ____/____/____

I authorize any healthcare provider, insurance company, or other medically related facility to release the following information to any authorized employee of Nightingale Clinical Care* for review and/or copy to be used for continuing medical care under Nightingale Clinical Care disease management program:

☒ **My entire medical record for all dates of service.**

I understand that information regarding the following conditions require an additional written authorization:

- HIV or AIDS
- Alcohol, drug, or substance use
- Mental/Behavioral health
- Sickle cell anemia

2. I understand I am not required to sign this form and that my treatment, payment, enrollment, or eligibility for benefits is not dependent upon signing this form. However, if I do not sign this form my information may not be disclosed to Nightingale Clinical Care.

3. I understand that if a non-healthcare provider, or non-health plan, receives my health information, federal privacy laws may no longer apply.

4. I understand that Nightingale Clinical Care is a healthcare provider and complies with all federal privacy laws related to my health information.

5. I understand I have the right to revoke this authorization at any time, except in regard to information that has already been released pursuant to this authorization.

6. You can revoke this authorization by writing to your Nightingale Clinical Care team or the Privacy Office at privacy@davita.com.

7. This authorization will expire 10 years from the date of signature. **Unless, you live in Maine, in which case it will expire in 30 months or Maryland, in which case, this authorization will expire in 1 year.**
A photocopy is as valid as the original. This form supersedes any and all previously completed.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Personal Representative Signature Date

☐ I am signing this form on behalf of a patient. I represent that I am the legal parent/guardian/personal representative of the patient named above. (Proof of legal representation is required if you are acting as a personal representative or court appointed guardian).

Nightingale Clinical Care is a California-based health care provider. Nightingale Clinical Care operates as a professional corporation in California that employs nurse practitioners. Nightingale Clinical Care is engaged with your insurance provider to provide you with dedicated care services. As the Management Service Organization for NCC, VillageHealth DM, LLC, dba: DaVita Integrated Kidney Care, assists NCC with administrative activities. By providing your consent to the terms in this documentation you also provide your consent to Nightingale Clinical Care's affiliated entities, including but not limited to, VillageHealth.

Permission to Discuss Health Information with Other Individuals

Please complete the form and return to us. Questions? Call us at 1-800-767-0063

If you would like to designate a family member or other individual that we may discuss your medical treatment, payment, and/or condition with, list them below including their name, relationship to you, and contact information.

Name	Relationship	Phone Number
1.		
2.		
3.		
4.		
5.		

I understand that Nightingale Clinical Care may still share my information with my family and friends or others if I am incapacitated or not present and Nightingale Clinical Care determines, that it is in my best interest or necessary for my care and/or payment for the health care services I have received. By completing this form I revoke all previously completed permission to discuss forms.

Disclosures

You may revoke or change this list of people at any time by requesting and completing a new form or speaking with your care team. A revocation or change to this list is only effective in regard to future disclosures following the revocation or change. This authorization/permission form will remain in effect for ten (10) years, unless you live in Maine, in which case this form will expire in 30 months or Maryland, in which case, this form will expire in 1 year. In no circumstance will this form remain in effect after your treating relationship with Nightingale Clinical Care has ended or you revoke this form.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Personal Representative Signature Date

☐ I am signing this form on behalf of a patient. I represent that I am the legal parent/guardian/personal representative of the patient named above. (Proof of legal representation is required if you are acting as a personal representative or court appointed guardian).

NOTICE OF PRIVACY PRACTICES

EFFECTIVE AS OF JAN. 01, 2023

THIS 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.

This notice covers Nightingale Clinical Care, PC*. If you have questions or concerns, please contact your clinic or our Privacy Office using the contact information provided at the end of this document.

OUR PRIVACY COMMITMENT

Nightingale Clinical Care is committed to respecting and protecting patient privacy, which includes explaining how we use and manage your health information, as well as what rights and choices you have related to that information. We hope this summary of your rights, including your choices and our responsibilities, helps you to understand how we follow the law and respect your privacy. We are providing you with this notice, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a health care provider, HIPAA requires Nightingale Clinical Care to respect and protect patient 'protected health information' (or, "PHI"), and requires us to be transparent with you regarding our practices concerning our collection, use and sharing of PHI obtained from or about you. HIPAA also requires us to make you aware of your privacy rights, including your ability to exercise your choice (i.e., "consent," also referred to as an "authorization") and provide your permission for us to collect, use, or share your PHI.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your privacy rights and our responsibilities to help you. Unless otherwise specified, you may exercise the rights listed below by contacting us.

