WELCOME!

Dear Patient:
Welcome to Providence Kidney Care. In order to allow our staff to focus their energy on your health care needs, please take a few moments to read and complete the following package of information before you arrive in our office.

Your first appointment
When you come for your first appointment, please bring the following documents:

- Completed Patient Registration Form
- Completed Health Questionnaire
- Completed Authorization For Release of Information (if applicable or if you have a personal representative (spouse) who you are authorizing us to communicate with regarding your care.)
- Completed Insurance Eligibility Waiver
- Completed Privacy Policy Acknowledgement Statement
- Completed Physician-Patient Arbitration Agreement
- Your current insurance identification card

Also, please read these documents:

- Notice of Privacy Practices
  When you arrive in the office, you will be asked to sign an acknowledgment that simply states you were offered a copy or you may sign the acknowledgement in this package and bring it with you to your visit.
- Office Policies

Don't forget! Please bring your current insurance identification card each time you visit our office.

We look forward to working with you and developing a mutually beneficial relationship. If you have any questions, please do not hesitate to contact us at 740-915-7475.

Phone: 740-915-7475 Office: 1406 Dickerson Street, Newark, Ohio 43055.
Fax: 740-915-7253

PATIENT REGISTRATION

Patient Last Name _____First Name _____ Middle Initial _____
Address _____City_____State _____Zip _____
Home Phone _____Work Phone _____Cell Phone _____
Email address _____Fax _____ SS# _____
Date of Birth _____Sex: ☐Female ☐Male
Marital Status _____Spouse/partner name (if any) _____
Employer Name _____Phone _____
Employer Address _____City _____State _____Zip _____
PCP Name & Address _____
PCP Phone _____ PCP Fax _____

Which is preferred phone number to call? ☐Home ☐Work ☐Cell.
Is it okay to leave voice mail messages with private health information? ☐Yes ☐No
Please list any family members with whom we can discuss your medical care: ☐None ☐List:_____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____Policy # _____Phone _____
Name of Insured _____Relationship _____
SS# _____Date of Birth _____
Employer Name _____Phone _____
Employer Address _____City _____State _____Zip _____

Secondary Insurance

Insurance Name _____Policy # _____Phone _____
Name of Insured _____Relationship _____
SS# _____Date of Birth _____
Employer Name _____Phone _____
Employer Address _____ City _____State _____Zip _____
Referring Physician Name _____Phone_____
PCP Name _____Phone_____
Emergency Contact _____ Phone_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. I also authorize Providence Kidney Care or insurance company to release any information required to process my claims. A copy of this signature is valid as the original. I also give my permission for a report of my evaluation, treatment and follow up evaluation to be sent to my referring physician or primary care physician.
I have read this authorization section completely and I understand and accept the writing.

Please Initial_____

Signature of Patient / Authorized Person _____Date _____

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PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Date of Birth _____
Referring Physician _____

REVIEW OF SYSTEMS

Have you recently had the following:

General			**Digestive System**		
Tire easily, weakness	Yes	No	Change in appetite	Yes	No
Marked weight change	Yes	No	Difficulty swallowing	Yes	No
Night sweats	Yes	No	Heartburn	Yes	No
Persistent fever	Yes	No	Abdominal distress	Yes	No
Skin			Belching	Yes	No
Eruptious(rash)	Yes	No	Nausea	Yes	No
			Vomiting	Yes	No
			Vomiting blood	Yes	No
			Rectal bleeding	Yes	No
			Tarry stools	Yes	No
			Dark urine	Yes	No
Eyes			Jaundice	Yes	No
Trouble seeing	Yes	No	Constipation	Yes	No
Eye pain	Yes	No	Diarrhea	Yes	No
Inflamed yes	Yes	No	Hemorrhoids	Yes	No
Double vision	Yes	No	**Genitourinary System**		
Worn glasses	Yes	No	Frequency of urination	Yes	No
Nose			Unable to hold urine	Yes	No
Loss of smell	Yes	No	Painful urination	Yes	No
Frequent colds	Yes	No	Bloody urine	Yes	No
Nosebleeds	Yes	No	Loss of erection	Yes	No
Mouth /Throat			Lack of sex drive	Yes	No
Sore gums	Yes	No	Painful intercourse	Yes	No
Hoarseness	Yes	No	**Musculoskeletal**		
Postnasal discharge	Yes	No	Muscle cramps	Yes	No
Breast			Muscle weakness	Yes	No
Lumps	Yes	No	Painful joints	Yes	No
Nipple discharge	Yes	No	Swollen joints	Yes	No
Breast tenderness	Yes	No	**Nervous System**		
Cardiorespiratory System			Headache	Yes	No
Persistent cough	Yes	No	Dizziness	Yes	No
Bloody sputum	Yes	No	Fainting	Yes	No
Wheezing	Yes	No	Seizures	Yes	No
Chest pain	Yes	No	Insomnia	Yes	No
Difficulty breathing	Yes	No	Depression	Yes	No
Ankle swelling	Yes	No	Memory loss	Yes	No
Palpitations	Yes	No	Weakness	Yes	No
High blood pressure	Yes	No	Poor coordination	Yes	No

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BLOOD PRESSURE MEDICATIONS ☐Yes ☐No
If yes, list the medication name(s), dose strength and frequency below.

