CDC
Centers for Dialysis Care

Notice of Privacy Practices

Effective June 2020

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 describes our legal duties and privacy practices with respect to your health information. CDC is committed to keeping your health information private, and we are required by law to respect your confidentiality, and to notify affected individuals following a breach of unsecured health information. This Notice also describes certain rights you have with respect to your health information.

This Notice applies to all health information that identifies you and the care you receive at CDC facilities. "Health information" basically means information (whether created or received by us) that relates to: (i) your past, present, or future physical or mental health condition; (ii) the provision of healthcare to you; or (iii) the past, present, or future payment for the provision of healthcare to you. Health information may consist of paper, digital or electronic records, but could also include photographs, videos and other electronic transmissions or recordings that are created during your care and treatment.

We reserve the right to change our privacy practices and to make the new provisions effective for all health information we maintain. You may get a copy of any revised notices at the facility or office where you receive your healthcare or by mailing a request to the Facility/Office Manager at the facility or office where you receive your healthcare.

Centers For Dialysis Care ("CDC") And Affiliated Facilities

All of CDC's dialysis facilities, employed physicians, physician offices and affiliated facilities follow the terms of this Notice. A complete list of these facilities and locations can be found at www.cdcare.org/our-facilities

If your individual physician is not an employed physician of CDC, your physician will likely provide you with his or her own privacy notice that describes their office practices.

How CDC Can Use Your Health Information Without Your Consent

We use and disclose your health information for many reasons. In many cases, we have the right to use and/or disclose your health information without your prior consent or authorization. The following categories describe the manner in which we can disclose or use your health information without your consent, although the categories below do not describe every permitted use or disclosure:

Uses and Disclosures for Treatment, Payment and Healthcare Operations:

For Treatment:

We will use and disclose your health information to provide, coordinate or manage your healthcare and related services. For example, information provided to a nurse will be disclosed to the treating physician so that the physician may better treat you. We may use or disclose your health information to reschedule treatments, follow-up on missed treatments or discuss your dialysis treatment. Healthcare providers will also record actions taken by them in the course of your treatment and note how you responded to the treatment. This information may be disclosed to other healthcare providers who give you treatment or evaluation and to outside healthcare providers such as laboratories or radiology.

For Payment:

We may use or disclose your health information to bill and collect payment for your healthcare services. For example, a bill containing health information may be sent to an insurance company or to a federal healthcare program such as Medicare.

Healthcare Operations: We may use or disclose your health information for operational purposes. In addition, we may use your information to evaluate the performance of our staff, assess the quality of our care, assess outcomes in your case and similar cases, and learn how to improve our facilities and services. Unless you have advised otherwise, we will also share your data to facilitate care across various sites where you may be obtaining care.

Public Interest and Benefit Disclosures:

Required by Law: We may use or disclose your health information as required by law.

Public Health: We may use or disclose your health information for public health activities such as reporting disease, injuries, births and deaths to public health authorities or other legal authorities; for required public health investigations; to report to the Food and Drug Administration adverse events, product defects, or to participate in product recalls.

Victims of Abuse, Neglect or Domestic Violence: We may use or disclose your health information for reporting suspected child abuse or neglect; or if you may be a victim of abuse, neglect, or domestic violence.

Judicial and Administrative Proceedings: We may use or disclose your health information pursuant to a court or administrative ordered subpoena or discovery request.

Health Oversight Activities: We may use or disclose your health information for government health oversight activities. For example, disclosures may be made to the Secretary of Health and Human Services (HHS) for HIPAA rules compliance and enforcement purposes (audits, investigations, legal proceedings).

Health and Safety: We may use or disclose your health information to avert a serious threat to the health or safety of you or any other person.

Law Enforcement Purposes: We may use or disclose your health information to report wounds, injuries and crimes to law enforcement officials.

Upon Death, Funeral Directors and Coroners: We may disclose your health information to funeral directors or coroners to enable them to carry out their lawful duties.

