Hello and welcome to Southwest Kidney Institute, PLC

You have been scheduled for an appointment in the next coming weeks. Please arrive at the office 30 minutes prior to your first visit so we can ensure all the appropriate information is updated in our state of the art Electronic Health Records.

For your convenience, we have enclosed a questionnaire. We request that you complete and return all enclosed documents (in the return envelope provided), two weeks prior to your appointment. You will need your insurance card(s) and a picture I.D. at the time of your appointment.

On your behalf, we will request your medical information from the referring physician with your permission. Please follow up with your physician's office to have these released.

Our policy is to collect co-payments and co-insurance at the time of service. If you are unable to make payment at the time of service, please contact our office prior to your appointment to make financial arrangements. For your convenience, we accept cash, check, Visa, MasterCard, and American Express.

To summarize the information above:

- Complete the enclosed forms and return via mail in the envelope provided.
- Arrive 30 minutes before your scheduled appointment;
- Bring all completed enclosed forms, if not previously mailed;
- Bring all insurance cards and photo I.D.;
- Bring a medication list and/or all your medications;
- Be prepared to give a urine specimen when you arrive in the office;
- Be prepared to make any necessary co-payment at the time of your visit.

We'd like to thank you for this opportunity to serve you and look forward to meeting you soon. If you have any questions, please contact our office and the staff will be happy to assist you in any way possible.

Sincerely,

Southwest Kidney Institute, PLC

Patient Registration Form

Please print, complete in full, and make any necessary corrections

Patient Information

Date: _________________

Last Name: ______________________ First Name: ____________________ MI: _________

Social Security Number: __________________ Date of Birth: __________________

Mailing Address: ____

____

City: _____________________ State: _____________ Zip: __________________

Home Phone: ______________________ Work Phone: ________________________

Mobile/Pager: _____________________________

Sex (circle) Female Male

Marital Status (circle) Married Widowed Divorced Separated Single

Race (circle) African American Caucasian Hispanic Asian Native American

Driver's License #: ________________________ Exp. Date: ____________________

Patient Employer Information

Status (circle) Employed Retired Disabled Student Other

Employer's Name ____

Employer's Phone ____

Occupation ____

Emergency Contacts

Name	Relationship	Phone

Responsible Party Other than Patient

Responsible Party Information ____

Name____

Address____

City and State ______________________ Zip ______________

Employer ____

Home Phone ____________________ Work Phone ______________

Social Security # ____________________ Date of Birth ______________

Relationship to Patient ____

Primary Care Physician and Referring Physician

Primary Care Physician ____

Phone ____________________

Referring Physician (if different from PCP) ____________________________

Phone ____________________

Insurance Information

Primary Insurance Name ____

ID# ______________________ Group # ____________________

Subscriber's Name ____

Subscriber's Phone# ______________ Relationship to Patient ____________

Subscriber's Employer ____

Subscriber's Date of Birth ____________ Subscriber's SS# ______________

Secondary Insurance Name ____

ID# ______________________ Group # ____________________

Subscriber's Name ____

Subscriber's Phone# ______________ Relationship to Patient ____________

Subscriber's Employer ____

Subscriber's Date of Birth ____________ Subscriber's SS# ______________

Pharmacy Information

Pharmacy Name:

____

Pharmacy Address:

____

____

Pharmacy Phone:

____

Pharmacy Fax:

____

Medication List

Name of Medication	Strength	Directions (i.e. 1 per day, 2 every 6 hours)

Have you ever taken any anti-inflammatory medications such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.? Yes____ No ____. If YES, please list medications:

____

Medication allergies:

Health History

Have you ever had the following? Please circle all that apply.

	NO	YES		NO	YES
Anemia	N	Y	Hyperlipidemia	N	Y
Arthritis	N	Y	Hyperparathyroidism	N	Y
Asthma/COPD	N	Y	Hypertension	N	Y
Atrial Fibrillation(AFIB)	N	Y	Kidney Cyst	N	Y
Congestive Heart Failure(CHF)	N	Y	Kidney Failure	N	Y
Cancer	N	Y	Kidney Stones	N	Y
Cancer within Last 5 Years	N	Y	Lupus	N	Y
Coronary Artery Disease	N	Y	Polycystic Kidney Disease	N	Y
Diabetes Type 2	N	Y	Protein in Urine - Proteinuria	N	Y

Diabetes Type 1	N	Y	Recurrent Urinary Tract Infections	N	Y
Blood in Urine - Hematuria	N	Y	Stroke	N	Y
Hepatitis A	N	Y	Thyroid Disorder	N	Y
Hepatitis B	N	Y	Transplant	N	Y
Hepatitis C	N	Y	Vitamin D Deficiency	N	Y

Other

____

____

Previous Hospitalizations and Surgeries (Please include dates)

____

____

____

____

____

____

____

____

Family Medical History

Has anyone in your family had any of the following:

Kidney disease Yes___ No___ If yes, list family member(s):______________________
Protein in urine Yes___ No___ If yes, list family member(s):______________________
Blood in urine Yes___ No___ If yes, list family member(s):______________________
Dialysis Yes___ No___ If yes, list family member(s):______________________
Diabetes Type 1 Yes___ No___ If yes, list family member(s):______________________
Diabetes Type 2 Yes___ No___ If yes, list family member(s):______________________
Hypertension Yes___ No___ If yes, list family member(s):______________________
SLE Yes___ No___ If yes, list family member(s):______________________
Kidney Stones Yes___ No___ If yes, list family member(s):______________________
Polycystic Kidney Disease Yes___ No___ If yes, list family member(s):______________________
Cancer Yes___ No___ If yes, list family member(s):______________________
Deafness Yes___ No___ If yes, list family member(s):______________________
Other? Yes___ No___

