Western Nephrology
Caring for People with Kidney Disorders

HOSPITAL FOLLOW UP PACKET

Our records indicate you were recently released from the hospital and referred for follow up care with one of our Nephrologists. Please complete the attached forms and bring them with you to your appointment.

In order to make your appointment with the consulting doctor more efficient and beneficial, we ask that you do the following:

- If you have insurance that requires a referral, you must check with your referring physician before your appointment to make sure that they have sent us a copy of the referral. If we do not have written verification, your appointment will have to be rescheduled.
- **Please arrive 20 minutes before your scheduled appointment time** to allow time to complete your registration.
- Please bring all pill bottles, including any vitamins and herbal supplements.
- Come to your appointment prepared to give a urine sample.
- Please provide the most up to date and accurate information regarding your current concerns and past medical history.
- If you need **to cancel or reschedule** your appointment, please **call 48 hours (2 days) in advance.**

Providing this information will help your appointment run smoothly and help your Kidney Care Team provide you with the best care possible.

Thank you.

Sincerely,
Western Nephrology Staff

Western Nephrology
Caring for People with Kidney Disorders

PATIENT QUESTIONNAIRE

Please complete the following questionnaire and bring it to your appointment.

Name: _____ **Date of Birth:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email Address: _____ **Social Security #:** _____

Do you have an Advance Directive? (Living will, Power of Attorney, Do Not Resuscitate) ☐ YES ☐ NO

Date of your last Flu Vaccine? (Month/Year if the date is uncertain) _____

List all your current doctors (please include your Primary Care Physician and all Specialists): _____

_____

_____

Preferred Pharmacy (pharmacy name and address, or major cross streets): _____

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Primary Language: _____

What is Your Ethnicity?

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to specify

What is Your Race?

☐ American Indian/Eskimo
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Black/African American
☐ Hispanic
☐ Asian
☐ Other Pacific Islander
☐ Other
☐ Prefer not to specify

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PATIENT FINANCIAL AGREEMENT

Thank you for choosing Western Nephrology as your health care provider. We are committed to being a partner in providing you conscientious medical care. Payment for services is considered an important part of that partnership. The following is a statement of our Financial Policy. Please take a moment to read and sign this Agreement.

It is your responsibility to:

- Understand your health care plan.
- Know if a referral is required.
- Know if preauthorization is required prior to a procedure.
- Know what services are covered by your health care plan.

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service. In the event that you are unable to pay the full amount of your deductible or coinsurance at the time of service, you will be asked to pay at least $50 as a deposit towards the total amount due.

We accept cash, checks, Visa, MasterCard, Discover and American Express. Any other arrangements *must be made in advance* with our Billing Office at 303-456-5484.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. Western Nephrology contracts with—and is able to bill—most insurance carriers. We also participate with both Medicare and Medicaid of Colorado.

If you are insured by a company with which we do not contract, we can supply you with a statement of your charges. You may submit that statement, along with any additional forms your insurance requires, to your insurance company.

By signing below I confirm:

1. I have read and agree to comply with this Financial Agreement.
2. I authorize and consent to the release of medical information necessary to bill and process insurance claims.
3. I authorize payment of medical benefits directly to the physician.
4. I agree that if Western Nephrology cannot successfully collect on an outstanding balance, and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees, shall be included as part of the obligation due.

_____

Name of Patient (please print) Date of Birth

_____

Signature of Responsible Party Date

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information may be used, disclosed and accessed. *Please review it carefully!*

Uses and disclosures of health information: This office is permitted by federal law to make use/disclosure of your health information for treatment, payment and health care operations. Protected health information (PHI) is the information we create and obtain in providing services. This includes documenting symptoms, examination and test results, diagnosis and treatment. It also includes billing for services. Information may be shared verbally, by mail, email, fax, or other methods. Without your authorization, we are prohibited to use or disclose your PHI for marketing purposes and may not sell your PHI without authorization.

We may use or disclose PHI about you without your authorization for several purposes. Subject to certain requirements, we may share PHI for evaluation by *our* research department, for auditing, for student training, for credentialing, for medical review, for legal services and for insurance. Where applicable, we may disclose PHI to dialysis facilities for dialysis treatment. We also provide information when required by law, such as law enforcement, judicial/administrative proceedings, or public health purposes. At your request, we may not disclose information about health care you have paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law.

