Dear Patient,

Thank you for selecting The Centers for Kidney Care for your nephrology needs. We have built a practice that is founded on the care and support of our patients.

In order to serve you better, please **complete and sign the Patient Information forms before your visit and bring them with you to your appointment**. The forms should be completed with your name as it appears on your insurance cards.

We ask that you bring all insurance cards (i.e. Medicare, Medicaid, Insurance cards) and referral information with you to each of your appointments, as well as picture identification. We participate in many insurance networks; however, it is the patient's responsibility to ensure we are in network for your coverage.

All patients are required to pay their deductible, copay or co-insurance amount at the time of service. For your convenience, we accept cash, credit/debit cards (MasterCard, Visa or Discover) and personal checks. Payment arrangements are available for patients who do not have insurance. Please call our office to discuss this option.

Please bring all current medications in their original bottles to each appointment.

The entire team at The Centers for Kidney Care will strive to make your visit with us informative and as pleasant as possible. We truly appreciate the confidence you have placed in us and look forward to meeting you and sharing in your healthcare needs.

Sincerely,

The Centers for Kidney Care

The Centers for Kidney Care

Patient Information Form

DATE _____

Patient's Name _____ Home Phone _____

Address 1 _____ Work Phone _____

Address 2 _____ Cell Phone _____

City _____ State _____ Sex: Male Female

Zip Code _____ County _____ Date of Birth _____

Social Security No. _____

Employer _____ Email Address _____

Employer's Address _____ **Marital Status** Single Married Divorced Widowed Separated

City _____ State ___ Zip _____ **Employment** Full time Part Time Not Employed Self-Employed Retired Military Duty

Primary Care Physician _____ **Student** Full Time Part Time Not a Student

PCP's Phone Number _____

Emergency Contact _____ Home Phone _____

Address _____ Work Phone _____

City _____ State ___ Zip _____ Cell Phone _____

Sex: Male Female Relationship _____ Date of Birth _____

Primary Insurance

Insurance Company _____

Policy Holder's Name _____

Relationship to Patient: Self Spouse Parent

Certification Number _____

Group Name _____ Group Number _____

Secondary Insurance

Insurance Company _____

Policy Holder's Name _____

Relationship to Patient: Self Spouse Parent

Certification Number _____

Group Name _____ Group Number _____

Race White Black/African American Asian Native Hawaiian or Other Pacific Islander American Indian/Alaska Native Decline to Specify

Ethnicity Hispanic/Latino Not Hispanic/Latino Unreported/Refused to Report

Language English Spanish Other _____

The Centers for Kidney Care

ENCOUNTER FORM

REVIEW OF SYSTEMS Check only those that apply

Patient Name _____

Constitutional	___ Fever	___ Fatigue
	___ Weight Gain	___ Chills
	___ Weight Loss	___ Weakness
HEENT	___ Vision Impaired	___ Sinus Problems
	___ Eye Pain	___ Sore Throat
	___ Redness	___ Nose Bleeds
	___ Color Blindness	___ Headache
	___ Double Vision	___ Hoarseness
	___ Hearing Loss	___ Tinnitus
	___ Ear Pain	___ Vertigo
Respiratory	___ Shortness of Breath	___ Cough
	___ Shortness of Breath at Rest	___ Wheezing
	___ Shortness of Breath with Activity	___ Blood in Sputum
	___ Pain with Breathing	___ Night Sweats
Cardiovascular	___ Chest Pain	___ Orthopnea
	___ Palpitations	___ Edema
	___ Claudication	___ PND - Wake up at Night Short of Breath
Gastrointestinal	___ Abdominal Pain	___ Constipation
	___ Nausea	___ Anorexia
	___ Diarrhea	___ Trouble Swallowing
	___ Heartburn	___ Indigestion
	___ Vomiting	
Genitourinary	___ Urinary Urgency	___ Urinary Hesitancy
	___ Urinary Burning or Pain	___ Foamy Urine
	___ Blood in Urine	___ Incontinence
	___ Urinary Frequency	___ Nocturia - Wake up at Night to Urinate
Musculoskeletal	___ Back Pain	___ Muscle Pain
	___ Neck Pain	___ Arm Weakness
	___ Joint Pain	___ Leg Weakness
Skin	___ Rash	___ Dryness
	___ Itching	___ Color Change
	___ Scaling	
Neurological	___ Numbness	___ Tingling
	___ Tremors	___ Fainting
	___ Seizures	
Psychiatric	___ Depression	___ Anxiety
	___ Insomnia	
Endocrine	___ Heat Intolerance	___ Excessive Thirst
	___ Cold Intolerance	___ Excessive Urination
Hematology	___ Bleeding Gums	___ Easy Bruising
Immuno/Allergy	___ Seasonal Allergies	___ Hives
Other	_____	

