Hello and welcome to Southwest Kidney Institute, PLC

You have been scheduled for an appointment with Southwest Kidney Institute in the coming weeks. Please arrive 30 minutes prior to your scheduled appointment time so we can ensure all needed information is updated in our electronic health records (EHR).

For your convenience, we have provided a questionnaire below. We request that you complete and submit this questionnaire and arrive 30 minutes before your scheduled appointment. Please be certain to bring your insurance card(s) and a picture I.D. to 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 sign a medical release form so we can obtain your medical records.

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 questionnaire below and bring it to your scheduled appointment.
- Arrive 30 minutes before your scheduled appointment.
- Bring your insurance cards and photo I.D. to your appointment.
- Bring a medication list, including prescribed medications, over-the-counter medications, vitamins and supplements.
- Be prepared to give a urine specimen when you arrive for your appointment.
- Be prepared to make any necessary co-payment at the time of your visit.

Thank you for the opportunity to serve you. We look forward to meeting you. If you have any questions, please contact

our office, and the staff will be happy to assist you.

Sincerely,

Southwest Kidney Institute, PLC

Southwest Kidney INSTITUTE, PLC

Patient Registration Form

Please complete in full and use blue or blank ink.

Patient Information

Date : _____

Last Name : _____ First Name :_____ MI: _____

Sex (circle) Female Male Date of Birth: _____

Social Security Number : _____

Mailing Address : _____

City : _____ State : _____ Zip : _____

Home or Mobile Phone : _____ Work Phone: _____

Email Address : _____

Marital Status (circle) Married Widowed Divorced Separated Single

Race (circle) African American Caucasian Hispanic Asian Native American European

Driver's License #: _____ Exp. Date: _____

Patient Employer Information

Status (Circle) Employed Retired Disabled Student Other

Employer's Name: _____ Employer's Phone: _____

Occupation : _____

Southwest Kidney INSTITUTE, PLC

Emergency Contacts

Name : _____

Relationship : _____ Phone : _____

Name : _____

Relationship : _____ Phone : _____

Responsible Party Other than Patient

Last Name : _____ First Name :_____ MI: _____

Sex (circle) Female Male Date of Birth: _____

Social Security Number: _____

Mailing Address: _____

City: _____ 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 (ie. 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:

_____

_____

_____

_____

Southwest Kidney INSTITUTE, PLC

Health History

	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, list 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 Smoked	Former Smoker	Current every day smoker	Current some day smoker	Smoker – current status unknown	Unknown if every smoked

Smoking – How much?	None	1PPW	2 PPW	¼PPD	1/2PPD	1PPD	2PPD	3+PPD

Has smoked since age: _____

Illicit Drugs : _____

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner

Occupation : _____

REVIEW OF SYSTEMS - Please check and describe how you are feeling today

Constitutional : ☐ Fever ☐ Fatigue ☐ Weight Gain (_____ lbs) ☐ Weight Loss (_____ lbs)	**Musculoskeletal:** ☐ Muscle aches ☐ Arthralgias/joint pain ☐ Back pain
Eyes : ☐ Dry Eyes ☐ Vision Change	**Skin:** ☐ Jaundice ☐ Rash ☐ Itching
Nose : ☐ Frequent Nosebleeds	**Psychiatric:** ☐ Depression ☐ Restless sleep
Mouth/Throat: ☐ Sore throat ☐ Snoring ☐ Dry mouth	**Endocrine:** ☐ Increased thirst ☐ Heat intolerance ☐ Cold intolerance
Cardiovascular: ☐ Chest pain on exertion ☐ Shortness of breath when walking ☐ Palpitations ☐ Known heart murmur ☐ Light-headed on standing ☐ Swelling in the extremities	**Hematologic/Lymphatic:** ☐ Swollen glands ☐ Easy bruising ☐ Excessive bleeding
Gastrointestinal: ☐ Abdominal pain ☐ Vomiting ☐ Change in appetite ☐ Frequent diarrhea ☐ Nausea	**Allergy/Immunologic:** ☐ Runny nose ☐ Itching ☐ Hives
Genitourinary: ☐ Urinary loss of control ☐ Difficulty urinating ☐ Increased urinary frequency ☐ Blood in urine	**Other :** _____ _____

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_____

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.

If you have any questions about this notice please contact our privacy officer who is: Lauren Ellenburg.

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 may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. 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 will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition. In this regard, we disclose patient data to the CommonWell network as part of a query-based data exchange for permissible treatment purposes.
2. 2. Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. 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 in order to support the business activities of your physician's practice. 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. You understand and acknowledge that we will disclose information in accordance with HIPAA laws to our affiliates (namely, Renal Care Organization, LLC and RCO Analytics, LLC) for the purposes of creating a population health care delivery model with goals of improving quality of health care and outcome, reducing costs of health care, and increasing savings to patients.
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. 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.
- Food and Drug Administration.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- If you are an inmate of a correctional facility.
- 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.
- In order to follow various mandates for clinical quality metric reporting, benchmarking, and related matters.
- 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.

Unless you object, company may also disclose your information to family members and/or other persons involved in your care or payment for your care. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death.

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.

Complaints:
You may complain to us or to the Secretary of Health and Human Services (Office for Civil Rights/U.S. Department of Health & Human Services) on-line at HHS.gov if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Lauren Ellenburg at (480) 610-6100 for further information about the complaint process.

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 than patient

_____ _____
Patient Signature Date

_____ _____
Witness Date

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for providers to send electronically, an accurate, error free, and understandable prescription from the provider's office to the pharmacy. This program also includes:

- Medication History Transactions: provides the healthcare provider with information about your current and past prescriptions. This allows your providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy reactions, adverse drug reactions, and duplicative therapy. The medication history information would include medications prescribed by your healthcare provider at Southwest Kidney Institute, P.L.C. as well as other healthcare providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease, and HIV/AIDS. As part of this consent form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form, you are agreeing that your provider at Southwest Kidney Institute, P.L.C. may request and use your prescription medication history from other healthcare providers and/or third party benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to receive medical care, payment for your medical care, or your medical care benefits. You also have the right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke your consent at any time in writing. Please note, this revocation will not have an effect on any actions taken prior to receipt of the revocation. Understanding all of the above, I hereby provide informed consent to Southwest Kidney Institute, P.L.C. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Signature of Individual (or Legal Representative):

_____

Individual's Name (Print):

_____ _____

Name of Legal Representative, if applicable (Print): Relationship

_____

Date