



PERSONAL INFORMATION

Legal Full Name :

Preferred Full Name :

Date Of Birth : ____ / ____ / ____

Address : _____

Primary Phone : _____ Secondary Phone _____

E-Mail : _____ SSN : _____

Gender | *Must match insurance* : Male Female Preferred Pronouns : She/Her He/His They/Them

How may we communicate with you regarding your health?

	Mail	Telecommunications	Appointment Reminders
Address :	<input type="checkbox"/> Yes <input type="checkbox"/> No	E-Mail <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Detailed voice message	Text Message	Automated Message
Primary Phone :	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary Phone :	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

EMERGENCY CONTACT DETAILS

Contact Name : _____ Home Number : _____

Relationship : _____ Mobile Number : _____

Release of information *Do you want this person to have information regarding your care?* Yes No

OTHER CONTACTS: RELEASE OF INFORMATION

Do you have a care taker/friend/family member etc. that you want us to communicate your care with?

Contact Name : _____ Primary Number : _____

Relationship : _____ Mobile Number : _____

Contact Name : _____ Primary Number : _____

Relationship : _____ Mobile Number : _____

Contact Name : _____ Primary Number : _____

Relationship : _____ Mobile Number : _____

By signing below, I verify that all information is accurate and up to date Date





INSURANCE INFORMATION

Policy Holder Full Name :

Insurance Carrier :

Policy Holder Date Of Birth : _____ / _____ / _____

Member ID : _____

Group Number : _____

Secondary Insurance Yes No

Policy Holder Full Name :

Insurance Carrier :

Policy Holder Date Of Birth : _____ / _____ / _____

Member ID : _____

Group Number : _____

PHARMACY INFORMATION

Local Pharmacy : _____ Phone Number : _____

Address : _____

Mail Order Pharmacy : _____ Phone Number : _____

DOCTOR CONTACTS

If you have more physicians that do not fit on this sheet, please bring a copy of the rest with you to your appointment.

PCP Name : _____ Phone Number : _____

Practice Name : _____ Fax Number : _____

Specialist Name : _____ Phone Number : _____

Practice Name : _____ Fax Number : _____

Specialist Name : _____ Phone Number : _____

Practice Name : _____ Fax Number : _____

By signing below, I verify that all information is accurate and up to date

Date





ADVANCED DIRECTIVE

Do you have advanced directive (Living Will, Power of Attorney, Do Not Resuscitate)?

Yes No

RACE & ETHNICITY

Race

- Prefer Not to Answer
- Black/African American
- Hispanic
- Native Hawaiian/Pacific Islander
- Other Pacific Islander
- Asian
- White
- Other

Ethnicity

- Prefer Not to Answer
- Hispanic/Latino
- Not Hispanic/Latino

By signing below, I verify that all information is accurate and up to date

Date





AUTHORIZATIONS & CONSENTS

ACCESS TO PRESCRIPTION HISTORY

I understand that prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewable by providers and authorized staff at Western Nephrology. This history is viewable in our electronic medical record (EMR) system and gives our providers information they need to give you the best possible care.

I authorize Western Nephrology to view my external prescription history. Yes No

CONTROLLED SUBSTANCE NOTIFICATION

If we prescribe you a "controlled" medication, your prescription information will be entered into Colorado's Prescription Drug Monitoring Program (PDMP) Database. The database is protected and your health record can only be accessed by caregivers or law enforcement officers in the case of an authorized investigation. You have the right to access your information in the PDMP through the Colorado Board of Pharmacy. You may also seek corrections to information in the database.

For more information go to: <http://hidinc.com/copdmp>

Name of Patient: _____ **DOB** _____
(Print)

Patient Signature: _____ **Date** _____



AUTHORIZATIONS & CONSENTS

PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your Nephrology health care provider. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our Financial Agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

- To understand your benefit plan
- To know if a referral is required
- To know if preauthorization is required prior to a procedure, and
- To know what services are covered

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service. In the event that you are unable to pay the full amount of your deductible or coinsurance at the time of service, you will be asked to pay a minimum of a \$50 deposit towards the total amount due. If your insurance requires a Referral/ Authorization, it is your responsibility to contact your PCP office to request the Referral/ Authorization prior to your appointment. If Western Nephrology does not receive the Referral/ Authorization 72 hours prior to your appointment, you will be asked to self-pay for your visit.

We accept cash, checks, Visa/MasterCard/Discover/AMEX.
Any other arrangements must be made in advance with our Billing Office.

Regarding Insurance:

Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. Western Nephrology contracts with and bills most insurance carriers. We also participate with both Medicare and Medicaid of Colorado. If you are insured by a company with which we do not contract, we can supply you with a statement of your charges. You may submit this, along with any additional forms your insurance requires, to your insurance company.

1. I have read and agree to this Financial Agreement.
2. I authorize and consent to the release of medical information necessary to bill and process insurance claims.
3. I authorize payment of medical benefits directly to the physician.
4. If we cannot successfully collect on an outstanding balance, and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees, shall be included as part of the obligation due.