Organ or Tissue Donation or Transplant: We may use or disclose your health information for arrangement of an organ or tissue donation from you or a transplant for you.

Research: We may use your health information for research purposes when the research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information and waived the requirement to obtain your authorization.

Government Functions: We may use or disclose your health information for specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers' Compensation: We may use or disclose your health information in order to comply with the laws, regulations and requirements related to workers' compensation.

Other Permitted Uses And Disclosures By CDC — Made With Your Consent

For uses and disclosures other than for treatment, payment, healthcare operations, and disclosures for public benefit or interest, we are required to have your written authorization to disclose your health information. Upon becoming a patient at CDC, you will be asked to sign a consent form allowing CDC to use your health information only as described in this (or the then current) Notice of Privacy Practices. You have the right to revoke an authorization at any time except that it will not apply to actions we have already taken by relying on the authorization. Your request to revoke an authorization must be in writing and must be given or mailed to the facility or office manager at the facility or office where you received your healthcare.

Based on your signing of the consent form, below are the additional types and uses and disclosures of your health information that CDC is permitted to make:

Others Involved in Your Healthcare:

Unless you object, we may use or disclose your health information to a member of your family, a relative, a close friend or any other person you identify if that information directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine it to be in your best interest based on our professional judgment. We may use or disclose your information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location, general condition or death. In some cases, CDC may also disclose your health information to parties involved in disaster relief to help them find your family member or other persons involved in your care or paying for your care.

Facility Directories:

We will include your name in our facility directory while you're a CDC patient. In addition, we may announce your name at the reception area so that the patient care staff will know that you have arrived for your treatment.

Business Associates:

As part of the services CDC provides, it sometimes seeks the help of outside persons or businesses. For example, we may use third parties to perform billing and collection services for us and they may be provided access to your health information in order to provide those services. We also may disclose your health information to advisors, including attorneys, accountants and other consultants to perform audits, advise us on operational issues, or to assist in strategic or other planning and evaluation activities. Before we give out any health information to these outside parties, we require them to protect the privacy of your information.

Health Information Exchanges:

CDC participates in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. CDC, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or

other healthcare operations. You have the right to opt out of the Health Information Exchanges by notifying CDC of your desire to do so.

Authorizations For Other Uses And Disclosures

Except for the uses and disclosures specifically described above, we will not use or disclose your health information for any other reason without your written authorization. For example, most users and disclosures of psychotherapy notes, uses and disclosure of health information for certain marketing purposes, and disclosures that constitute a sale of health information require your written authorization. In addition, Ohio law requires that we obtain your consent for any disclosures of the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition, drug or alcohol treatment that you have received as part of a drug or alcohol treatment program, or mental health services that you have received. If you give CDC such authorization, you may revoke the authorization in writing at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

Your Rights Regarding Your Health Information

Right to Inspect and Copy Your Health Information:

You may inspect and get a copy of your health information for as long as we retain the information. CDC has the right to charge its reasonable costs for copying and for postage. Your right to obtain and copy health information may be limited. For example, you may not inspect or copy notes from psychotherapy sessions or information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding. Your request must be in writing and must be given or mailed to the facility or office manager at the facility or office where you received your healthcare. You can get a form for making the request from the facility or office manager. CDC must act on information requests within 30 days of receiving such request.

To Request a Restriction on Certain Uses and Disclosures of Your Health Information:

You may request restrictions on certain uses and disclosures of your health information for the purposes of treatment, payment or healthcare operations. CDC may not be able to agree to your request but will review it and if it considers it appropriate allow the restriction. CDC may stop the restriction at any time by giving you written notice. Your request must be in writing and must be given or mailed to the facility or office manager where you received your healthcare. You can get a form for making the request from the facility or office manager. Your request must specifically describe what information you would like to restrict and to whom you would like the restriction to apply.

