Kidney Associates
OF KANSAS CITY

PATIENT INFORMATION SHEET

Last Name _____ First Name (legal) _____ (MI) _____

Preferred Name _____ Address_____

City _____ State _____ Zip code _____

Home Phone No. _____ Mobile 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, other _____Declined to Specify

Ethnicity: (Circle One) Hispanic, Non-Hispanic, Other _____ Declined to Specify

Language: (Circle One) English, Spanish, Indian (includes Hindu), Russian, other _____

Pharmacy Name _____

Pharmacy Address_____Pharmacy No._____

Emergency Contact:_____**Phone Number**: _____

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 _____