If yes, please specify illness and family member(s):
____

Current Social History (circle)

Alcohol intake: None Occasionally Moderate Heavy ______________________________

Chewing Tobacco: None | 1 per day | 2-4 per day | 5+ per day ______________________________

Tobacco - years of use: ______________________________

Smoking Status: Never Smoker | Former Smoker | Current every day smoker | Current some day smoker | Smoker - current status unknown | Unknown if ever smoked

Smoking - How much?: None | 1 PPW | 2 PPW | 1/4 PPD | 1/2 PPD | 1 PPD | 1 1/2 PPD | 2 PPD | 3+ PPD

Has smoked since age: ______________________________

Illicit drugs: ______________________________

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner

Occupation: ______________________________

REVIEW OF SYSTEMS

Please circle and describe how you are feeling today

Constitutional: Fever Fatigue Weight gain (_______ lbs) Weight loss (_______ lbs)

Eyes: Dry eyes Vision change

Nose: Frequent nosebleeds

Mouth/Throat: Sore throat Snoring Dry mouth

Cardiovascular: Chest pain on exertion Shortness of breath when walking Palpitations Known heart murmur Light-headed on standing Swelling in the extremities

Respiratory: Cough Wheezing Shortness of breath Coughing up blood Sleep apnea

Gastrointestinal: Abdominal pain Vomiting Change in appetite Frequent diarrhea Nausea

Genitourinary: Urinary loss of control Difficulty urinating Increased urinary frequency Blood in urine

Musculoskeletal: Muscle aches Arthralgias/joint pain Back pain

Skin: Jaundice Rash Itching

Psychiatric Depression Restless sleep

Endocrine: Increased thirst Heat intolerance Cold intolerance

Hematologic/Lymphatic: Swollen glands Easy bruising Excessive bleeding

Allergy/Immunologic: Runny nose Itching Hives

Consent for Release of Information and Test Results

I, ______________________________________, give my consent and authorization to the staff of Southwest Kidney Institute, PLC to relay medical information to the following persons. This information may include but is not limited to scheduled appointments and/or surgeries, lab, radiology testing and medications.

Please check and complete the following:

Contacts: Phone: Relationship to patient:

____

____

____

____

____

____

____

____

OK to leave messages/fax:

YES NO

___ ___ Answering Machine at Home ______________________________

___ ___ Mobile Phone#____

___ ___ Fax Machine#____

Date______________ Signature____

Southwest Kidney
INSTITUTE

Financial Policy

Welcome to SOUTHWEST KIDNEY INSTITUTE, PLC. We are dedicated to quality healthcare. We have experienced staff that understands your need for confidentiality and compassion. We are required to have you provide information to our office in order to file your insurance. Please be sure you have given us the correct insurance card as we will need to copy both front and back of the card. We also will ask that you provide us with a picture ID for your chart (i.e. driver's license, etc.). Co-payments are due at the time of service. We ask that any balance owing be paid promptly.

Please read and sign the following so that we may file your insurance.

I, ___________________________________ authorize SOUTHWEST KIDNEY INSTITUTE, PLC to release information regarding my health to my insurance company. I understand that my insurance company may request records from my physician in order to pay the claims submitted. I give permission to SOUTHWEST KIDNEY INSTITUTE, PLC to send any records necessary to obtain payment for the claims submitted. I assign all insurance benefits to SOUTHWEST KIDNEY INSITUTE, PLC. I understand that I am fully responsible for any/and all unpaid charges and agree to pay any balance unpaid by my insurance company. This authorization will remain in effect from this date until revoked by me in writing.

____ ____________________
Patient Signature Date

____ ____________________
Witness Date

Notice of Privacy Practices

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.

Southwest Kidney Institute, PLC (the "Practice") is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed. Company will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present or future.

Company may use your individually identifiable health information for the following purposes without your authorization:

1. Treatment: We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children or parents.
2. Payment: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. Health Care Operations: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing or to identify you by name when you visit the office.
4. Appointment Reminders: We may use and disclose your information to remind you of appointments. We may also mail you a reminder postcard for follow-up visits.
5. Treatment Options: We may use your health information to inform you of treatment options or other health-related services which may be of interest to you.
6. Business Associates: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as afterhour’s telephone answering, billing or quality assurance. Our Business Associates agree to protect the privacy of your health information.
7. Research: We may use your information in conjunction with agents of the Practice who may be required to review your files, just as our employees are so permitted, in order to determine whether you are qualified for a research project. If you are asked to join a research project, you will be asked first to execute an authorization, granting the Practice or a research organization the right to use your protected health information.

Company may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- To health oversight agencies.
- To your employer if we provide health care services to you at the request of the employer, whereupon we shall provide you written notice of release so such information.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner or funeral director.
- For the facilitation of organ, eye or tissue donation if you are an organ donor.

- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.
- Sign in sheet.

Company may also disclose your information to family members and/or other persons involved in your care or payment for your care. Company may leave messages for you at work or home about your visits. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Company will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential Communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Company if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. Accounting of Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Company has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have any questions about this notice, please contact Practice’s Privacy Office; (480) 610-6100

Acknowledgement of Receipt of
Notice of Privacy Practices

I acknowledge that I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed and protected.

Patient Name: ___________________________________

____
Name/Relationship if signed by individual other that patient

____ ___________
Patient Signature Date