View your health information

- You can ask to see the health information we have about you or request a copy of your medical record.
- If we are unable to fulfill your request, we will tell you why in writing.

Ask us to correct your medical record

- You can ask us to correct your health information about you that you think is incorrect or incomplete.
- We may reject your request, but we'll tell you why in writing.

Request confidential communications

- You can ask us to contact you in a specific way *(Ex: home or office phone)* or to send mail to a different address to enhance your privacy.
- We will work to accept all reasonable requests.

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.
- There are some instances where we will not agree to your request. *Ex: We may deny your request if your request would negatively affect your care.*
- If you pay for a healthcare service out-of-pocket, you can ask us not to share the information pertaining to that service or item with your health insurer for the purpose of payment or our operations. We will work to accept this request unless an applicable law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (also referred to by HIPAA as an "accounting") of the times we've shared your health information, who we shared it with, and why. We can provide a list of these details over the six (6) years prior to your request. We will include all the disclosures except those made for treatment, payment, and health care operations, and certain other disclosures. We'll provide one (1) accounting in a calendar year for free but will charge a reasonable, cost-based fee if you ask for others within twelve (12) months.

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.

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.

Nightingale Clinical Care is a California-based health care provider. Nightingale Clinical Care operates as a professional corporation in California that employs nurse practitioners. Nightingale Clinical Care is engaged with your insurance provider to provide you with dedicated care services. As the Management Service Organization for NCC, VillageHealth DM, LLC, dba: DaVita Integrated Kidney Care, assists NCC with administrative activities. By providing your consent to the terms in this documentation you also provide your consent to Nightingale Clinical Care's affiliated entities, including but not limited to, VillageHealth.

File a complaint if you believe your rights are violated

- If you believe we have violated your privacy rights described in this Notice of Privacy Practices, you can complain by contacting the Nightingale Clinical Care Privacy Office at privacy@davita.com, or by calling **(855) 472-9822**, or writing to: **DaVita, Privacy Office, 2000 16th St., Denver, CO 80202**.
- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775, or sending a letter to 200 Independence Ave. SW, Washington, DC 20201.
- We will not retaliate against you for filing a complaint or making us aware of any HIPAA complaints or grievances.

Information We Collect

We collect from or about you individually identifiable personal information, including PHI as defined by HIPAA that is collected at our clinics, and other personal information that we may obtain from you or other sources such as our DaVita.com website and third-party partners and service providers that you may have interacted with. We will combine the information we obtain from or about you from such sources. For additional information and examples of the types of individually identifiable personal information we collect, please review our DaVita.com Privacy Policy, available at: https://www.davita.com/privacy-policy.

YOUR CHOICES

For certain health information, you can tell us your choices about what we use or share. If you prefer how we use or share your information in the situations described below, talk to us. Tell us what you want us to do, and we will work with you to understand your request and determine how we can follow your instructions.

You have both the right and choice to permit or prohibit us from:

- Using or sharing information with your family, close friends, or others involved in your care. *Ex: If you are not able to tell us your preference. Ex: you are unconscious, we may use or share your information if we believe it is in your best interest.*

We require your written permission before we:

- Use or share your information for marketing purposes, except in limited circumstances.
- Share your psychotherapy notes, except in very limited circumstances.

- **In the case of fundraising:**
  We may contact you for fundraising efforts, but you can tell us not to contact you again for fundraising reasons.

In the case of highly confidential information:

When required by state or federal law, we apply additional privacy protections for certain information about you such as: HIV testing, substance use, and mental health. Unless permitted or required by law, we will obtain your permission before collecting, using or sharing that information.

Health Information Exchanges (HIE): We may share and access your health information electronically with other health care organizations through a Health Information Exchange (HIE), for treatment, payment, and health care operations.