We participate in Colorado's Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. The HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other health care providers. 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. You may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

We ask for your written authorization before using or disclosing any PHI. If you chose to sign an authorization, you can later revoke *in writing* that authorization to stop future uses and disclosures.

When we make a significant change in our policies, we will change and post the new notice in the waiting area. You can also request a copy of our notice at any time, or download this notice at our website: *www.westneph.com.* For more information, contact our Compliance Officer listed below.

Your individual rights: You have the right to look at or obtain a copy of your health information. If you request copies, we will charge you copy fees. You also have the right to receive a list of instances where we have disclosed your information for reasons other than treatment, payment, or administrative purposes and other than when you authorized it. If you believe that information in your record is incorrect or missing, you have the right to request that we correct or add the information. We have **30 days** to respond to your request.

To file a complaint: If you are concerned we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact the Compliance Officer listed below. You may also send a written complaint to the US Department of Health and Human Services. Our Compliance Officer can provide you with the appropriate address, upon request.

Our legal duties and responsibilities: If a security breach occurs, we are required to notify you within 60 days of discovery. We are required to maintain the privacy of your PHI, provide this notice, follow terms described in this notice, and obtain your acknowledgment of receipt of this notice.

If you have questions or concerns, please contact Western Nephrology Compliance Officer at 4891 Independence St., Suite 120, Wheat Ridge, CO 80033, 303-456-5495.

I hereby acknowledge that I have received Western Nephrology's Notice of Privacy Practices.

_____

Name of Patient (please print) Date of Birth

_____

Patient's Signature Date

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CONTROLLED SUBSTANCES NOTIFICATION

If we prescribe you a "controlled" medication, your prescription information will be entered into Colorado's Prescription Drug Monitoring Program (PDMP) Database. The Database is protected and your health record can only be accessed by caregivers or law enforcement officers in the case of an authorized investigation.

You have a right to access your information in the PDMP through the Colorado Board of Pharmacy. You may also seek corrections to information in the database.

For more information go to: http://www.hidinc.com/copdmp

Name of Patient (please print)	Date of Birth
Patient's Signature	Date

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AUTHORIZATIONS

Please read the below sections carefully and initial next to the item(s) you wish to authorize.

Access to Prescription History: I understand that prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewable by providers and authorized staff at Western Nephrology. This history is viewable in our electronic medical record (EMR) system and gives our providers information they need to give you the best possible care.

_____ I authorize Western Nephrology to view my external prescription history.

Text Messages: the Telephone Consumer Protection Act (TCPA) rules were revised as of October 16, 2013. The revision focused on the requirement to have prior written consent to receive text messages.

_____ I consent to receiving text message appointment reminders from Western Nephrology.

_____ I consent to receiving text message clinical details from Western Nephrology.

Phone Calls: the TCPA revision also required written consent for all autodialed and/or pre-recorded calls made to cell phone and residential land lines.

_____ I consent to receiving phone call appointment reminders from Western Nephrology.

_____ I consent to receiving phone call clinical details from Western Nephrology.

Voice Messages: may we leave detailed voice messages regarding your health?

Home Phone: ☐ YES ☐ NO Cell Phone: ☐ YES ☐ NO

Authorization to Share Health Information: please list any family members, friends, or caregivers with whom you authorize Western Nephrology to share your health information. **If no, please leave blank. Note: we will not leave detailed voice messages for the contacts listed below.**

Name	Relationship	Home Phone	Work Phone	Cell Phone
Emergency Contact? ☐ Yes	☐ No			

Name	Relationship	Home Phone	Work Phone	Cell Phone
Emergency Contact? ☐ Yes	☐ No			

Patient Information:

Name of Patient (please print) Date of Birth

Patient's Signature Date

Western Nephrology
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Medical History

Patient Name: _____ Date of Birth: _____

Date of Appointment: _____

Marital Status: ☐ Single/Never Married ☐ Married ☐ Divorced ☐ Widow/Widower

Living with: _____ Your Occupation: _____

What was the date of your last FLU Vaccine? _____ (Month/Year if you don't know the exact date)

