Patient Acknowledgements and Consents

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

In consideration of services rendered, I hereby assign to Texas Kidney Consultants, and/or any physician who has treated me, all the rights, title, and interest in any payment due for services described herein as provided in the policy, or policies, of insurance. I agree to pay the charges of Texas Kidney Consultants, which are greater than the amount paid by the insurance company or companies. I understand that it is my responsibility to know the benefits of my insurance plan and whether or not the services I am to receive are covered or not. I understand that I am, financially responsible for all the services rendered to me. **I understand and agree to pay all co-pays, co- insurance and/or deductibles at the time of service rendered**.
I authorize Texas Kidney Consultants, and its billing agents to release pertinent medical information to my insurance company or companies when requested, or to facilitate payment of a claim.

____________________ __________________________ ____________

Printed Name Signature Date

Cancellation/No Show Policy

Texas Kidney Consultants requires a minimum of 24 hours notice for appointment cancellation except in the case of Emergency. This allows us to accommodate another patient.

Excessive cancellations and/or no shows may result in the practice discharging you from care.

I have read and understand the above policy

____________________ __________________________ ____________

Printed Name Signature Date

Labs prior to visit policy

Most return and follow-up visits will require the patient to have had labs drawn and resulted prior to the visit.
We will send orders to the requested lab and provide a paper copy of the orders for you to take with you.
It is your responsibility to make sure all labs are drawn prior to your visit. Failure to have labwork done as requested may result in the appointment being rescheduled

I have read and understand the above policy

____________________ __________________________ ____________

Printed Name Signature Date

© Jan 2018 Texas Kidney Consultants -registered DBA of Dialysis Associates

Patient Acknowledgements and Consents

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign this Acknowledgement*

I understand that as part of the provision of healthcare services, Texas Kidney Consultants originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Texas Kidney Consultants for treatment, payment, and health care operations. For example, my health information serves as:

- A basis for planning my care and treatment;
- A means of communication among other health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payor can verify that services billed were actually provided;

I acknowledge that I have been provided with Texas Kidney Consultants' Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Texas Kidney Consultants reserves the right to change its Notice of Privacy Practices at any time and that I will be provided a copy of the revised Notice of Privacy Practices.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Texas Kidney Consultants is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that Texas Kidney Consultants has already taken action in reliance thereon.

By signing this form, I consent to Texas Kidney Consultants use and disclosure of my health information for treatment, payment, and health care operations.

☐ I request the following restrictions to the use or disclosure of my health information:

____

____

____

☐ Restrictions Accepted ☐ Restrictions Denied

Print Patient Name ________________________ DOB__________ Last 4 SS# ________

Signature of Patient/Patient Representative ______________________Date __________

© Jan 2018 Texas Kidney Consultants -registered DBA of Dialysis Associates

PAST HISTORY

Write in the names and dates of any diseases you have had which required hospitalization:

____

____

____

Write the names and dates of any serious illnesses you have had NOT requiring hospitalization:

____

____

____

Serious operations, injuries or accidents

____

____

____

Do you know of any relative (mother, father, sisters or brothers) who have had: (Circle and give relationship)

Stroke________________________________ Cancer________________________________

Heart disease__________________________ Arthritis_______________________________

Tuberculosis___________________________

SOCIAL HISTORY

Y N Do you smoke? If so, how many per day?_________________ How long? ______________________

Y N Do you regularly drink alcohol? If so, about how many drinks per week?______________________

HYPERTENSION

Y N Have you ever been told that your blood pressure was too high? If so, when?

Y N Have you ever been diagnosed as having high blood pressure (hypertension)? If so, when?

Y N Are you currently on medication for high blood pressure? If so, please list:

Y N Do you avoid salt?

Y N Do you have a family history of high blood pressure?

DIABETES

Y N Do you have diabetes? If so, when was this disease first diagnosed?_____________________

Y N If so, are you on treatment? What type of treatment?

Diet____

Oral Drugs? If so, medication and strength_____________________________________

Insulin? If so, type and dose____