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:

- Mail in the self-addressed stamped envelope provided
- Email to denvernephpatientpackets@cokidneycare.com
- Fax to _____ at least 1 week prior to your appointment.

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

Office hours are: Monday – Friday 8:00 a.m. – 5:00 p.m. / Closed daily 12:00 p.m. – 1:00 p.m.

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 for your visit?
If so please list their name and phone number below.

_____
_____
_____

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.

_____
_____
_____
_____

What surgeries (e.g. heart bypass) or interventions (e.g. heart cath or stent) have you had? 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

Yes No Are you widowed or divorced?

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)

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:_____
_____
__

Colorado Kidney Care

Where Quality Comes to Life

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): _____

Patient Date of Birth: _____

Patient Signature: _____

Date of Signing Consent Form: _____

Colorado Kidney Care
Payment Policy Acknowledgement
(Office copy) As of March, 2013

Insurance Coverage: We will bill your health insurance carrier for services rendered by our providers, but 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 staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Copays: We have a contractual obligation (with your insurance company) to **collect** your copay at the time of service, and you have a contractual obligation (with your insurance company) to **pay** 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. If you fail to pay your copay at the time of your appointment, we will charge an Administrative Fee of $5.00 per month for each month that your copay remains unpaid. Insurance will not cover the Administrative Fee, and you are personally financially responsible for payment.

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

Patient Outstanding Balances: If you have an outstanding balance with our company we will send a "Billing Statement" monthly to your home. We expect that you will pay your full balance upon receipt of our billing statement. If you are unable to pay the outstanding balance in full in a single payment, please contact our Billing Office. Our Billing Office is available Monday – Friday from 8:00am to 5:00pm. Please call us to discuss payment plans, patient financial evaluations and discounts available. Our direct phone number is (720) 343-1600.

Unpaid Accounts: In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency. If your account is sent to an outside collection agency, we will add a collection fee to your account balance. The collection fee we charge you will be equal to the amount that the collection agency charges us. You will be responsible for paying the full balance, including this fee in order to continue receiving medical care from our physicians. 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.

Returned Check Fee – We charge $20.00 to patients whose checks are returned by our bank for non-sufficient funds. If a patient puts a stop payment on a check, the amount we will charge is $25.00. This is the amount our bank charges for these items

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

Patient Name Printed: _____

Patient Signature: _____ Date: _____

Colorado Kidney Care
Where Quality Comes to Life

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: _____

DOB: _____