(317) 888-1100 - Office Telephone
(317) 888-1118 - Office Fax

PATIENT NAME: ____

LAST FIRST MIDDLE

DOB: _______________ MALE FEMALE (circle one) **SOCIAL SECURITY #**: ____________________

ADDRESS: ___________________________________ **CITY** ____________ **STATE**_______ **ZIP**___________

HOME PHONE: ________________________ **CELL PHONE:** _______________________________________

WORK PHONE: __________________ **PREFERRED CONTACT #**: Work Home Cell (circle one)

EMAIL ADDRESS: ____

EMERGENCY NAME & PHONE: ____

ETHNICITY: Hispanic/Latino Not Hispanic or Latino Declined (circle one)

PREFERRED LANGUAGE(S): ____

MARITAL STATUS: Married Single Divorced Widowed Other (circle one)

REFERRED BY OTHER THAN PHYSICIAN: ____

REFERRING PHYSICIAN: ______________________________ **PHONE:** ___________________________

PRIMARY PHYSICIAN: _____________________________ **PHONE:** ____________________________

PRIMARY INSURANCE COMPANY: ____________________________________ **ID #:** __________________

GROUP #: _________________ **SUBSCRIBER NAME/RELATIONSHIP**: _______________________________

SECONDARY INSURANCE COMPANY: _______________________________ **ID #:** ____________________

GROUP #: ___________________ **SUBSCRIBER NAME/RELATIONSHIP:** _____________________________

SUBSCRIBER DOB: _____________________ **EMPLOYER:** ____

I have read, understand, and agree to the Financial Policy presented by **Kidney Physicians of Indiana**

I understand charges not covered by my insurance, as applicable copays, co-insurance, deductibles, and any charges denied due to patient negligence are my responsibility. In addition, I agree to pay: (A) collections cost in the amount of $20 if my account is forwarded to a collection agency; (B) reasonable attorney's fees incurred in the collection of my account whether or not legal proceedings are instituted; (C) court costs, and (D) interest on the unpaid balance of the account at the statutory rate from the service

I authorize benefits to be paid directly to **Kidney Physicians of Indiana.**

I authorize the release of any pertinent medical information necessary to facilitate payment of my claim(s).

My signature also acknowledges I have been given the opportunity to review the Privacy Notice.

SIGNATURE: ____

PATIENT OR RESPONSIBLE PARTY DATE

Patient's First Name: ________________________ **Last Name:** __________________________

Referring Physician: _________________________ **Phone Number:** ______________________
Reason for Referral: ____
____
____
Any Prior Surgeries? (surgery and year): ____
____
____
____

Marital Status: Married / Single / Divorced / Widowed **Number of Children:** ______

Have you ever smoked? YES/NO
If yes, do you still smoke? YES/ NO
How many years have you smoked? _____ How many cigarettes per day? _______

Do you drink alcohol? YES/NO
If yes, how many drinks per day? ______
Have you ever been diagnosed with alcoholism? YES/NO

Have you ever used illicit or intravenous drugs? YES/NO

How many caffeinated drinks do you consume per day? ________

Family History: Mother- Alive / Deceased Age if alive: _____ Mother passed of: _______________
Father- Alive / Deceased Age if alive: _____ Father passed of :________________

How many siblings?: ________ How many still alive?: _________ Sibling(s) passed of :_____________

Please check which of the following diseases are found in your family:

- Kidney Disease
- Cancer
- Hypertension
- Diabetes
- High Cholesterol
- Other (Specify): ___________________________
____

Patient's First Name: __________________________ Last Name: __________________________

Please check any of the following medical conditions that you have now or have had in the past

- Diabetes How long? _________ Any damage to your eyes? YES/NO
  Any laser surgery to eyes? YES/NO
  Do you have any pain/numbness/tingling in your feet? YES/NO
- High Blood Pressure
- Poor blood flow to legs
- History of bypass to your legs
- High Cholesterol
- Prostate related problems

Have you ever taken any of the following medicine (check all that apply):

___ Advil	___ Naproxen	___ Bextra	___ Vioxx	___ Ibuprofen
___ Motrin	___ Feldene	___ Celebrex	___ Aleve	___ Voltaren
___Lodine	___ Relafen	___ Day pro	___ Clinoril	___ Indomethacin
___ Penicillamine	___ Gold	___ Ansaid	___ Ketoprofen	___ Naproxen

Have you had significant exposure to Lead/Benzene/ or Carbon Tetrachloride? YES/NO

Please check which of the following symptoms you have had in the last six months:

___ Blood in Urine	___Sinus Problems	___ Joint/Muscle Pain	___ Difficulty w/urination
___Cough	___ Frequency in urination	___ Swelling (legs, hands)	___ Pain w/urination
___Weight Loss	___ Vomiting	___ Night Sweats	___ Skin Rash
___ Weight Gain	___Constipation	___ Chills	___Foamy urine
___ Fever	___ Diarrhea	___Nausea	___ Bloody nasal discharge

Please check any of the following that you have been diagnosed with previously:

___ CAD	___Stomach Ulcers	___ Deafness	___ Gout	___ Gastritis
___ Heart Cath	___ Colon Disease	___ Alport's Disease	___ Glomerulonephritis	___CHF
___Polycystic Kidney	___Thyroid Disease	___ Lung Disease	___ Heart Rhythm Problems	___Arthritis
___Liver Disease	___ Crohn's Disease	___ Lupus	___Blood Transfusion	___ Stroke
___ Cancer (_________)	Diagnosed: ________	Chemo or Radiation	YES/NO	

Please list any allergies to medications: ____
____
____

- I DO NOT have any drug allergies

PLEASE BRING A LIST OF MEDICATIONS WITH YOU AND GIVE TO THE FRONT DESK

Kidney Physicians of Indiana

Acknowledgement Form

This form allows/disallows KHC to leave voicemails and/or talk to family or friends of your choice about your medical records.