_____
_____
_____

PATIENT MEDICATIONS (All other except Blood Pressure meds)
List all prescription and over the counter medications and supplements you take

MEDICATION NAME (Example: Aspirin)	DOSE STRENGTH (81mg)	DOSE FREQUENCY (1 Tab once daily)

PHARMACY INFORMATION

Name _____ Phone _____
Address _____

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Patient Name_____ Date of Birth _____

PATIENT MEDICAL HISTORY

Do you currently have or have had any of the following problems.

DIAGNOSIS	CHECK IF YES	DIAGNOSIS	CHECK IF YES
Diabetes		Liver problems	
High Blood Pressure		Stomach ulcer	
Cholesterol Problems		Heartburn	
Heart Disease		Anxiety	
Kidney Failure		Depression	
Overactive Thyroid		Panic attacks	
Underactive Thyroid		Arthritis	
Stroke		Thyroid cancer	
Seizures		Prostate cancer	
Osteoporosis		Breast cancer	
Fractures		Vascular problems	

PATIENT SURGICAL HISTORY

List all surgeries you have had and year occurred. Please be as accurate as possible.

SURGERY (For Example: Gall bladder removal)	YEAR (1992)

SOCIAL HISTORY

Marital Status _____

Number of children with ages _____

Occupation (If retired list previous occupation)_____

Tobacco: ☐Cigarette ☐Cigar ☐Chewing tobacco ☐Other (Specify) _____

Quantity per day _____Years Used _____Year Quit _____

Alcohol: Type (Example: Beer, Wine)_____

Quantity per week _____ Years Used _____ Year Quit _____

Recreational Drugs: Type _____ Years Used _____Year Quit _____

Exercise: Type _____ Amount per Week _____

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Patient Name _____ Date of Birth _____

FAMILY HISTORY

Indicate if your family members have any of the following –

DIAGNOSIS	CHECK IF YES	WHICH FAMILY MEMBER(S) HAVE IT?
Diabetes		
High Blood Pressure		
Cholesterol Problems		
Heart Disease		
Kidney Failure		
Thyroid Problems		
Osteoporosis		
Stroke		

MEDICATION ALLERGIES

Please list medications you are allergic to and the reaction you have to each one of them.

MEDICATION	ALLERGIC REACTION

FOR WOMEN ONLY

- Are your cycles regular? ☐Yes ☐No
- When was your last period?_____
- When did you undergo menopause?_____

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Authorization For Use & Disclosure Of Protected Health Information

This authorization is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights to privacy with respect to your health care information. It authorizes the entity listed below to disclose your medical records to Providence Kidney Care.

Patient Name: _____ DOB: _____

Address: _____

_____

Information to be released (eg. History, Labs, Imaging, etc.): _____

_____

Release from the following entity(ies):

Name: _____

Phone: _____Fax: _____

Address: _____

_____

I understand that under the privacy rules, I have the right to revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. This authorization will expire automatically 60 days from the date on which it is signed. If I choose to revoke this authorization sooner I must do so in writing to:

Providence Kidney Care
1406 Dickerson Street
Newark, OH 43055

I understand that by disclosing these records to Providence Kidney Care the practice will not re-disclose or use the records in a way that violates the privacy rules.

Patient/Guardian Signature _____Printed Name_____
Relationship to patient (if guardian) _____
Date _____

INSURANCE ELIGIBILITY WAIVER

It is imperative that you confirm your insurance information with us before each and every appointment with your doctor. It is ultimately your responsibility to know which providers and services are covered by your insurance. Please ask us if you have any questions or concerns.

Billing We need to know your current insurance carrier so we can meet their deadlines for billing for our services. If you have changed insurance and not informed us, we will bill the last plan in your records. When they deny the claim, we bill you directly for payment, and you must seek reimbursement from your current insurance.

Referrals If you have to be referred for services outside our office, your doctor will try to direct you to a contracted service covered by your insurance, provided he or she has current information. Otherwise, you may be referred to a non-contracted service, which will happily provide you with service, and you will be responsible for the bill. We are not responsible for non-covered services or for the cost of services provided by a non-contracted provider.

It is our desire to provide a hassle free experience at Providence Kidney Care. This can only be accomplished with your assistance by bringing us your current insurance identification card at every visit. Please help us make your experience as enjoyable as possible.

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WAIVER

I understand that if I am not eligible for insurance benefits for today's visit, I will be financially responsible for the services performed by Providence Kidney Care.

