WESTERN NEPHROLOGY

Caring for People with Kidney Disease

PATIENT REGISTRATION

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 :	☐ Yes ☐ No	**E-Mail** ☐ Yes ☐ No	☐ Yes ☐ No
	Detailed voice message	**Text Message**	**Automated Message**
Primary Phone :	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Secondary Phone :	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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**

____ ____

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

PATIENT REGISTRATION

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**

____ ____

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

PATIENT REGISTRATION

ADVANCED DIRECTIVE

Do you have advanced directive (Living Will, Power of Attorney, Do Not Resuscitate)? ☐ Yes ☐ No

RACE & ETHNICITY

Race

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

Ethnicity

- ☐ Prefer Not to Answerer
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

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

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

AUTHORIZATIONS & CONSENTS

ACCESS TO PRECRIPTION 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: (Print) _____ **DOB** _____

Patient Signature: _____ **Date** _____

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

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.

Note: Self-pay patients that are able to pay in full are subject to a 20% discount.

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: (Print) _____ **DOB** _____

Patient Signature: _____ **Date** _____

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

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: (Print) _____ **DOB** _____

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: (Print) _____ **DOB** _____

Patient Signature: _____ **Date** _____

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

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

A DEDICATED

NOTES SPACE

WESTERN NEPHROLOGY
Caring for People with Kidney Disease

MEDICAL HISTORY

HEALTH CONDITIONS

Name: DOB:

Condition	Y	N	Condition	Y	N
Kidney Disease			Blood Clot in Lung		
Irregular Heart Beat			Blood Clot in Leg		
High Blood Pressure			Bleeding Problems		
Heart Attack			Kidney Stones		
Heart Murmur			Tuberculosis		
Rheumatic Fever			Gallstones		
High Cholesterol			Liver Disease		
Congestive Heart Failure			Ulcers in stomach/bowels		
Emphysema/Chronic Bronchitis			Bleeding from bowels		
Arthritis			Gout		
Prostate Problems			Skin Disease		

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Caring for People with
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MEDICAL HISTORY

HEALTH CONDITIONS

Name: DOB:

Condition	Y	N	Condition	Y	N
Diabetes/ High Blood Sugar			Blood Transfusion		
Stroke			Depression		
Epilepsy/Seizures			Anxiety		
Thyroid Problems			Cancer Details:		
Anemia			Other Please attach document if exceeds the provided space below	-	-
Asthma					

MEDICATIONS

Please list any medications you currently taking along with dosage and directions (including birth control, vitamins and OTC medications): Attach document if exceeds provided space below.

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Caring for People with Kidney Disease

MEDICAL HISTORY

VACCINES

Name: DOB:

Condition	Y	N	Date of last received: Month & Year
Flu			
COVID			

ALLERGIES

Please list any allergies you may have: Attach document if exceeds provided space below.

SURGERIES

Please leave blank if no

Condition	Y	Date: Month & Year
Nephrectomy		
Cataract surgery		
Tonsillectomy		
Neck Artery surgery		

MEDICAL HISTORY

Name: DOB:

SURGERIES CONTINUED

Condition	Y	Date: Month & Year
Open Heart surgery/ catheterization		
Appendectomy		
Gallbladder removal		
Abdominal Surgery		
Bladder Surgeries		
Joint Scope Surgery		
Knee/Hip Joint Replacement		
Back Disk Surgery		
Prostate surgery		
Hernia Surgery		
Vasectomy		
Hysterectomy		

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MEDICAL HISTORY

Name: DOB:

FAMILY MEDICAL HISTORY

Condition	Alive (A) Deceased (D)	Age	Diabetes	Kidney Disease	Cancer	Hypetension
Mother						
Father						
P- Grandfather						
P- Grandmother						
M- Grandfather						
M- Grandmother						
Sibling(s)						
Daughter(s)						
Son(s)						

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Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

FAMILY MEDICAL HISTORY

Condition	Alive (A) Deceased (D)	Age	Heart Disease	Stroke	Other
Mother					
Father					
P- Grandfather					
P- Grandmother					
M- Grandfather					
M- Grandmother					
Sibling(s)					
Daughter(s)					
Son(s)					

Siblings: How many? Please list brothers & sisters

Children: How many? Please list sons & Daughters

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Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

