



New Patient Packet

Dear Patient,

Hello and welcome to Southwest Kidney Institute, PLC. In order for your first visit with us to run smoothly, please review and complete the information in this packet as completely as possible prior to your appointment.

We ask that you arrive at the office 15 minutes prior to your first visit so we can ensure all the appropriate information is completed prior to your appointment, otherwise you may need to be rescheduled.

Please bring a medications list and/or bring all your medications to your first visit. Bring your insurance card(s) and a picture I.D. with you to your appointment.

Many insurance companies require a referral, prior authorization or both before they will provide payment for your visit. If you have such a plan, please contact your primary care physician to get the necessary referral and/or authorization. If you are unsure whether a referral or authorization is needed, please call our office at least 7 business days prior to your appointment, and we will be happy to help. If we have not received the insurance authorization or referral by your appointment time, we will contact you to reschedule your appointment to a future date.

In addition, we will need a copy of your medical records from your current physician. We will request the information from the physician; however, if we are unable to get a copy of your medical records we may need to reschedule your appointment to a future date.

It is required that we collect co-payments and co-insurance at the time of service. If you are unable to make payment at the time of service, you will need to contact our office prior to your appointment to make financial arrangements. For your convenience, we accept cash, check, Visa and Mastercard.

To summarize the information above:

Upon receipt of this letter:

- Contact your primary care or referring physician to obtain a referral or authorization, if needed;
- Ensure your primary care or referring physician has sent a copy of your medical records to us;



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On the day of your visit:

- Arrive 15 minutes before your scheduled appointment;
- Bring all completed enclosed forms;
- 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 assist you in any way possible.

Sincerely,

Southwest Kidney Institute, PLC

Southwest Kidney Institute, PLC
Patient Registration Packet
Please print and complete in full

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: _____ Email Address _____
Sex (circle) Female Male
Marital Status (circle) Married Widowed Divorced Separated Single
Race (circle) African American Caucasian Hispanic Asian Native American
Drivers License #: _____ Expiration. 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

Name: _____
Address: _____
City, State, Zip _____
Employer: _____
Home Phone: _____ Work Phone _____
Social Security # _____ Date of Birth _____
Relationship to Patient _____

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Primary Care Physician and Referring Physician

Primary Care Physician _____ Phone _____

Referring Physician
(if different from PCP) _____ Phone _____

Insurance Information

Primary Insurance Name _____

ID#: _____

Group/Policy # _____

Subscriber's Name _____

Subscriber's Phone # _____

Relationship to Patient _____

Subscriber's Employer _____

Subscriber's Date of Birth _____

Subscriber's Social Security # _____

Secondary Insurance Name _____

ID # _____ Group/Policy # _____

Subscriber's Name _____

Subscriber's Phone # _____

Relationship to Patient _____

Subscriber's Employer _____

Subscriber's Date of Birth _____

Subscriber's Social Security # _____

Pharmacy Information:

Pharmacy name: _____

Pharmacy Address: _____

Pharmacy Telephone #: _____

Pharmacy Fax #: _____

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Patient: _____

Patient DOB: _____

Health History

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

	No	Yes		No	Yes
Heart Disease	N	Y	Asthma	N	Y
Diabetes	N	Y	Neurological Diseases	N	Y
High Blood Pressure	N	Y	Kidney Infections	N	Y
Stroke	N	Y	Kidney Stones	N	Y
Hepatitis	N	Y	Blood Transfusions	N	Y
Arthritis	N	Y	Anemia	N	Y
Kidney Failure	N	Y	Ulcers	N	Y
Pneumonia	N	Y		N	Y

Other _____

Previous Hospitalizations and Surgeries (Please include dates)

Current Social History (circle)

Alcohol per day None Occasionally 1 drink/day 2 drinks/day 3+ drinks/day

Use of Tobacco Never Previously, but quit in _____ (year) Current packs/day _____

Use of Drugs Never Type/Frequency _____

Family Medical History

Has anyone in your family had any of the following:

Kidney disease Yes ___ No ___ If yes, list family member(s): _____

Diabetes Yes ___ No ___ If yes, list family member(s): _____

Hypertension Yes ___ No ___ If yes, list family member(s): _____

Deafness Yes ___ No ___ If yes, list family member(s): _____

Blood in urine Yes ___ No ___ If yes, list family member(s): _____

Have any family members been on dialysis? Yes ___ No ___ If yes, list family member(s): _____

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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, radiological testing and medications.

Please complete the following:

Contacts:	Phone #:	Relationship to patient:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Okay to leave message on:	Yes	No	Number
Fax Machine	Y	N	
Answering Machine at Home	Y	N	
Mobile Phone	Y	N	

Date _____

Signature _____

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Financial Policy

Welcome to SOUTHWEST KIDNEY INSTITUTE. We are dedicated to quality healthcare. We have an 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 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 to send any records necessary to obtain payment for the claims submitted. I assign all insurance benefits to Southwest Kidney Institute. 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

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Southwest Kidney Institute, PLC
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 after hours 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

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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.

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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 questions about this notice, please contact Practice's Privacy Officer at 480-610-6100

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**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

Rev: 7/29/2005, 8/19/2005,9/06/2006, 7/12/2010