Please list any medications you currently taking along with **dosage and directions** (including birth control, vitamins and OTC medications):

☐ I brought all my bottles with me ☐ See attached medication list

Medical History – Health Conditions

	Yes	No		Yes	No		Yes	No
Kidney Disease (if yes, please specify)			Kidney Stones			Diabetes/High Blood Sugar		
Irregular Heart Beat			Tuberculosis			Stroke		
High Blood Pressure			Gallstones			Epilepsy/Seizures		
Heart Attack			Liver Disease (if yes, please specify)			Thyroid Problems		
Heart Murmur			Ulcers in Stomach/Bowel			Anemia		
Rheumatic Fever			Bleeding from Bowels			Asthma		
High Cholesterol			Arthritis			Cancer *(if yes, please specify)*		
Congestive Heart Failure			Prostate Problems			Blood Transfusion		
Emphysema/Chronic Bronchitis			Gout			Depression		
Blood Clot in Lung			Skin Disease *(if yes, please specify)*			Anxiety		
Blood Clot in Leg			Bleeding Problems *(if yes, please specify)*			Other *(if yes, please specify)*		

Please list **any allergies** you have: _____

_____

_____

Hospitalizations (please list the location and reason for your recent hospital visit): _____

_____

_____

Surgeries

	Yes	Date	No		Yes	Date	No
Nephrectomy				Bladder surgeries			
Cataract Surgery *(if yes, please specify)*				Joint Scope Surgery			
Tonsils Removed				Knee/Hip Joint Replacement			
Neck Artery Surgery				Back Disk Surgery			
Open Heart Surgery/Catheterization				Prostate Surgery			
Appendectomy				Hernia Surgery			
Gallbladder Removal				Vasectomy			
Abdominal Surgery				Hysterectomy			

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Family Medical History

(Please specify relation to you i.e. mother, father, sister, brother, child, etc.)

Condition	Relation	Condition	Relation	Condition	Relation
Heart Attack		Kidney Disease		Diabetes/High Blood Sugar	
High Blood Pressure		Gout/Arthritis		Liver Disease	
High Cholesterol		Osteoporosis		Alcohol Abuse	
Asthma		Stroke		Anxiety or Depression	
Tuberculosis		Epilepsy/Seizures		Glaucoma	
Cancer *(if yes, please specify)*		Bleeding Problems		Other *(if yes, please specify)*	

Mother: ☐ Alive ☐ Deceased **Father:** ☐ Alive ☐ Deceased

Siblings: How many brothers? _____ How many sisters? _____

Children: How many sons? _____ How many daughters? _____

Other History

Have you ever smoked? ☐ Yes ☐ No

- If Yes, for how many years? _____
- If you have stopped smoking, when did you quit? _____
- If you currently smoke, how many packs per day? _____
- Do you use smokeless tobacco (i.e. chewing tobacco)? _____

Alcohol/Drugs

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how often did you have a drink containing alcohol in the past year?
  ☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week
- If yes, how many drinks did you have on a typical day when you were drinking in the past year?
  ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7-9 ☐ 10 or more
- If yes, how often did you have 6 or more drinks on one occasion in the past year?
  ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily ☐ Almost daily

Do you currently use recreational drugs? ☐ Yes ☐ No

- If yes, how often and which drugs? _____
- If no, have you used recreational drugs in the past? _____

Exercise *(please check frequency)*: ☐ Walking ☐ Other _____

Frequency: ☐ Rarely ☐ Occasional ☐ Never ☐ Daily ☐ Other _____

Have you experienced any of the following symptoms ***since your hospital visit?***

*****Do Not Include Chronic Symptoms*****

	Y	N		Y	N		Y	N
Change in appetite			Painful joints			Difficulty urinating		
Shortness of breath at rest			Unexplained Weight Gain			Unexplained Weight Loss		
Heart trouble			Shortness of breath with exertion			Chest Pain		
Abdominal Pain			Swelling of ankles			Nausea/Vomiting		
Blood in urine			Diarrhea			Painful urination		