SOCIAL HISTORY

Social History	Y	N	Follow up questions	Answers
Smoking: Have you ever smoked?			For how many years?	
			If you stopped smoking, when did you quit?	
			If you are currently smoking how many packs per day?	
			Do you use someless tobacco I.e chewing tabacco?	
Alcohol: Do you drink alcohol?			If yes, how often did you have a drink containing alcohol in the past year? (Never, monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week)	
			o If yes, how many drinks did you have on a typical day when you were drinking in the past year? (1 or 2, 3 or 4, 5 or 6, 7-9, 10 or more)	
			If yes, how often did you have 6 or more drinks on one occasion in the past year? (never, less than monthly, monthly, weekly, daily, almost daily)	

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

SOCIAL HISTORY

Social History	Y	N	Follow up questions	Answers
Recreational Drugs: Do you currently use recreational drugs?			If yes, how often and which drugs?	
			If no, have you used recreational drugs in the past?	
Exercise: Do you exercise?			How many times per week and/or month?	
			What type of exercise? (cardio, walking, biking, running, swimming, weights, yoga, HITT)	

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

SYMPTOMS: CHECK ALL THAT APPLY

General	Y	N	Head/Eyes/Nose/Thorat	Y	N
Chills			Chronic Nasal discharge		
Fatigue			Impaired hearing		
Fever			Diabetic Eye Disease		
Night sweats			**Endocrine**	-	-
Unexplained weight loss/gain			Thyroid (hyper,hypo, Hashimoto's etc.)		
Head/Eyes/Nose Throat	-	-	Excessive Hunger		
Frequent headaches			Cold intolerance		
Severe headaches			Excessive thirst		
Wears glasses/contacts			Heat intolerance		

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

SYMPTOMS: CHECK ALL THAT APPLY

Respiratory	Y	N	Gastrointestinal	Y	N
Asthma			Hemorrhoids		
Cough			Rectal disease		
Shortness of breath			Abdominal pain		
Wheezing			Blood in stool		
Cardiovascular	-	-	Change in bowel movements		
Heart trouble			Constipation		
Swelling of ankles			Decreased appetitie		
Rheumatic fever			Diarrhea		
Chest pain			**Hematology Continued**	-	-
Irregular heart beat			Excessive bleeding		
Palpitations			Abdominal bleeding		
Hematology	-	-	Swollen glands/nodes		
Anemia					

WESTERN NEPHROLOGY

Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

SYMPTOMS: CHECK ALL THAT APPLY

Genitourinary	Y	N	Skin	Y	N
Blood in urine			Oral ulcers		
Difficulty urinating			Itching		
Frequent urination	-	-	Rash		
Painful urination			Skin Cancer		
Urinary Tract Infections			**Neurological Continued**	-	-
Musculoskeletal			Trouble sleeping		
Chronic back pain			Frequent depression		
Medication for pain	-	-	Anxiety		
Painful joins			Nervousness		
Neurological	-	-	Convulsions		
Numbness			History of stroke		
Dizziness			Memory Loss		
Fainting			Seizures		

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MEDICAL HISTORY

Name: DOB:

WOMEN HEALTH: CHECK ALL THAT APPLY

Women Only	**Y**	**N**	**Pregnancy** Circle Y/N	**-**
Birth Control Use			Total pregnancies?	
Sexual Dysfunction			Total living children?	
Lump in Groin			Have you been diagnosed with preeclampsia?	Y | N
			Have you been diagnosed with proteinuria?	Y | N
			Total elective abortions?	
			Total miscarriages	

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Caring for People with Kidney Disease

MEDICAL HISTORY

Name: DOB:

WOMENS HEALTH: CHECK ALL THAT APPLY

Reproductive Health	-
Last Menstual Cycle?	
If Applicable, what age did you go through menopause?	
Last Pap Smear?	
History of Abnormal Pap Smear?	
If Yes, When? What was the abnormality? What treatment did you have?	
Last Mammogram?	
History of Abnormal Mammogram? If yes, When? What was the abnormality? What treatment did you have?	

WESTERN NEPHROLOGY

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MEDICAL HISTORY

Name: DOB:

MENS HEALTH: CHECK ALL THAT APPLY

Men Only	Y	N
Lump in groin		
Scortal pain		
Sexual dysfunction		