Western Nephrology
Caring for People with Kidney Disorders

We look forward to seeing you soon. In order to make your appointment with the consulting doctor more efficient and beneficial, we ask that you do the following:

If you have insurance that requires a referral, you must check with your referring physician before your appointment to make sure that they have sent us a copy. If we do not have written verification, your appointment may have to be rescheduled or payment of the visit may become your responsibility.
Please arrive at your appointment approximately 30 minutes before the appointed time to complete your registration.

- Complete the attached forms and bring them with you to your appointment.
- Please come prepared the leave a urine sample.
- Bring all of your pill bottles, including any vitamins and herbal supplements.
- Provide the most up to date and accurate information regarding your current concerns and past medical history.
- Please call no less than 48 hours in advance if you need to cancel or reschedule your appointment.

By providing the above information your appointment will run smoothly and your Kidney Care Team will be able to provide you with the best care possible.

Sincerely,

Western Nephrology Staff

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Caring for People with Kidney Disorders

Patient Registration

Name: ________________________ **DOB:** _______________ **Social Security #:** ______________________

Sex: ☐ Male ☐ Female **Mailing Address:** ____

Email Address: ______________________________________ **Primary Language:** ______________________

How may we communicate with you regarding your health?

	Detailed Voice Messages?	**Text Messages?**	**Automated Messages?**
Home Phone:__________________	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Cell Phone: __________________	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

Primary Insurance: __________________________ **Secondary Insurance**: ___________________________

PCP: _______________________________________ **Referring Provider:** _____________________________

Local Pharmacy: ____________________________ **Major Cross Streets:** ____________________________

Mail Order Pharmacy: ________________________________

Do you have an Advance Directive? (Living Will, Power of Attorney, Do Not Resuscitate) ☐ YES ☐ NO

What was the date of your last FLU vaccine? ______________________Month/Year if you are unsure of the exact date

Please list all doctors you currently see (Primary Care and Specialists i.e. Cardiologist)

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Race: ☐ **Prefer Not To Answer**

☐ American Indian/Eskimo
☐ 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,

_________________________ _________________________
Patient Signature **Date**

Authorizations and 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**

***Authorization to Share Health Information:**

Are there any family members, friends, or other person(s) involved in your care or the payment of your care that you authorize Western Nephrology to share your health information with? Please provide their information below.

Emergency Contact:

Name: ____________________________ **Relation:** ______________________ **Phone #:** __________________

Name: ____________________________ **Relation:** ______________________ **Phone #:** __________________

Name: ____________________________ **Relation:** ______________________ **Phone #:** __________________

***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 (please print) **Date of Birth**

____ ___________________________
Patient’s Signature **Date**

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 at least a $50 deposit towards the total amount due.

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 (please print) **Date of Birth**

______________________________________ __________________________
Signature of Responsible Party **Date**

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.

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. The 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 complaints, please contact Compliance Officer:
Anthony Ray 4891 Independence St., Suite 120, Wheat Ridge, CO 80033, (303)456-5495, ext. 121

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

____ _______________________________

Name of Patient (please print) **Date of Birth**

____ _______________________________

Signature of Responsible Party **Date**

Name: ________________________ **DOB:** _________________________

What was the date of your last FLU Vaccine? _____________________ **Month/Year if you don't know the exact date**

Medications

Please list any medications you currently taking along with **dosage and directions** (including birth control, vitamins and OTC medications):

☐ **I brought all my bottles with me** ☐ **See attached/below medication list**

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____

____

____

Medical History – Health Conditions

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Kidney Disease			Kidney Stones			Epilepsy/Seizures		
Irregular Heart Beat			Tuberculosis			Thyroid Problems		
High Blood Pressure			Gallstones			Anemia		
Heart Attack			Liver Disease			Asthma		
Heart Murmur			Ulcers in Stomach/Bowels			Blood Transfusion		
Rheumatic Fever			Bleeding from Bowels			Depression		
High Cholesterol			Arthritis			Anxiety		
Congestive Heart Failure			Prostate Problems			Cancer		
Emphysema/Chronic Bronchitis			Gout			Details:		
Blood Clot in Lung			Skin Disease					
Blood Clot in Leg			Diabetes/High Blood Sugar			Other:		
Bleeding Problems			Stroke					

Allergies

List **any allergies** you have: ☐ **NO KNOWN ALLERGIES**

____

____

Surgeries **If NO, Leave Blank**

TYPE	YES	Date	TYPE	YES	Date
Nephrectomy			Bladder surgeries		
Cataract Surgery			Joint Scope Surgery		
Tonsils Removed			Knee/Hip Joint Replacement		
Neck Artery Surgery			Back Disk Surgery		
Open Heart Surgery/Catheterization			Prostate Surgery		
Appendectomy			Hernia Surgery		
Gallbladder Removal			Vasectomy		
Abdominal Surgery			Hysterectomy		

Hospitalizations

Please list any recent hospitalizations including the reason, location and date:

____

Family Medical History

Check all that apply

Member	Alive or Deceased	Age	Diabetes	Kidney Disease	Cancer	Hypertension	Heart Disease	Stroke	Other
Mother									
Father									
M-Grandpa									
M-Grandma									
P-Grandpa									
P-Grandma									
Sibling(s)									
Daughter(s)									
Son(s)									

Siblings: How many brothers? ____________________ How many sisters? ____________________ Healthy ☐

Children: How many sons? ____________________ How many daughters? ____________________ Healthy ☐

Social History

Have you ever smoked? *(please check)*: ☐ Yes ☐ No

If Yes:

- For how many years? ____________________
- If you have stopped smoking, when did you quit? ____________________
- If you currently smoke, how many packs per day? ____________________
- Do you use smokeless tobacco? (i.e. chewing tobacco) ________________

Alcohol/Drugs

- 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)
  - 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)

- Do you currently use recreational drugs? ____________________
  - If yes, how often and which drugs? ____________________
  - If no, have you used recreational drugs in the past? _______________

Exercise *(please check frequency)*: ☐ Walking ☐ Rarely ☐ Occasional ☐ Never ☐ Daily ☐ Other_________________________

Marital Status: ☐ Single/Never married ☐ Married ☐ Divorced ☐ Widow/Widower

Living with: _________________________ Your Occupation: ___________________

Have you experienced any of the following symptoms ***since your hospital visit?***

*****Do not include chronic symptoms*****

Symptom			Symptom			Symptom		
Change in appetite	Y	N	Unexplained Weight Gain	Y	N	Unexplained Weight Loss	Y	N
Shortness of breath at rest	Y	N	Shortness of breath with exertion	Y	N			
Heart trouble	Y	N	Swelling of ankles	Y	N	Chest Pain	Y	N
Abdominal Pain	Y	N	Diarrhea	Y	N	Nausea/Vomiting	Y	N
Blood in urine	Y	N	Difficulty urinating	Y	N	Painful urination	Y	N
Painful joints	Y	N						