WELCOME TO OUR OFFICE

Please Print and Complete All Parts Fully

PATIENT INFORMATION

NAME ______________________ Date of birth ____________ Gender M/F (please circle one)
MAILING ADDRESS ______________________ City ____________ State______ Zip________
PHONE Home (___)______ Cell (___)_______ Work (___)_______ Ext___ Preferred Home☐ Cell☐ Work☐
Ok to leave detailed voicemail? ☐ Yes ☐ No
EMAIL ADDRESS ______________________ Would you like an invite to our Patient Portal ☐Yes ☐ No
MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Widowed
OCCUPATION ______________________ EMPLOYER______________________
Primary Care Physician ______________________ Phone (___)__________ Fax ______________
Referring Physician ______________________ Phone (___)______________ Fax ____________

EMERGENCY CONTACT INFORMATION

NAME ______________________ Date of birth ____________ Relationship to patient__________
MAILING ADDRESS ______________________ City ______________ State______ Zip_________
PHONE Home (___)_____ Cell (___)______ Work (___)______ Ext____ Preferred Home☐ Cell☐ Work☐
EMAIL ADDRESS ______________________

PREFERRED LOCAL PHARMACY ______________________ Phone (____)__________
Pharmacy Address ______________________ City ______________ State ______ Zip _____
PREFERRED MAIL ORDER PHARMACY (if applicable) ______________________ Phone (___) ________
Pharmacy Address ______________________ City ______________ State _________ Zip _____

INSURANCE INFORMATION

Primary Insurance ______________________ Group No. ________ ID No.______________
Policy Holder ______________ Date of birth __________ SSN__________ Employer______________

Secondary Insurance ______________________ Group No. ____________ ID No.______________
Policy Holder ______________ Date of birth __________ SSN__________ Employer______________

RELEASE OF INFORMATION & Protected Health Information (PHI)

Please acknowledge each section with your initials and sign and date at the end of the document

INSURANCE ASSIGNMENT AND RELEASE:
I certify that I have coverage with the insurance company above and assign directly to Kidney Associates of Colorado, PC, any and all benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature for all insurance submissions.This provider may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

***Initials*______**

MEDICARE/MEDIGAP AUTHORIZATION (if applicable)
I request that payment of authorized Medicare benefits and any Medigap benefits, be made either to me or on my Behalf to Kidney Associates of Colorado, PC for any services rendered. To the extent permitted by law, I authorize any Holder of medical or other information about me to release to the Center of Medicare and Medicaid Services, my Medigap insurer, and their agents, any information needed to determine these benefits or benefits for related services.

I hereby acknowledge that I have received a copy of Kidney Associates of Colorado, PC Notice of Privacy Practices. I authorize the release of any medical information necessary to process a claim and payment of medical benefits to this Provider. I agree to be responsible for any deductible, coinsurance, co-pay or any other balance not paid by my Insurance provider.

***Initials*______**

PARTICIPATION IN CORHIO (Colorado Regional Health Information Organization)
Kidney Associates of Colorado endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

☐ **I would like to opt-out of CORHIO HIE**
(please see the front desk for opt-out form)

____
Patient/Authorized Representative (please print)

____
Patient/Authorized Representative Signature

____
Date

RELEASE OF INFORMATION & Protected Health Information (PHI)

NOTICE OF PRIVACY PRACTICES

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

As a patient, you have the following rights
1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request your information be restricted
4. The right to request confidential communications
5. The right to a report of disclosures of your information
6. The right to a paper copy of this notice

We want to assure you that your health information is protected and secure with us.
This Notice contains information about how we will insure your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office at 303-777-3333. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be modified, amended or changed in any way.

____

Patient or Representative (please print)

____________________________________ ________________________

Patient or Representative Signature *Date*

RELEASE OF INFORMATION & Protected Health Information (PHI)

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

NAME OF PRACTICE:______________________________________

PATIENT NAME: ___________________________________ DATE OF BIRTH: ____________

1. You may use or disclose the following health care information (check all that apply)

☐ All my health information maintained by the above named practice
   - Include/Exclude - my health info related to drug abuse
   - Include/Exclude- my health info related to alcohol abuse
   - Include/Exclude- my health info related to HIV/AIDS
   - Include/Exclude - my health info related to psychiatric or psychological conditions, including psychotherapy notes

☐ My health info relating to the following treatment or condition ____________________________

☐ Other ____

2. Reason(s) for authorization
   - At my request
   - Other____

This authorization ends on _______________________ or when the following event occurs _______
(date)

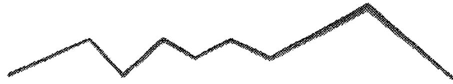
You may disclose this information to: Kidney Associates of Colorado
850 East Harvard Avenue, Suite 565
Denver CO 80210 Phone 303-777-3333 Fax 303-733-4441

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health info for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I can fill out a revocation form (available in the office) or write a letter to the office. Privacy laws may no longer protect health information if the receiving person or organization rediscloses it.

____________________________________ ____________________

Patient/Authorized Representative Signature Date



KIDNEY ASSOCIATES
OF COLORADO

CREDIT CARD PAYMENT AUTHORIZATION

In order to keep our treatment costs and clerical fees down, we require a credit or debit card number on file. This credit card number will only be used if there is an outstanding balance in your ledger not paid by you or your insurance company upon resolution of your insurance claim. We will mail you a receipt upon posting these charges.

NAME ____
(as it appears on your card)

I, the undersigned, authorize **KIDNEY ASSOCIATES** or its billing service provider, Flatirons Practice Management, to retain on file the credit/debit card that I provide and to charge this credit/debit card for services rendered upon resolution of my insurance claim and am thereby agreeing to pay amounts due and owing according to the card issuer agreement (merchant agreement if credit voucher).

______________________________ ______________________________
Cardholder Name (Print) Cardholder Signature

____
Today's date