KIDNEY ASSOCIATES OF KANSAS CITY

PHONE: (816) 361-0670 FAX: (816) 444-6936

(YOU CAN FILL THIS OUT OR YOU CAN CALL THE OFFICE TO GET A PASSWORD/USER ID AND VISIT OUR WEB SITE "KIDNEYKC.COM" TO SIGN ON TO OUR PATIENT PORTAL)

RICHARD S. MUTHER, M.D., GERALD M. REID, M.D., WALTER L. BENDER, M.D., TIMOTHY K. NEUFELD, M.D.
KELLY R. ALFORD, M.D., WILLIAM J. PETERSON, M.D., AHMED I. AL-ABSI, M.D., PRANAV DALAL M.D.
YOLANDA THOMPSON-MARTIN, ANP-C JENNIFER HUFFMAN ANP-C

PATIENT INFORMATION SHEET

Date: _____

Patient's Legal Name _____ Birth Date: ____/____/____/ Age: ____
Last First MI

Address_____
Street City State Zip

____Single ____Married ____ Widowed ____Male ____Female Social Security Number _____/_____/_____

Home No. ( ) _____ Cell No. ( ) _____ Spouse's Name _____

Race: (circle one) Am. Indian, Asian, Native Hawaiian, Black or African Am., White or Caucasian, Hispanic, Other_____ Refuse to Report
Language: (circle one) English, Spanish, Indian (includes Hindu), Russian, Other_____
Ethnicity: (circle one) Hispanic, Non-Hispanic, Refuse to Report

Email Address _____ Would you like to receive appointment reminders by email? _____Yes_____No

Employer _____ Position_____ Work Phone ( ) _____

Please provide us with the name and phone number of one person (**not living with you**) to contact in case of an emergency:

Emergency contact_____Relationship_____Phone ( )_____

Primary Care Physician _____

Who referred you to us? _____Have you ever been seen by our group? _____ If so, when_____

Is your insurance in your name or another family member? _____Self OR _____ (Name of Subscriber)

Primary Insurance Co: _____ ID Number: _____

Secondary Insurance Co:_____ ID Number: _____

HIPPA CONSENT TO VIEW HISTORY OF SCRIPTS, SIGNED BY PATIENT OR AUTHORIZED PERSON

I, the undersigned, give consent to Kidney Associates to view my prescription history.

Signature: _____ Date: _____

I, the undersigned, authorize release of my medical records as required by my insurance company(s). I hereby authorize payment directly to Kidney Associates, or Richard S. Muther, M.D., or Gerald M. Reid, M.D., or Walter L. Bender, M.D., or Timothy K. Neufeld, M.D., or Kelly R. Alford, M.D., or William J. Peterson, M.D., Ahmed I. Al-Absi M.D., or Pranav Dalal, M.D., of any insurance coverage for office procedures or hospital charges.

I, the undersigned, understand that I am fully responsible for all services and charges, including any balance due after payment of insurance and that insurance coverage does not necessarily pay all charges. I understand I am responsible when services are rendered. I give consent to bill my insurance carrier for all services rendered. I also understand that all copays for office fees are due when services are rendered.

I, the undersigned, authorize treatment by the doctor at Kidney Associates.

Signature _____ Date: _____
(If minor, parent or guardian signature)

Medicare Patients Please Complete

I request that payment of authorized Medicare benefits be made on my behalf to Drs Richard S. Muther, Gerald M. Reid, Walter L. Bender, Timothy K Neufeld, Kelly R. Alford, William J. Peterson, Ahmed I. Al-Absi, and Pranav Patal, for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Name of Beneficiary or Patient **Date Signed** **Patient's Medicare Number**