KIDNEY ASSOCIATES
OF COLORADO

WELCOME TO OUR OFFICE

Please Print and Complete All Parts Fully

PATIENT INFORMATION

Name_____ Date of Birth _____ Gender M F

ADDRESS _____City _____State_____ Zip_____

PHONE: Home _____ Cell_____ Work _____

Preferred way of Contact: Home ___ Cell ____ Work____ Okay 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 _____ Relationship to Patient_____
ADDRESS _____ City _____ State_____ Zip_____
PHONE: Home _____ Cell _____ Work_____ Ext_____
EMAIL ADDRESS _____

PREFERRED PHARMACY _____ Phone_____
Pharmacy Address _____ City_____ State _____ Zip_____
PREFERRED MAIL ORDER PHARMACY _____ Phone _____
Pharmacy Address _____ City _____ State _____ Zip ____

INSURANCE INFORMATION
Primary Insurance _____ ID No. _____ Group No_____
Policy Holder _____ DOB _____ SSN_____
Employer_____

Secondar Insurance _____ ID No. _____ Group No_____
Policy Holder _____ DOB _____ SSN_____
Employer_____

KIDNEY ASSOCIATES
OF COLORADO

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, P.C, 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.

Initials _____

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

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 NOTCE 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

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.

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 redisclosed 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: _____ Date: _____
Print Name _____

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

_____ by checking here, I DECLINE to release my protected health information. I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits will not be affected by this decision.

KIDNEY ASSOCIATES
OF COLORADO

PATIENT AUTHORIZATION FORM

HIPPA 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 (HIPPA) 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 conditions(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 conditions(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 members 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_____

KIDNEY ASSOCIATES
OF COLORADO

NO SHOW POLICY

I understand that there will be a $50.00 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: _____

KIDNEY ASSOCIATES
OF COLORADO

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:

_____

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

Name Printed _____ Date _____

Signature _____

Date of Birth _____

KIDNEY ASSOCIATES OF COLORADO

RELEASE OF INFORMATION & PROTECTED HEALTH INFORMATION (PHI)

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

NAME OF PRACTICE(S) _____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

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

____ All my health information maintained by the above named practice(s)

- My health information 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 – Include/Exclude

____ 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 303-777-4441

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(s) 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 redisclosures it.

_____ _____

Patient/Authorized Representative Signature Date