To Request to Receive Confidential Communications by a Different Means or at a Different Location:

You have the right to ask and we will allow reasonable requests to receive communications about your health information from us in a different way or at a different place. This request may be conditioned on the receipt of additional payment information or clarification. Your request must be in writing and must be given or mailed to the facility or office manager at the facility or office where you received your healthcare. You can get a form for making the request from the facility or office manager. Unless you ask us in writing otherwise, we will leave messages at the phone number, and send information related to your care to the address, which we have listed for you.

To Amend your Health Information as Provided:

If you believe your health information is incorrect or incomplete, you may ask us to change it. Your request needs to describe why you believe the information is incorrect or incomplete. If we do not agree to change your information, we will give you a reason for our denial of your request, and you can disagree. Your request must be in writing and must be given or mailed to the facility or office manager at the facility or office where you received your healthcare. You can get a form for making the request from the facility or office manager.

Right to Receive Notice:

You may request to receive this Notice by email, withdraw such a request, by contacting the facility or office manager at the facility or office where you received your healthcare. You have the right to receive a copy of this Notice on paper even if you have

requested the Notice by e-mail or in some other electronic transmission. You can ask for a copy of this Notice from a facility staff member.

To Receive an Accounting of Certain Uses and Disclosures of your Health Information:

You have a right to get an accounting of certain disclosures CDC makes of your health information. The right to receive this information is subject to certain exceptions, restrictions and limitations. To get this accounting, you must sign and fill out a written Accounting Request Form (CC3.13) that you can get from the facility or office manager. Your request must be given or mailed to the facility or office manager at the facility or office where you received your healthcare.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with CDC's Privacy Officer by utilizing the Patient Privacy Complaint Form (CC3.16). You can get the complaint form from the facility or office manager at the facility or office where you received your healthcare. CDC will review your complaint and respond to you. You may also file a complaint with the Department of Health and Human Services in writing within 180 days of a violation of your rights at Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL, 60601. You will not be retaliated against for filing a complaint.

For Further Information

If you have any questions about this Notice, you can talk to CDC's Privacy Officer directly by calling 216-658-0456.

CDC
Centers for Dialysis Care

Consents, Assignments And Authorizations

1. CONSENT FOR TREATMENT. The undersigned hereby authorizes and specifically consents to Community Dialysis Center d/b/a Centers for Dialysis Care and its related entities and providers (collectively, "CDC"), and the members of the CDC medical staff, to provide the undersigned dialysis treatment and any other treatment made necessary by the procedure itself, including emergency care. I understand that in order to be treated at CDC, I must be under the care of a physician on the CDC medical staff. Should my relationship with my physician end, I recognize I must obtain care from another physician on the CDC Medical Staff or arrange to obtain dialysis at a facility other than a CDC facility.

The procedure of routine dialysis, its necessity and complications have been explained to me by my physician. In the case of hemodialysis, I understand that the process involves cleaning my blood by pumping it through a device that will remove wastes and excess fluids. I understand that hemodialysis involves, among other things, the insertion of tubes and/or needles into my veins or fistula or through a catheter and the use of artificial kidneys to filter my blood. In the case of peritoneal dialysis, I understand the process involves the introduction of a special fluid into my peritoneal cavity (abdomen) at a frequency prescribed by my physician, typically seven days a week. I understand that the fluid is left in my abdomen for a set period of time to absorb certain impurities and other chemicals from my blood. Once the impurities are absorbed, the fluid is drained out of my abdomen.

I also understand that, in addition to peritoneal or hemodialysis treatment, I may need laboratory tests, radiology and surgical procedures to assure adequate function of the equipment and effectiveness of the treatment.

I also acknowledge that the purpose of dialysis has been explained, as well as the risks and consequences associated with dialysis, some of which can be potentially life threatening.

I understand that the success of dialysis, and the avoidance of complications, depends, in part, upon my compliance with the entire treatment regime, including following certain dietary restrictions, and consistently taking the medication prescribed by my physician. In addition, I understand that the frequency of my dialysis, as prescribed by my physician, and in the case of hemodialysis, the length of time I remain on the hemodialysis machine, are both critical to the success of the dialysis.

