



RENAL CARE HOUSTON

Please fill out completely.

Last Name _____ First Name _____ Middle Name _____

SSN _____ - _____ - _____ Date of Birth _____ Gender M/F Marital Status _____

Street Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Email Address _____

Preferred Method of Contact ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Primary Language _____ Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino Race ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ White ☐ Other

Emergency Contact

Name _____ Phone (____) _____ Relationship _____

Primary Insurance Company _____ ID/Policy # _____

Group # _____ Insurance Phone (____) _____

Is this policy through your employer? Y / N Spouses employer? Y / N

Secondary Insurance Company _____ ID/Policy # _____

Group # _____ Insurance Phone (____) _____

Is this policy through your employer? Y / N Spouses employer? Y / N

Patient's Signature _____ Date _____

***Are you currently under the care of another kidney doctor OR have you been seen by a kidney doctor within the last 10 years? (Please choose one) YES NO If yes:

Doctor's Name: _____ Date Last Seen: _____

Ethnicity (Please circle)				
Hispanic or Latino			Non-Hispanic or Latino	
YOUR MEDICAL HISTORY				
Acute Kidney Disease	☐	Yes	☐	No
Anemia	☐	Yes	☐	No
Anxiety	☐	Yes	☐	No
Arthritis	☐	Yes	☐	No
Asthma	☐	Yes	☐	No
Auto Immune Disease	☐	Yes	☐	No
Bleeding problems	☐	Yes	☐	No
Cancer	☐	Yes	☐	No
CKD- Chronic Kidney Disease	☐	Yes	☐	No
Congestive Heart Failure	☐	Yes	☐	No
Coronary Artery Disease	☐	Yes	☐	No
Depression	☐	Yes	☐	No
Diabetes	☐	Yes	☐	No
DVT (Deep Venous Thrombosis)	☐	Yes	☐	No
Eye disease	☐	Yes	☐	No
Frequent colds	☐	Yes	☐	No
GI Disorders	☐	Yes	☐	No
Gout	☐	Yes	☐	No
Hearing problems	☐	Yes	☐	No
Hepatitis	☐	Yes	☐	No
High blood pressure	☐	Yes	☐	No
Hyperlipidemia (High Cholesterol)	☐	Yes	☐	No
MI (Heart attack)	☐	Yes	☐	No
Nephrolithiasis (kidney stones)	☐	Yes	☐	No
Neuromuscular disease	☐	Yes	☐	No
Neuropathy (disease of nerves)	☐	Yes	☐	No
Protein in Urine	☐	Yes	☐	No
Retinopathy (Retina disease)	☐	Yes	☐	No
Sleep apnea	☐	Yes	☐	No
Stroke	☐	Yes	☐	No
Thyroid	☐	Yes	☐	No
UTI (Urinary tract infections)	☐	Yes	☐	No
Other: Please Explain				

Personal & Social History			
Born (place of birth)			
Marital Status			
Occupation			
Live alone	☐ YES	☐ NO	
If no, who lives with you?			
Do you have children	☐ YES	☐ NO	
If so, how many?	Sons	Daughters	
Habits			
Diet			
Exercise			
Alcohol	☐ YES	☐ NO	
If yes, how much			
Smoke	☐ YES	☐ NO	
If yes, how long			
Have you ever smoked	☐ YES	☐ NO	
Quit, when			
Transfusions	☐ Yes	☐ No	Date:
Drug use	☐ Yes	☐ No	Explain:

YOUR FAMILY MEDICAL HISTORY					Relation
Anemia	☐	YES	☐	NO	
Auto Immune disease	☐	YES	☐	NO	
Cancer	☐	YES	☐	NO	
Coronary artery disease	☐	YES	☐	NO	
Diabetes Mellitus	☐	YES	☐	NO	
Hyperlipidemia (High Cholesterol)	☐	YES	☐	NO	
Hypertension	☐	YES	☐	NO	
Kidney disease	☐	YES	☐	NO	
Kidney stones	☐	YES	☐	NO	
Strokes	☐	YES	☐	NO	
Other medical history - please explain					

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care options (TPC) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as a necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.

These situations include: as required by law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your right with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered.

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to Renal Care Houston for any equipment or services provided to me by its physicians or clinical staff. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Renal Care Houston, my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by Renal Care Houston. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and I understand the information above. I agree to be financially responsible for all charges as discussed above.

Patient Signature _____ Date _____

Witness _____ Responsible Party _____

Patient Contact Record

Patient's Name: _____

Date _____

The HIPAA Privacy Rule gives individuals the right to restrict release of their Private Health Information (PHI). Please list the individual(s) you will allow Nephrology Associates, P.A. to release or discuss your PHI with. Do not list other physicians.

1. _____

2. _____

3. _____

4. _____

5. _____

Signature _____ Date _____

RECEIPT NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT OF FORM I,
_____ have received a copy of Renal Care Houston notice of privacy
Practices.

Print Patient's Name _____

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Phone: _____

Address: _____

City/State/Zip: _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patients authorizes the following healthcare to make record disclosure:

Facility Name: _____

Facility Phone: _____

Facility Address: _____

Facility Fax: _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen

☐ Dates Other: _____

☐ Specific Information Requested: _____

The purpose of disclosure is:

☐ Change of Insurance or Physician

☐ Continuation of Care (e.g., VA Med Ctr)

☐ Referral

☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested.

This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: **Renal Care Houston PLLC**

Address: **705 S Fry Rd Ste 300**

City, ST, Zip: **Katy, TX 77450**

Fax: **832-844-1998**

Phone: **832-940-9746**

☐ Please mail records

☒ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation 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 revoked, this authorization will expire on the following date, event, or condition: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/ Parent/ Guardian or Authorized Representative

(Guardian or Authorized Representative must attach documentation of such status)

Printed name of Authorized Representative

Date

Address and telephone number of authorized representative

Relationship/ Capacity to patient