Colorado Kidney Care
Where Quality Comes to Life

Welcome to Colorado Kidney Care! This packet contains important information to ensure a productive and thorough visit. Please take the time to complete these forms in as much detail as possible. Please bring with you to your appointment a **list of your medications** or your **medication bottles,** including vitamins and herbal supplements, and a **list of medication allergies**, **a photo id, or proof of residency** and your **insurance card**. ***Upon your arrival, also please be prepared to supply us with a urine specimen.***

This packet of information includes **"review of systems form"** which is a brief medical history for you**.** Remember, please be as detailed as possible as this will ensure a thorough visit. Also included are the **Statement of Payment Policy, Release of Information Form** and **Advanced Directive and Healthcare Proxy.**

Please complete the above forms and return to us via three options:

- Email to ckcpatientpackets@cokidneycare.com
- Fax to 303-327-4711 at least 1 week prior to your appointment.
- Bring the completed forms to the office

If you choose to email or fax your packet back to the office please bring your hard copies with you to the appointment. This will eliminate any delay for check-in if there was an error in receiving these forms.

It is important that you arrive **at least 30 minutes** early since we have a lot of information to exchange. Please note that patients arriving late for scheduled appointments may need to be rescheduled per the physician's discretion. We accept credit cards, checks, and cash for payment and your co-payment is required to be paid at the time of service. We do not keep change on site so please bring the correct amount. If for any reason you need to reschedule or cancel your appointment, please give us at least 24 hour notice so we can accommodate other patients. Please note that due to the fact that missed appointments or cancellations/reschedules with less than 24 hours notice cause us financial loss, we will not be able to reschedule your appointment in the following situations:

1. If you have not shown up for your initial appt. with us on 2 separate occasions.
2. You have cancelled or rescheduled your initial appt. with us 3 different times with less than 24 hour notice.

These situations do not allow us enough time to schedule another patient in your place and therefore the physician's time is lost. Thank you for your understanding of this policy and for giving us ample notice if you need to change your appointment time. Our primary source of communication with patients after their first visit is via our online Patient Portal. All non-urgent communication with our staff and your provider will be through our Patient Portal so our staff will be signing you up for Portal access at your first visit. Please be prepared to supply us with an email address either for yourself or a primary caretaker at this visit. You will receive more details at your visit.

Attached are directions and map to our office, please see notes for parking instructions on map page.
We look forward to meeting you. If you have any question or concerns prior to your visit, please contact our Central scheduling office at 303-327-4700 – option #4.

Thank You, Colorado Kidney Care Team

See our website for office hours. www.cokidneycare.com

Review of systems

Name: _____ Date of Birth: _____

Date of appointment: _____ **Physician:** _____

Below are the numbers we have on file to contact you.
Please circle yes or no if we are able to leave messages for you at the following numbers.

May leave message at:

Home Phone: _____ yes / no
Work Phone: _____ yes / no
Cell Phone: _____ yes / no
Emergency Phone: _____ yes / no
Name: _____
Relationship: _____

Which contact number would you prefer our office staff to use when trying to reach you between 8am and 5pm on weekdays? Home Work Cell Emergency (circle one)

Please list your:
Referring Physician: _____, **Phone #:** _____
Primary Care Physician: _____, **Phone #:** _____

Are there other providers you see routinely (for example, Cardiologist, endocrinologist, etc..) that are not listed above that you feel we should obtain records from and/or send copies of your visit notes to?
If so please list their name and phone number below.

Name **Phone**

_____
_____
_____

Which pharmacy do you use to fill most of your prescriptions?
Pharmacy Name _____
Pharmacy Address _____
Pharmacy Phone # _____ Fax # _____

Which lab do you routinely use?
Lab Name _____

Signature: _____ **Date:** _____

Year: _____/ _____ *Year:* _____/ _____ *Year:* _____/ _____

Patient Name: _____ Date of Birth: _____

Review of systems

Why are we seeing you? _____

_____

_____

Medications you are taking (all prescription, over the counter medications, vitamins & herbals)

Name	Dose(mg,mcg,ml,etc)	Frequency(daily, twice daily, etc)

Have you ever been told by a doctor that you have…? (Circle Answer)

Renal History

Yes	No	Kidney disease	
Yes	No	Kidney stones	
Yes	No	High blood pressure	
Yes	No	Urine infections	
Yes	No	Blood in your urine	
Yes	No	Protein in your urine	
Yes	No	Foamy urine	
Yes	No	Burning with urination	
Yes	No	Trouble passing urine	
Yes	No	Get up at night to pass urine	How many times?
Yes	No	Swelling of legs	
Yes	No	Do you check BP	