Name of Patient: _____ **DOB** _____
(Print)

Patient Signature: _____ **Date** _____

AUTHORIZATIONS & CONSENTS

MEDICAL APPOINTMENT CANCELLATION/ NO SHOW POLICY

When you schedule an appointment with Western Nephrology we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/ No Show Policy below:

- Effective July 1, 2018 any patient who fails to show or cancels/ reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a \$50 fee.
- The fee is charged to the patient, not the insurance company, and will be invoiced to the patient and due no later than the patient's next office visit.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact your provider's office and the fee may be able to be waived. You may contact Western Nephrology during regular business hours at the telephone numbers listed below. You may also send us a message through the patient portal.

Clinic Office Locations

Arvada/ Avon (303) 232-3366

Lafayette (303) 443-4200

Lakewood (720) 651-9500

Longmont (303) 776-7759

Westminster (303) 430-7000

Name of Patient: _____ DOB _____
(Print)

Patient Signature: _____ Date _____

AUTHORIZATIONS & CONSENTS

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information may be used, disclosed and accessed. Please review it carefully!

Uses and disclosures of health information: This office is permitted by federal law to make use/disclosure of your health information for treatment, payment and health care operations. Protected health information (PHI) is the information we create and obtain in providing services. This includes documenting symptoms, examination and test results, diagnosis and treatment. It also includes billing for services. Information may be shared verbally, by mail, email, fax, or other methods. Without your authorization, we are prohibited to use or disclose your PHI for marketing purposes and may not sell your PHI without authorization.

We may use or disclose PHI about you without your authorization for several purposes. Subject to certain requirements, we may share PHI for evaluation by our research department, for auditing, for student training, for credentialing, for medical review, for legal services and for insurance. Where applicable, we may disclose PHI to dialysis facilities for dialysis treatment. We also provide information when required by law, such as law enforcement, judicial/administrative proceedings, or public health purposes.

At your request, we may not disclose information about health care you have paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law. We participate in Colorado's Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. The HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other health care providers. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. You may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

We ask for your written authorization before using or disclosing any PHI. If you chose to sign an authorization, you can later revoke in writing that authorization to stop future uses and disclosures.

Continued on next page



AUTHORIZATIONS & CONSENTS

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

When we make a significant change in our policies, we will change and post the new notice in the waiting area. You can also request a copy of our notice at any time, or download this notice at our website: www.westneph.com. For more information, contact our Compliance Officer listed below.

Your individual rights: You have the right to look at or obtain a copy of your health information. If you request copies, we will charge you copy fees. You also have the right to receive a list of instances where we have disclosed your information for reasons other than treatment, payment, or administrative purposes and other than when you authorized it. If you believe that information in your record is incorrect or missing, you have the right to request that we correct or add the information. We have 30 days to respond to your request. To file a complaint: If you are concerned, we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact the Compliance Officer listed below. You may also send a written complaint to the US Department of Health and Human Services. Our Compliance Officer can provide you with the appropriate address, upon request.

Our legal duties and responsibilities: If a security breach occurs, we are required to notify you within 60 days of discovery. We are required to maintain the privacy of your PHI, provide this notice, follow terms described in this notice, and obtain your acknowledgment of receipt of this notice.

If you have questions or concerns, please contact Western Nephrology Compliance Officer at 4891 Independence St., Suite 120, Wheat Ridge, CO 80033, 303-456-5495.

I hereby acknowledge that I have received Western Nephrology's Notice of Privacy Practices.

Name of Patient: _____ DOB _____
(Print)

Patient Signature: _____ Date _____



PATIENT RESPONSIBILITIES

STATEMENT OF PATIENT RESPONSIBILITIES

1. Provide accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health, and answer any questions concerning these matters.
2. Participate in your health care planning by talking openly and honestly about your concerns with your physician and other health care professionals.
3. Understand your health problems, treatment course and care decisions to your own satisfaction and ask questions if you do not understand.
4. Cooperate with your physician and other health care professionals in carrying out your health care plan both as an inpatient and after discharge.
5. Participate and cooperate with our health care professionals in creating a discharge plan that meets your medical and social needs.
6. Inform the hospital or any of its professionals of the existence of any advanced directive (proxy, DNR, living will) you have created.
7. Take responsibility for the consequences and outcomes if you do not follow the care, service or treatment
8. Provide accurate information related to insurance or other sources of payment. You are responsible for ensuring payment of your bills and you may be responsible for charges not covered by your insurance.
9. Treat other patients, visitors and staff with respect and consideration. Support mutual consideration and respect by maintaining civil language and conduct in interactions with staff and providers.
10. Follow instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals.
11. Be considerate of your fellow patients, respecting their need for privacy and a quiet environment.

**Please take advantage of our notes page to jot down any questions/comments/concerns regarding your health.

Thank you,
Western Nephrology