This consent is for regular and repeated dialysis treatments, unless I specifically revoke this consent.

I understand that regular dialysis does not guarantee me a general sense of well-being. I understand that dialysis treatments are life-sustaining procedures but they are not a cure for kidney failure.

I understand quality improvement is an essential part of normal healthcare operations and I consent to a reasonable level of cooperation with ongoing quality improvement activities.

I understand and agree to abide by the patient care policies as outlined in the patient orientation handbook.

I have been oriented to my responsibilities for contributing to a safe environment including CDC's healthcare team agreement and discharge policies. I understand that dialysis may not be initiated if I am under the influence of drugs or alcohol.

I understand that should I choose to have a DNR order; the order will not be valid unless confirmed by a member of CDC's medical or affiliate staff.

I certify that I have received a copy of the Patient's Rights and Responsibilities and the Grievance Procedure and that they have been reviewed with me.

2. FINANCIAL RESPONSIBILITY. I understand and agree that, to the extent not covered by Medicare, Medicaid or private commercial insurance (including applicable copays and deductibles), I will be responsible for and shall pay for all the dialysis and other services and supplies provided to me by CDC, members of the CDC staff and other providers who provide supplies and/ or services to me incident to my treatment including outside laboratories and pharmacies.

I understand it is my responsibility to obtain Medicare Part B coverage or other co-insurance through a private carrier.

I agree to inform CDC of all health insurance programs and policies from which I receive direct payment for

dialysis or other services in connection with the treatment of my kidney disease. In the event I receive payments directly from any health insurance program for dialysis services provided by CDC, I will promptly pay CDC such amounts and/or endorse such payments over to CDC.

I agree to fully cooperate with CDC and its staff in connection with obtaining coverage for the dialysis and other services provided by CDC, and all other all financial related matters.

I certify that I have provided CDC with true and accurate information regarding all financial matters.

3. ASSIGNMENT OF BENEFITS. I hereby assign to CDC any and all benefits payable by Medicare, any insurance or healthcare plan or other third party as a result of charges incurred by me for services rendered by CDC. I also assign to CDC any and all contractual rights I may have against insurance company, healthcare benefit plan or any other third party liable to me for payment of CDC's charges, and I authorize CDC to represent me in any appeal process or claim denial appeal in order to collect payment from the appropriate insurance company or other responsible party.

4. CONSENT TO USE AND DISCLOSE HEALTH INFORMATION I hereby acknowledge receipt of CDC's Notice of Privacy Practices that describes CDC's uses and disclosures of health information. By signing this document, I hereby consent to CDC's use and disclosure of my protected health information in accordance with the Notice of Privacy Practices.

This consent to use and disclose my protected health information shall be valid for the duration of my treatment by CDC, unless earlier revoked by me in writing in accordance with the Notice of Privacy Practices. Any action taken by CDC in reliance on this consent prior to the expiration or revocation of this consent shall be deemed to be approved and agreed to by the undersigned pursuant to this consent.

5. LANGUAGE BARRIER. This Consents and Authorizations form was explained to me by the social worker or nurse. [ ] I did not need an interpreter because I can read or speak English or [ ] I need an interpreter which was provided by CDC.

My signature indicates acknowledgment and agreement to the foregoing consents, assignments and authorizations.

Patient Name (printed) Patient Signature Date

Signature of Insured (Required only if different from patient)

Witness to Signature

If the patient is a minor or otherwise unable to consent, complete the following:

The Patient is (a minor _____ years of age) or (unable to consent because):

Printed Name of Responsible Party Signature of Legal Guardian/Responsible Party Legal Guardian

Authority of Legal Guardian/Responsible Party to act for Patient Date

Witness

Related Documents:

- Notice of Privacy Practices
- Patient Orientation Handbook (Includes: Patient Rights & Responsibilities and Grievance Procedures)