Physician Notes

Please check if any blood relative has had:

Disease	Mother	Father	Sibling	Children
Kidney Disease				
Diabetes				
Stroke				
Heart Disease				
Heart Attack				
Hypertension				
Cancer				
Thyroid				
Tuberculosis				

Date of Last Flu Shot: _____

Date of Last Pneumonia Shot: _____

Do you have a Medical Power of Attorney? _____ Yes _____ No

If yes, who is your healthcare agent or surrogate decision maker? _____

Please bring your Medical Power of Attorney to your next visit.

SOCIAL HISTORY

Marital Status: Please Circle

Married Single Divorced Separated Widowed

Occupation: _____

Coffee _____ Cups Per Day

Tea _____ Cups Per Day

Soft Drinks _____ Per Day/Per Week

Beer _____ Per Day/Per Week

Alcoholic Beverages _____ Per Day/Per Week

Do you smoke? _____Yes _____ No

If you did smoke, date you quit _____

Cigarettes _____ packs/day for _____ years

Do you smoke a pipe/cigar? _____Yes _____ No

Do you use smokeless tobacco? _____ Yes _____ No

Do you take any of the following:

Advil/Aleve ___ Yes ___ No

NSAIDS ___ Yes ___ No

Ibuprofen ___ Yes ___ No

Herbal Supplements ___ Yes ___ No

The Centers for Kidney Care

Patient Medical History Form

Patient Name _____ Birthday _____

Referring Doctor's Name _____

Chief Complaint that brings you here _____

MEDICATION LIST

Current medications, dosage and frequency. Include over-the-counter medications.		BRING all medications with you to your appointment.
1	6	
2	7	
3	8	
4	9	
5	10	

ALLERGIES

Please list any allergies to any medication, food, x-ray dye, etc.

ILLNESSES

Please note if you have or had any of the following:

	When		When		When
___ Sugar Diabetes	_____	___ Asthma	_____	___ Prostate Problems	_____
___ Kidney Stones	_____	___ Hepatitis	_____	___ Kidney / Bladder Infections	_____
___ High Blood Pressure	_____	___ Bladder Problems	_____	___ Other Major Illness	_____
___ Tuberculosis	_____	___ Heart Disease	_____		

SURGERIES

Please list previous surgeries and date.

Family History	Living		Deceased	
	Age	Health	Age	Cause of Death
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Husband/Wife				
Children				
Children				
Children				
Children				
Children				

The Centers for Kidney Care
Patient Authorization

Assignment of Benefits

_____ I certify that the information I have provided in applying for payment of Medicare/ Medicaid Insurance benefits are correct. I irrevocably assign benefits to The Centers for Kidney Care for the payment of services rendered. I understand it is my responsibility to comply with all pre-certification requirements and that I am responsible for any health insurance co-payments, co-insurance and deductibles.

Financial Responsibility

_____ I understand that insurance coverage is not a guarantee of payment and I agree that **I am ultimately responsible for the payment of services** rendered at The Centers for Kidney Care. I will honor the clinic's financial policy. If I cannot pay in full at the time of services, I agree to set up payment arrangements until my debt with The Centers for Kidney Care is paid in full.

