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 ______________________
Pharmacy Address ______________________ Phone (___)__________
PREFERRED MAIL ORDER PHARMACY (if applicable) ______________________ City __________ State ______ Zip ______
Pharmacy Address ______________________ Phone (___) __________
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 __________

Email & Text Message – HIPAA Compliance

We offer helpful administrative information by regular text messaging and email like appointment reminders. There is some level of risk that information in a regular text message or email could be read by someone besides you. Please let us know if you would like us to communicate with you by text message or email.

☐ Yes – Please communicate with me by email. My email address is:

____

I will let you know right away if my email address changes.

☐ No – Do not communicate with me by regular (unencrypted) email.

☐ Yes – Please communicate with me by text message. My cell phone number is:

____

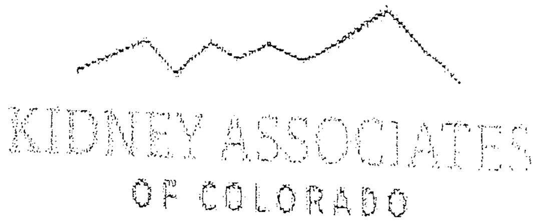
I will let you know right away if my cell phone number changes.

☐ No – Please do not communicate with me by regular (unencrypted) text message

Name Printed ______________________ Date ____________

Signature ______________________

Date of Birth ______________________



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.

MEDICARE/MEDIGAP AUTHORIZATION (if applicable) *Initials*______
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

KIDNEY ASSOCIATES
OF COLORADO

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

PATIENT NAME: ______________________ LAST NAME: ______________________

DATE OF BIRTH: ______________________

TELEPHONE CONTACT: ________________ EMAIL ADDRESS: ______________________

I, ______________________________, do hereby authorize, **Kidney Associates of Colorado,**

located at 850 East Harvard Avenue, Suite #565, Denver, Colorado 80210, (303) 777-3333,

to release my protected health information (PHI) including copies of my medical records to the

Frenova Renal Research Team, apart of Fresenius Kidney Care for the purpose of research data review.

I allow Frenova to review records from the Kidney Associates of Colorado to allow to identify patients that may be candidates for clinical trials. No data will be collected without patient approval.

Information to be released may include:

- Clinic visit notes
- Discharge Summary
- Lab Reports
- Pathology Reports
- Medical Records Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary).

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization, and that this Designation will not expire unless and until I actively revoke it.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.
- Information released on this authorization, if re-disclosed by the recipient is no longer protected by the Kidney Associates of Colorado.

I acknowledge that I have carefully read this authorization form and I fully understand all aspects involving the release of my protected health information.

Patient's Signature: ______________________________

Print Name: ______________________________ Date: ______________

-------------------------------- OR, I would like to DECLINE --------------------------------

☐ By checking this box, I DECLINE to release my protected health information. I understand that my health care treatment or payment, or my enrollment or eligibility for benefits will not be affected by this decision.

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

Patient Authorization Form

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

This form is for use when such authorization is required and complies with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards. It is the responsibility of Kidney Associates of Colorado to ensure that information regarding patient information is confidential. Information regarding medical conditions, insurance and financial matters, or any protected information identified under HIPAA, cannot be released to anyone unless authorization is obtained in writing, to whom you want information released to.

In the event of a critical circumstance, or if you are unable to give authorization due to the severity of your medical condition(s), the law stipulates that these rules and regulations may be waived.

We understand that you may want another party to be knowledgeable about your medical condition(s) or act on your behalf. You can, if desired, name a person(s) to whom you want the staff to speak with regarding your medical information. To do so, please complete the form below.

- This authorization is valid until you cancel it in writing
- If you do not authorize a person or party, Kidney Associates of Colorado cannot release your information to anyone, including family member or friends.

Authorization:

I, ______________________________ Date of Birth ____________________ authorize Kidney Associates of Colorado to release any and all information concerning my medical care to the following individuals

Name: ______________________________ Relationship to Patient: ______________________

Phone number: ____________________

Name: ______________________________ Relationship to Patient: ______________________

Phone number: ____________________

Patient signature: ______________________________ Date: ________________

NO SHOW POLICY

I understand that there will be a $50 charge if I no-show or cancel less than 24 hours before the appointment date and time; except when prohibited by law. If you are late arriving to your appointment, your appointment may be shortened to fit within the remaining time of your allotted appointment slot, or it may be cancelled and rescheduled. This is at the discretion of the provider.

Initials______

By signing below, I certify that I have read these agreements and/or that they have been fully explained to me. I understand their contents and I am the patient, or a person authorized by the patient to execute the agreement. I accept all the terms above.

Patient/ Representative Name ________________

Patient/ Representative Signature ______________

Date ________________

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