PATIENT INFORMATION SHEET

Last Name ____________________________ First Name (legal) ___________________________(MI) ________

Preferred Name ________________________ Address____

City ____State ____________________ Zip code _______________

Home Phone No. _______________________ Mobile No. ____________________ Work No. _______________

Primary care doctor ___________________________ who referred you to us? _____________________________

Birth Date: ___/___ /_______ Sex: Male or Female Marital Status: _____________________________

Primary Insurance ____________________________ ID# ___________________________ Grp# _____________

Secondary Insurance __________________________ ID# ___________________________ Grp# _____________

Email Address ____

Race: (circle one) Am. Indian, Asian, Native Hawaiian, Black or African Am., White or Caucasian, Hispanic, other ____________________Refuse to report

Ethnicity: (circle one) Hispanic, Non-Hispanic, Refuse to report

Language: (circle one) English, Spanish, Indian (includes Hindu), Russian, other _________________________

Pharmacy Name ____

Pharmacy Address_______________________________________Pharmacy No.___________________________

CONSENT TO VIEW PRESCRIPTION HISTORY

I, the undersigned or the authorized person, gives consent to Kidney Associates of Kansas City to download and view the prescription history of the patient listed above.

Signature ____Date ___________________________

(If minor, parent or guardian signature)

Full Name ____

I, the undersigned, authorize release of my medical records as required by my insurance company(s). I hereby authorize payment directly to Kidney Associates of Kansas City and all of its providers, of any insurance coverage for services and procedures provided for me in the office or hospital. I give consent to bill my insurance carrier for all services rendered.

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. As required by my insurance, I understand that all copays for office visits are due when services are rendered. I authorize treatment by the provider(s) at Kidney Associates of Kansas City.

Signature ____Date ____________________________
(If minor, parent or guardian signature)

MEDICARE & MEDICARE REPLACEMENT PLAN (MCOS) PATIENTS PLEASE COMPLETE
I request that payment of authorized Medicare Benefits be made on my behalf to the providers at Kidney Associates for any services furnished for me. As required by Medicare, I authorize the 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.

Signature ____**Medicare #** ____________________________
(Beneficiary or legal guardian signature)

HIPAA CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient: ____
In order to protect your confidentiality and to comply with government regulations (HIPAA), Kidney Associates of Kansas City, PC (KAKC) is required to obtain authorization from you in order to leave messages and /or provide information regarding your care with any persons(s) other than yourself.

RELEASE OF MEDICAL INFORMATION:
The physicians and staff at KAKC may discuss my medical information and/or care to the following:

My spouse, (Name) ____ Phone Number __________________________

Name _________________________________ Relationship _______________ Phone Number ____________________

Name _________________________________Relationship _______________Phone Number ____________________

◯ **No one (please initial)** _________

MESSAGES:
I give my consent to the physicians and staff of KAKC to leave messages or discuss scheduling, treatment, surgery, lab, radiology results or other information regarding my care as follows:

On answering machine or voice mail at home YES OR NO (circle one)
On cell phone YES OR NO (circle one)

◯ **I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.**

HIPAA CONSENT:
I have received Kidney Associates of Kansas City notice of privacy practices. This is the form titled HIPAA Notice of Privacy Practices (**Please Initial) ___________**

Patient's Name (please print)____

Signature ____Date _____________________________________