Patient Name: _____

Past Medical History

Yes	No	Diabetes
Yes	No	High blood pressure
Yes	No	Stroke
Yes	No	Seizure disorder
Yes	No	Heart disease
Yes	No	Heart murmur
Yes	No	Heart rhythm disturbance
Yes	No	Emphysema/COPD
Yes	No	Asthma
Yes	No	Blood clots legs or lung
Yes	No	Sleep Apnea
Yes	No	Gastrointestinal bleeding
Yes	No	Liver disease or hepatitis
Yes	No	Thyroid trouble
Yes	No	Cancer
Yes	No	Have you ever had a Blood transfusion?
Yes	No	HIV infection
Yes	No	Tuberculosis
Yes	No	Lupus

For Women

Yes	No	Do you have menstrual periods?
Yes	No	Have you been pregnant? If yes, # of pregnancies?
Yes	No	Did you have toxemia/preeclampsia/complications in any of your pregnancies?
Yes	No	Do you have an annual Pap smear? If yes, any abnormalities?
Yes	No	Do you have a regular mammogram? If yes, any abnormalities?

Other medical history (please specify) _____

_____

_____

Are you allergic to any medication?

List allergies and state what kind of reaction, if known. Circle "none" if you have no known allergies.

_____

_____

_____

_____

List your history of surgeries. Include any heart stents or bypass surgeries. Please include dates (year is adequate).

_____

_____

_____

Have you been hospitalized recently?

_____

_____

_____

Patient Name: _____

Family Medical History

Member	A – alive D - deceased	Kidney Disease	High blood pressure	Diabetes	Coronary Heart disease	Stroke	Cancer	Autoimmune disease (lupus, RA)
Father								
Mother								
Sibling(s)								
Son(s)								
Daughter(s)								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Paternal Uncle								
Paternal Aunt								
Maternal Uncle								
Maternal Aunt								

Other _____

Social History

Yes	No	Did you receive the seasonal flu shot this year?
Yes	No	Do you smoke? If yes, how many packs/day?
Yes	No	Did you previously smoke? If yes, when did you quit?
Yes	No	Do you drink alcohol? If yes, how much?
Yes	No	Do you follow any diet? (low salt, vegetarian, low carb, etc?)

What kind of work do you do?_____

If retired, what did you do?_____

What type of exercise do you do, and how often?

_____

Who do you live with? (Circle all that apply)

Spouse Child/children #____ Significant Other Parent(s) Other

Marital Status (Circle Answer)

Single Married Significant Other Widowed Divorced Separated

Do you have symptoms such as: (Circle all that apply)

Fever
Chills
Fatigue or loss of energy
Loss of appetite
Weight loss of more than 10lbs
Headaches

Remarks:

_____

_____

_____

Patient Name:_____

Eyes (Circle all that apply)

Blurred vision	Loss of vision
Double vision	Eye pain
Laser therapy	Cataract surgery

Remarks: _____

Ear/Nose Throat/Mouth (Circle all that apply)

Sinus problems	Sores in mouth
Sore throat	Nose bleeds

Remarks: _____

Cardiovascular (Circle all that apply)

Chest pain or discomfort	Swelling of legs
Calf pain when walking	

Remarks: _____

Respiratory (Circle all that apply)

Shortness of breath at rest	Frequent cough
Shortness of breath with walking	Wheezing
Shortness of breath when you lie down	

Remarks: _____

Gastrointestinal (Circle all that apply)

Abdominal (stomach) pain	Frequent diarrhea
Frequent nausea/vomiting	Frequent heartburn/indigestion

Remarks: _____

Musculoskeletal (Circle all that apply)

Joint pains	Frequent Muscle pain
Swollen joints	Broken bones

Remarks: _____

Patient Name: _____

Skin (Circle all that apply)
Skin Rash Persistent itching
Remarks: _____
_____

Neurological (Circle all that apply)
Trouble with memory Pain in your hands or feet
Numbness or tingling in hands or feet
Remarks: _____
_____

Endocrine (Circle all that apply)
Too hot/cold Tired/Sluggish Excessive thirst
Remarks: _____
_____

Hematologic/Lymphatic (Circle all that apply)
Swollen glands Blood clotting problems
Remarks: _____
_____

Immunologic (Circle all immunizations that you have received)
Influenza vaccine Hepatitis B vaccine Pneumococcal vaccine
_____

Psychologic
Yes No In the past month, have you had little interest or pleasure in doing things?
Yes No In the past month, have you felt down, depressed, or hopeless?
Remarks: _____
_____

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Consent to Obtain Prescription History

This consent form authorizes Colorado Kidney Care to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Colorado Kidney Care can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Colorado Kidney Care to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed):_____Signature: _____

Patient Date of Birth:_____Date of Signing Consent Form: _____

Advance Directive and Healthcare Proxy

Yes ☐ **No** ☐ Do you have an Advance Directive?