Patient Consent – Authorization for Care

_____ I grant permission for The Centers for Kidney Care to render care that my physician may deem necessary in my diagnosis and treatment. I understand that such care may include medical treatment and minor surgical procedures. I understand that I may receive care and I consent to the care that is provided to me by a Nurse Practitioner (NP) and/or Physician Assistant (PA). I understand that a Nurse Practitioner and Physician Assistant are licensed professionals who work with The Centers for Kidney Care under the supervision of my physician and that they may discuss my care with my physician.

Signature of Patient/Representative	Relationship to Patient	Date

The Centers for Kidney Care

Authorization for Release of Protected Health Information (PHI)

Please complete all fields below for the release of PHI or Right to Access		
Patient's Name:	**Birth Date:**	**Social Security No. (optional):**

Name of the person information is being released to:	**Relationship to the Patient:**
1.	
2.	
3.	
4.	

This authorization shall remain valid until written notice is given by me revoking said authorization or unless the following information is completed below: (Fill in the date or event, but not both).

Date: Event:

Purpose of Disclosure:

___ All PHI in Record	___ Physician Orders	___ Demographics
___ History and Physical	___ Laboratory	___ Rehabilitation Services
___ Consult Report	___ Imaging/Radiology	___ Special Tests/Therapy
___ Operative Report	___ Nursing Notes	___ Itemized Bill(s)/Claim(s)
___ Progress Notes	___ Medication Record	___ Other

I acknowledge that all medical records released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____**(Initial)**

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing; but, if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

I have read the above and authorize The Centers for Kidney Care to release the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

The Centers for Kidney Care
Financial Policy

The physicians and staff at The Centers for Kidney Care are committed to providing you with the best care possible. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Our physicians participate in a number of PPO networks. **It is your responsibility to verify that the doctor you are seeing is "in-network".** You can verify this with your insurance company by calling the "800" telephone number on your group insurance card or check with your employer as to how to obtain this information.

Co-pays are collected at EACH visit. If you are not insured by one of the participating PPO insurance companies, payment will be collected according to your plan's out-of-network benefits. If you carry no medical coverage, payment in full is required at the time of your visit unless prior arrangements have been made. For your convenience, we accept cash, checks and the following credits cards: Visa, MasterCard, Discover and any Visa Debit Card.

The Centers for Kidney Care only bills for our physicians, nurse practitioners, physician assistants and some labs. You may receive additional bills from another provider for services; such as, lab, pathology or radiology.

We gladly accept Medicare and Medicaid patients. We accept Medicare/Medicaid Assignment of Benefits and will bill Medicare/Medicaid for you. You may be responsible for any charges that Medicare/Medicaid deems as patient responsibility. Medicare beneficiaries may also be responsible for the Medicare deductible and co-insurance amounts.

The Centers for Kidney Care charges a $25.00 fee for all returned checks. We do not accept postdated checks.

We must emphasize that as healthcare providers, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services were rendered. If you receive a request from your insurance company, we ask that you complete that request in a timely manner so that your claims will be processed. If you are unable to pay the balance in full, suitable payment arrangements can be made to assist you in meeting your obligations.

I have read the above Financial Policy of The Centers for Kidney Care and understand my financial responsibilities.

_____ _____

Signature of Patient and/or Responsible Party Date

The Centers for Kidney Care

Acknowledgement of Receipt of Privacy Notice

Patient's Name: _____

Patient's Date of Birth: _____

By signing this form, you are agreeing that you have received a copy of The Centers for Kidney Care Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgement, in which case we must document our good faith effort to obtain your acknowledgement and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

Signature: _____ **Date:** _____

Printed Name: _____

Relationship to Patient: _____

Employee Witness Signature: _____

Documentation of Good Faith Efforts

Patient's Name: _____

Date: _____

The patient presented for his/her appointment on this date and was provided a copy of The Centers for Kidney Care Privacy Notice. A good faith effort was made to obtain a written acknowledgement of receipt of the notice; however, an acknowledgement was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because:

_____

_____

_____

____ There was a medical emergency (The Centers for Kidney Care will attempt to obtain acknowledgement at the next available opportunity).

____ Other reason, described below:

_____

_____

_____

Signature of employee completing form: _____