_____ ___/___/___

SIGNATURE OF PATIENT/GUARDIAN TODAY'S DATE

_____

PRINT NAME OF PATIENT (& GUARDIAN, IF SIGNED BY GUARDIAN)

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PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT

I hereby acknowledge that I have been made aware that Providence Kidney Care has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Providence Kidney Care I understand and acknowledge the following:

1. Providence Kidney Care has a privacy policy in effects in her office.

2. Providence Kidney Care has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access and/or having a copy available for download and review on her website.

3. Providence Kidney Care has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Providence Kidney Care and have read and understand the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ NO, I do not want a copy, but acknowledge the Privacy Policy Exists

_____ Yes, I DO want a copy of the Privacy Policy and I received requested copy. Patient Initials___

_____	_____	_____
Patient Name	Patient Signature	Date

For more information contact Providence Kidney Care Compliance & Privacy Officer at 740-915-7475

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For Office 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

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other _____

Staff Signature_____

Date_____

PROVIDER-PATIENT VOLUNTARY ARBITRATION AGREEMENT

Phone: 740-915-7475 Office: 1406 Dickerson Street, Newark, Ohio 43055.
Fax: 740-915-7253

In the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the healthcare provider, the dispute or controversy shall be submitted to binding arbitration.

Within fifteen days after a party to this agreement has given written notice to the other of demand for arbitration of said dispute or controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Expenses of the arbitration shall be shared equally by the parties to this agreement.

The patient, by signing this agreement, also acknowledges that the patient has been informed that:

(1) Care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate;

(2) The agreement may not even be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

(3) The decision whether or not to sign the agreement is solely a matter for the patient's determination without any influence;

(4) The agreement waives the patient's right to a trial in court for any future malpractice claim the patient may have against the healthcare provider;

(5) The patient must be furnished with two copies of this agreement.

PATIENT'S RIGHT TO CANCEL AGREEMENT TO ARBITRATE

The patient, or the patient's spouse or the personal representative of the patient's estate in the event of the patient's death or incapacity, has the right to cancel this agreement to arbitrate by notifying the healthcare provider in writing within thirty days after the patient's signing of the agreement. The patient, or the patient's spouse or representative, as appropriate, may cancel this agreement by merely writing "cancelled" on the face of one of the patient's copies of the agreement, signing the patient's name under such word, and mailing, by certified mail, return receipt requested, the copy to the healthcare provider within the thirty-day period.

Filing of a medical claim in a court within the thirty days provided for cancellation of the arbitration agreement by the patient will cancel the agreement without any further action by the patient.

A signed copy of this document is to be given to the Patient. Original is to be filled in Patient's medical records.

Physician's Authorized Representative's Signature/Date

Patient Signature /Date

Ohio Revised Code Ann. § 2711.24
June 2007

Phone: 740-915-7475 Office: 1406 Dickerson Street, Newark, Ohio 43055.
Fax: 740-915-7253

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate Providence Kidney Care properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Office Manager.

A. How Providence Kidney Care (Practice) May Use or Disclose Your Health Information
Practice collects health information about you and stores it in a chart and/or on a computer. The medical record is the property of Practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide such as a pharmacist.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate Practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or to train our professional staff, or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our business associates who may perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under Ohio law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts

4. Appointment reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone or we may send you a postcard.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care, about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Ohio law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that Practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, Practice will not use or disclose health information which identifies you without your written authorization. If you do authorize Practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights
1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Ohio law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about Practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by Practice, except that Practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent Practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Office Manager.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how Practice handles your health information should be directed to the Office Manager. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Financial Policy

Our commitment is to provide the very best care to our patients, providing appropriate treatment while avoiding unnecessary services. To meet this commitment, we recognize the need for a definite understanding and agreement concerning your health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments: Co-payment, deductibles, payment for services not covered by your insurance plan, and outstanding balances are due at the time of your appointment. Payment may be made by: cash, check, or credit card.

Insurance Payments: We participate in assignment of payment with specific insurance plans in the area. When the correct insurance information is provided, we will submit your claims for you. Your insurance coverage is a contract between you and your insurance plan. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Self-Pay: If you are not billing a third party or health insurance, payment is required at the time of service. If the patient has no insurance, they must bring a minimum of half (1/2) of the standard new patient consult fee. (Example, if the average new patient consult fee is $300, then the patient must bring $150 to pay at the time of service). Once that transaction is complete, the patient must see the billing financial counselor or the Front Desk lead to set up an appropriate payment plan.

Bad Checks: Checks not honored by your financial institution will be subject to a $30.00 charge, or your account may be placed immediately with a third party collection agency for collection.

Collection Agencies: If it becomes necessary to place your account with a third party collection agency because of non-payment, your account will be turned over to collections, and you will be dismissed from our practice.

We thank you for coming to Providence Kidney Care. Please feel free to contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

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Fax: 740-915-7253

Appointment Cancellation Policy

Providence Kidney Care requires a notification of at least 24 hours prior to your appointment for any cancellations. We request this in order to allow adequate time to be able to offer your appointment slot to another patient. If you miss an appointment without providing the required advance notice, a rescheduled appointment cannot be guaranteed.

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