- If your state requires an affirmative opt-in consent to participate in the HIE, you will be provided with an opt-in form to review, sign, and return. In other states, you can simply choose not to have your health information shared through any of our HIE networks at any time (i.e. “opt-out”).
- To “opt-out” from your health information being shared and accessed in a HIE, you may contact your care team. Even if you decide to opt-out, there may still be instances where your health information is shared through the HIE as required by state law. Additionally, your health information can continue to be shared through other means, such as fax or mail, pursuant to state and federal law.
- If you previously opted-out and now want to opt back in, you may do so at any time by contacting your Nightingale Clinical Care team.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treating you

We can use your health information and share it with other health care professionals who are treating you. *Ex: treatment may include interdisciplinary conferences with team members from Nightingale Clinical Care and support care teams from other facilities involved in your care and treatment or other providers who may be able to provide information or insight in the development and coordination of your plan of care.*

Billing for your services

We can use and share your health information to bill and receive payment from health plans or other entities. *Ex: We give information about you to your health insurance plan so it will pay for your services.*

Running our organization (also known as Health Care Operations)
We can use and share your health information to run our facilities, improve your care, and contact you when necessary. *Ex: We use your information in connection with other information we have to learn more about our patients so we can improve the treatment we provide.*

How else can we use or share your health information?
We are allowed, and sometimes required, to use or 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 certain conditions in the law before we can share your information for these purposes.

Helping with public health and safety issues
We can use and share health information about you for certain purposes such as:
- Preventing disease
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Ensuring the safety of a workplace

Conducting clinical research
We can use or share your information for health research if you have authorized it or if an Institutional Review Board/Privacy Board has granted the researcher a Waiver of Authorization

Complying with the law
We will share information about you if required by state or federal laws, including when the Department of Health and Human Services wants to see that we are complying with federal privacy law.

Responding to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Working with a coroner, medical examiner, or funeral director
We can share health information with a coroner, medical examiner, or funeral director so they can carry out their duties.

Addressing workers' compensation, law enforcement, and other government requests, we can use or share health information about you:
- For workers' compensation claims to the extent authorized by state law
- For law enforcement purposes or to a law enforcement official if required;
- With health oversight agencies for activities authorized by law; or
- For special government functions such as prisons, military, national security, and protective services for the President of the United States.

RESPOND TO LAWSUITS AND LEGAL ACTIONS:
We can share health information about you in court or an administrative proceeding, or in response to a legal order, after certain requirements have been met.

Our Responsibilities
- We are required by law to maintain the privacy and security of your PHI.
- We will let you know if the privacy or security of your information was compromised.
- 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. You may change your mind at any time.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes may apply to all health information we have about you. The new notice will be available in our offices, on our website and upon your request.

Contact Information
Nightingale Clinical Care Privacy Office: 2000 16th St., Denver, CO 80202, privacy@davita.com, (855) 472-9822.

Patient Activation

(also known as Patient Activation Measure)

East Bay Nephrology Medical Group

This confidential, 5-minute survey, called the **Patient Activation Measure**, helps your kidney doctor and VillageHealth team better understand your needs and how to help you. Once we receive your completed survey, we will review it with your kidney doctor and you. Together, we will make health goals and an action plan to reach them.

Once your survey is complete, please return it to your kidney doctor or mail it with the prepaid envelope.

When taking the survey:

- Be truthful
- Do not let what others think or say affect your answers
- Know that there are no right or wrong answers, and it is OK to disagree with a statement

Questions?

Call your kidney doctor or VillageHealth: 800-767-0063 or TTY #711 (7 a.m. to 7 p.m., Monday through Friday). These times are EST, or Eastern Standard Time.

East Bay Nephrology Medical Group

Name: _____
Date of birth: _____
Medicare #/ID: _____
Today's date: _____
Practice name: _____

Below are statements people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally.

Circle the answer that is most true for you today. If the statement does not apply, select N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my own health care is the most important thing that affects my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I am confident I can help prevent or reduce problems associated with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I know what each of my prescribed medications do.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I am confident that I can follow through on medical treatments I may need to do at home.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I understand my health problems and what causes them.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I know what treatments are available for my health problems.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11.	I know how to prevent problems with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12.	I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13.	I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Insignia was acquired by Phreesia in late 2021 and is now operating fully as Phreesia.

Emotional Health

(also known as Patient Health Questionnaire)

East Bay Nephrology Medical Group

This confidential, 5-minute survey, called the Patient Health Questionnaire, helps your kidney doctor and Village Health team understand if there are any ways we can help you with emotional support.

Once your survey is complete, please return it to your kidney doctor or mail it with the prepaid envelope.

When taking the survey:

- Be truthful
- Do not let what others think or say affect your answers
- Know that there are no right or wrong answers, and it is OK to disagree with a statement

Questions?

Call your kidney doctor or VillageHealth: 833-820-0842 (11 a.m. to 7 p.m., Monday through Friday). These times are EST, or Eastern Standard Time.

East Bay Nephrology Medical Group

Name: _____
Date of birth: _____
Medicare #/ID: _____
Today's date: _____
Practice name: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.