Colorado Kidney Care

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, and bring with you to your appointment with 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, please be prepared to supply us with a urine specimen.***

This packet of information includes the **"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, Consent to Obtain Prescription History**, **Advanced Directive and Healthcare Proxy and Acknowledgement of Receipt of Notice of Privacy Practices.**

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-hour 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

Name: _____Date of Birth:_____

Date of appointment:_____Physician:_____

Please circle preferred language: English Spanish

Please circle preferred pronoun: He/Him, She/Her, They/Them, Other_____

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: _____

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	How many times?
Yes	No	Swelling of legs	
Yes	No	Do you check BP	

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?

_____

_____

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

Remarks: _____

_____

_____

Patient Name:_____

Eyes (Circle all that apply) **Remarks**: _____

Blurred vision Loss of vision _____

Double vision Eye pain _____

Laser therapy Cataract surgery

Ear/Nose Throat/Mouth (Circle all that apply) **Remarks**: _____

Sinus problems Sores in mouth _____

Sore throat Nose bleeds

Cardiovascular (Circle all that apply) **Remarks**: _____

Chest pain or discomfort Swelling of legs _____

Calf pain when walking

Respiratory (Circle all that apply) **Remarks**: _____

Shortness of breath at rest Frequent cough _____

Shortness of breath with walking Wheezing _____

Shortness of breath when you lie down

Gastrointestinal (Circle all that apply) **Remarks**: _____

Abdominal (stomach) pain Frequent diarrhea _____

Frequent nausea/vomiting _____

Frequent heartburn/indigestion

Musculoskeletal (Circle all that apply) **Remarks:** _____

Joint pains Frequent Muscle pain _____

Swollen joints Broken bones _____

Skin (Circle all that apply) **Remarks:** _____

Skin Rash Persistent itching _____

Neurological (Circle all that apply) **Remarks:** _____

Trouble with memory Pain in your hands or feet _____

Numbness or tingling in hands or feet _____

Endocrine (Circle all that apply) **Remarks:** _____

Too hot/cold Tired/Sluggish Excessive thirst _____

_____

Hematologic/Lymphatic (Circle all that apply) **Remarks:** _____

Swollen glands Blood clotting problems _____

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: _____

_____

Colorado Kidney Care

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 ordosages.

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 Care Plan and Surrogate Decision Maker

Yes ☐ **No** ☐ Do you have an Advance Care Plan?

I. An Advance Care Plan is a legal document (Living Will or Power of Attorney) 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 who you have designated to make medical decisions for you, if you are unable to?

If yes, what is the name of your Surrogate Decision Maker?

_____

Surrogate Decision Maker phone number:

_____

Patient Name: _____ DOB: _____

Date this form was completed: _____

Colorado Kidney Care Payment Policy Acknowledgement

As of February 2024

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 or office 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/Deductables/Co-Insurance: Your insurance is a contract between the patient and the insurance company. CKC has an obligation with your insurance company to **collect** your patient portion payment at the time of service. **Copays/Deductables/ Co-Insurance amounts 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 Visa, MasterCard, American Express and Discover, or cash, check and money order.

Patient Outstanding Balances: If you have an outstanding balance with CKC we will send you a Billing Statement by either a text, email, or US mail, depending on the preferences you have set up with us on how you prefer us to contact you. 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, you can either set up a payment plan (if your balance amount is eligible for such a plan) via the text or email we send with your Billing Statement, or you can contact our Billing Office at 720-343-1600 to discuss a payment plan or to determine if you qualify for a discount due to financial hardship.

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:

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, and you are responsible for paying this amount.

Outside Services Ordered by our Providers – Once you have established care with one of our providers, they may order tests such as labwork (blood or urine tests), diagnostic imaging (Ultrasound, CT scan, MRI) or procedures (biopsy or medication infusion) with outside facilities that are not part of our practice. Please note it is the patient's responsibility to tell us where they would like to go to have testing and procedures done, to ensure that the facility where they go is "In-Network" with their insurance plan, and they do not incur extra fees for out-of-network facilities. While our staff will assist in sending orders to a facility of the patient's choice so that their appointment can be set up, we will not direct a patient to go to any specific facility for these tests or procedures. If a patient is unsure which facilities are in-network with their insurance our staff will provide them with a copy of the test or procedure order form and the patient can then call their insurance carrier and ask for a list of facilities where they can be seen, and the patient can then contact one of the facilities to arrange for their appointment. If a patient schedules testing or procedure services at a facility that is not in-network with their insurance plan, CKC is not responsible for any out-of-network fees the patient may be billed for, these fees will be the patient's responsibility. Patients also need to make sure that any prior authorizations that may be required by your insurance are completed prior to their appointment.

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:_____

Colorado Kidney Care

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 prevented us from obtaining acknowledgement
- ☐ Other (Please specify): _____

Year: _____/_____ *Year:* _____/_____ *Year:* _____/_____
date / initials *date / initials* *date / initials*