I. An Advance Directive is a legal document (or Will) that provides guidance for medical or healthcare decisions should you be unable to make these decisions.

II. If yes, please provide a copy to us at next visit.

Yes ☐ **No** ☐ Do you have a surrogate decision maker, also known as a "healthcare proxy", who you have designated to make medical decisions if you are unable to?

If yes, what is the name of your healthcare proxy? _____

Healthcare proxy phone number: _____

Patient Name:_____Date:_____

DOB:_____

Colorado Kidney Care
Payment Policy Acknowledgement
(Office copy) As of September, 2019

Insurance Coverage: Colorado Kidney Care (CKC) will bill your health insurance carrier for services rendered by our providers, however it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy you must make our billing staff aware and present a new insurance card at your appointment. The direct phone number for the Billing Office is (720) 343-1600. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of our "Billing Statement."

Copays: Your insurance is a contract between the patient and the insurance company. CKC has an obligation with your insurance company to **collect** your copay at the time of service. **Copays are the patient's responsibility and are due at the time of service**. We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care you will be expected to pay this amount at the time of service.

Accepted Forms of Payment: We accept payment by cash, check, Money Order, Visa, MasterCard, American Express and Discover.

Patient Outstanding Balances: If you have an outstanding balance with CKC we will send a "Billing Statement" monthly to the address on file. We expect that you will pay your full balance upon receipt of our "Billing Statement". If you are unable to pay your balance in full in a single payment, please contact our Billing Office to discuss a payment plan or to determine if you qualify for a discount due to financial hardship. The direct phone number is (720) 343-1600. If you have received a "Billing Statement", you can now pay your statement online through the Patient Portal. If you have not registered for our Patient Portal please contact our office to be set up.

Unpaid Accounts: In the event that you do not pay your account balance in a timely manner, we may send your account to an **outside collection agency**. Once your account has been sent to collections, you will need to make payment arrangements with the collection agency.

Other Possible Fees:

Missed Appointment Fee - A missed appointment is a scheduled appointment that you miss without notifying us in advance. An appointment that is cancelled or rescheduled with less than 24 hours' notice is also considered a missed appointment. Our policy is that the first time you miss or cancel an appointment with less than 24 hours' notice, a letter will be sent to you. The 2nd time you miss or cancel an appointment with less than 24 hours' notice a $25.00 fee will be charged to your account. Insurance companies do not cover this charge, and you will be responsible for paying this fee prior to being seen again by our physicians. **Disclaimer:** The missed appointment fee will not be charged if you missed your appointment because you were an inpatient in the hospital.

Interpreter Fee - If a patient requires CKC to schedule an outside interpreter service to come onsite to assist with their appointment, and the patient cancels the appointment with less than 24 hour notice (unless the patient is hospitalized) or if the patient does not arrive for their appointment then the patient assumes the financial responsibility for the interpreter fee. The fee for the interpreter service can range from $50.00 - $200.00 per appointment. The interpreter service still charges CKC for their fee for an appointment that is cancelled with less than 24 hours' notice. Should this occur, CKC will pass this cost to you in our "Billing Statement".

Returned Check Fee – There will be a $25.00 service fee on all returned checks.

I have read, and agree to the above Payment Policy. I understand charges not covered by my insurance company, as well as copays, deductibles, and co-insurance are my responsibility.

Patient Name Printed: _____

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please review our Practice's Notice of Privacy Practices on our website www.cokidneycare.com or wait to review upon arrival to our office.

_____ _____
Print Name Date of Birth

_____ _____
Patient Signature Date
(or Patient Legal Representative*)

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

Below is a list of individuals that I authorize to receive my medical information from Colorado Kidney Care. This includes emergency contact, spouse, friends and family members.

☐ Check this box if you do not authorize access to your medical information to any family member, friend or emergency contact. This excludes release to medical professionals, physicians and hospitals.

Emergency Contact:

_____ _____ _____
Name Relationship Phone

Below list any other family members or friends you will allow us to talk to about your medical care:

_____ _____ _____
Name Relationship Phone

_____ _____ _____
Name Relationship Phone

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement An
☐ emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify _____

*Year:*_____/_____ *Year:*_____/_____ *Year:*_____/_____

date / initials *date / initials* *date/initials*