Instructions for Communication
I authorize my doctor or staff to <u>leave messages</u> including certain medical information:

- **YES.** On my answering machine or voicemail
- At home
- At work
- Cell Phone

OR with the following individuals:
- My spouse or significant other:____
- My son or daughter:____
- Relative:____
- Other:____

This information may include information such as:

- Lab tests and x-ray results
- Instructions regarding treatments or medications
- Information regarding prescription refills
- Information regarding appointments

- **NO.** I prefer that my doctor or staff speak to me personally regarding any medical information. **Please DO NOT LEAVE MESSAGES** concerning medical information.

I understand that I may notify the doctor's office at any time of changes to this request, which would request a new form to be completed.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices ("Notices"). I understand that I may obtain a written copy of this notice at any time upon request.

_______________________________________	___________________________
Patient's Name (Print)	**Date of birth**
_____________________________________	___________________________
Patient's Signature	**Date**

Kidney Physicians of Indiana

Authorization to Disclose Health Information
(To other offices)

Patients name: _______________________________________ Date of Birth: ____________

Social Security #: _____________________________________

Address: _____________________________ _____________________________ ___________
(Street) (City/State) (Zip Code)

Information to be released:
The type and amount of information to be used or disclosed is as follows: (Include dates, if appropriate. Be specific) ALL____

For the following dates: N/A____

This information may be disclosed to and used by the following individuals or organization:
Kidney Physicians of Indiana
7830 S. Madison Ave. Suite B
Indianapolis, IN 46227

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, as provided in CFR 164.524. I understand that if I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of the form upon request. I understand that I have the right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the Health Information Management Department of the entity listed above. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will not expire.

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to receive treatment. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of the health information, I can contact Kidney Physicians of Indiana at 317-888-1100.

____ ____________________
Patient's Signature or legal representative **Date**

____
(If signed by rep, state relationship and authority to do so)

Kidney Physicians of Indiana

Our Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is a part of this care. Your clear understanding of our financial policy is important to our professional relationship. Please ask our staff if you have any questions about fees, our financial policy, or your responsibility.

All patients must complete in full our “Patient Information Form” and provide us with accurate insurance information including an insurance card at each visit before seeing the provider.

Full payment is due at the time of service; we accept cash, checks, Visa, and MasterCard.

Responsible Party

You will be responsible for your charges regardless of any divorce decree or court order regarding payment of medical bills

Minor accompanied by an adult
A parent or legal guardian must accompany patients who are minors on the patient’s visit and must sign the financial statement for the patient accepting responsibly for the account.

If you have…	You are responsible…
HMO, PPO, and POS plans with which we have a contract	**If the services are covered by the plan:** All applicable co-pays, deductibles are expected at the time of the office visit. **If the services you receive are not covered by the plan:** Payment in full is expected at the time of visit We suggest that you call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services. It is your responsibility to obtain any necessary referrals. We will file an insurance claim as a courtesy to you.
Medicare	If you have regular Medicare, and have not met your $100.00 deductible, we expect it to be paid at the time of service. Any services not covered by Medicare will be your responsibility. If you have Medicare as primary and also have a secondary insurance: No payment is necessary at the time of the visit. If you have Medicare as primary but no secondary insurance: Payment of 20% co-pay is expected at the time of the visit. We will file an insurance claim as a courtesy to you.
No insurance/ Self Pay Commercial Insurance	Payment in full at the time of the visit. If the total cost of the visit is not able to be determined, you will be asked to make an estimated payment and will be billed or credited for the difference. Please ask to speak with our staff if you need assistance or an extended payment schedule.

….Next

...Continued

Non-Sufficient fund check
Your account will be charged $20.00 for each time a check is returned for non-sufficient funds. If your bank does not honor these checks, you will be responsible for the payment of the check and additional charges within 10 days. If payment is not made, a claim will be filled in court for three times the amount of the check, NSF charges, costs, and any past due balance. Any further payments charged to your account will need to be made with cash or credit card.

Collection policies
If your account is 90 days delinquent, it will be subject to a 15% interest charge accrued monthly. If your account has not been satisfied within a reasonable period of time your account will be sent to a collection agency or an attorney. If your account is given to an attorney for collection, you will be responsible to pay court costs allowed, cost of collection, and reasonable attorney fees. Patient care with our office will be canceled once your account goes to collection.

Missed Appointment
Unless the cancellation is at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us service you better by keeping your scheduled appointment.

I have read, understood, and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits to be paid directly to Kidney Physicians of Indiana and I authorize them to release and pertinent medical information to facilitate payment of the claim.

____
Patient's Name

______________________________________ ____________________________
Patient's Signature **Date**