DaVita. KidneySpecialists

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

First name:	Middle:	Last:
Former name:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed	
Street address:	Birthdate:	SSN:
Email Address:_____	Sex: ❑ Male ❑ Female	Home phone no.: ( )
City: State:	Zip:	Cell phone no: ( )
Occupation: Employer:		Work phone no.: ( )
Can we leave a message on your home phone? ❑ Yes ❑ No	Can we leave a message on your cell phone? ❑ Yes ❑ No	Can we send communication via mail? ❑ Yes ❑ No

How did you hear about our office? ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend

❑ Close to home/work ❑ Yellow Pages ❑ Newspaper If so, which one? _____

❑ Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Subscriber's name:	Subscriber's SSN:	Subscriber's birthdate:
Subscriber's address (if different than patient):		
Home phone no.: ( )	Occupation:	Employer:

Please indicate primary insurance: ❑ Medicare ❑ Medicaid ❑ United ❑ Medical Mutual ❑ Aetna ❑ Blue Cross/Blue Shield

❑ Anthem ❑ Cigna ❑ Emerald ❑ Other _____

Policy ID:	Group no. :	Copay: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

SECONDARY INSURANCE

Subscriber's name:	Subscriber's SSN:	Subscriber's birthdate:
Subscriber's address (if different than patient):		
Home phone no.: ( )	Occupation:	Employer:

Please indicate secondary insurance: ❑ Medicare ❑ Medicaid ❑ United ❑ Medical Mutual ❑ Aetna ❑ Blue Cross/Blue Shield

❑ Anthem ❑ Cigna ❑ Emerald ❑ Other _____

Policy ID:	Group no. :	Copay: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

IMPORTANT: Do you require a referral from your Primary Care Dr.? ❑ Yes ❑ No

If you have a copy of your referral, please give it to the receptionist. Thank you

EMERGENCY CONTACT

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DaVita Nephrology Partners/DKS of Fredericksburg or insurance company to release any information required to process my claims.

Patient signature:	Date:
Legal guardian signature:	Date:

Thank you for providing accurate information.

DaVita. KidneySpecialists	**NAME:** **DOB:** **Date:**
Primary Care Physician:_____	**Pharmacy Name:** **Pharmacy Number:**

MEDICATIONS

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND HERBAL SUPPLEMENTS

Name the Drug	Strength	Frequency Taken	Doctor that prescribed the medication

Allergies to medications (Please list Iodine, latex, or adhesives as well)

Name the Drug	Reaction You Had

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):*	☐ **M** ☐ **F**	**BIRTHDATE:**

MARITAL STATUS:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: **Race:**	**Language:**
Primary Care Provider:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

SURGERIES

Year	Type of surgery & Reason	Hospital/Doctor

OTHER HOSPITALIZATIONS

Year	Type of hospitalization & Reason	Hospital

WOMEN ONLY
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ☐ Yes ☐ No
Foamy or cloudy urine? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Any urinary tract, bladder, or kidney infections within the last year? ☐ Yes ☐ No
Any problems with control of urination? ☐ Yes ☐ No
MEN ONLY
Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times _____ Any blood in your urine? ☐ Yes ☐ No
Do you feel pain or burning with urination? ☐ Yes ☐ No Foamy or cloudy urine? ☐ Yes ☐ No
Have you had any urinary tract, kidney, bladder, or prostate infections within the last 12 months? ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ☐ Yes ☐ No
Foamy or cloudy urine? ☐ Yes ☐ No

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Personal Safety	What is your occupation?			
	Do you live alone? ☐ Yes ☐ No If no, who lives with you?			
	Do you have a power of attorney or legal guardian? ☐ Yes ☐ No Do you have an Advance Directive or Living Will? ☐ Yes ☐ No			
Children	Do you have children? ☐ Yes ☐ No Number of daughters _____ Sons_____			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____ What kind?			
	Are you concerned about the amount you drink? ☐ Yes ☐ No			
Tobacco	☐ Never smoker ☐ Current every day smoker ☐ Current someday smoker ☐ Former smoker How long have you smoked? _____ When did you quit? _____			
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day			
Transfusion	Have you ever had a blood transfusion? ☐ Yes ☐ No If so, when?			
Drugs	Recreational or street drug usage? ☐ Yes ☐ No Analgesic/painkiller drug abuse? ☐ Yes ☐ No			
Salt	Rank salt intake	☐ High	☐ Med	☐ Low
NSAIDS	Have you taken any of the following: ☐ Ibuprofen ☐ Aleve ☐ Advil ☐ Aspirin ☐ Motrin ☐ Celebrex ☐ Other _____ *****If so, when was the last time?*			

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FAMILY HEALTH HISTORY

Please indicate ✓ who has the history

Health Problems	*You*	*Father*	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*	*Other*
Anemia								
Arthritis								
Asthma								
Bleeding Problems								
Broken Bones								
Coronary Artery Disease								
Cancer								
Congestive Heart Failure								
Depression								
Diabetes								
Deep Venous Thrombosis								
Eye Disease								
GI Disorders								
Gout								
Hearing Problems								
Heart Disease								
Hepatitis								
High Blood Pressure								
Hyperlipidemia								
Kidney Disease								
Kidney Stones								
Neuromuscular Disease								
Neuropathy								
Peripheral Vascular Disease								
Retinopathy								
Sleep Apnea								
Stroke								
Thyroid								
UTIs								

Thank you for providing this important information about your medical history.

NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document a patient's acknowledgement of receipt of our Privacy Practices or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

PATIENT NAME: _____

TO THE INDIVIDUAL: Please complete the following acknowledgement.

❑ I acknowledge that I received the Privacy Practices Notice of this health care provider.
(Please sign in the space indicated below)

TO THE TEAMMATE: Please complete the following if the patient is unable to sign and sign in the space below.

If the individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice, please check appropriate box below. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful.

❑ Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

❑ Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are therefore not required to obtain an acknowledgement.

THIS FORM HAS BEEN SIGNED BY: (please check one)

❑ PATIENT

❑ PATIENT'S PERSONAL REPRESENTATIVE

❑ TEAMMATE

I attest that the above information is correct.

_____ _____
Signature Date

_____
Printed name

_____
Witness signature

FINANCIAL POLICY
(PRIVATE INSURANCE AND SELF-PAY PATIENTS)

Patient name: _____ Date: _____
(Please Print)

Any healthcare insurance policy that you may have is a contract between you and your insurance company and/or employer. DaVita Kidney Specialist of Fredericksburg will assist you in obtaining payment from any healthcare insurance policy for medical services and goods that you receive at our practice; however, you remain primarily responsible to pay for all medical services and goods rendered from DaVita Kidney Specialist of Fredericksburg.

OUR FINANCIAL POLICY	
_____ Initial	You are responsible for any and all applicable co-payments, coinsurance, and unmet deductibles. It is the patient's responsibility to provide us with current insurance information at each visit. According to your insurance, payment is expected at time of your visit. Some insurance carriers charge a co-pay for each type of provider seen during one day; therefore, if you are seen by more than one provider on the same day, you may be responsible for more than one co-payment. You will also be responsible for any past due balances that may be remaining on your account. Patients with delinquent accounts will be required to make payment on date of visit. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment.
_____ Initial	Payment is Due When Services are Provided. DaVita Kidney Specialist of Fredericksburg requires that all applicable co-payments, coinsurance, deductibles and any past due amounts on the account be paid on date of visit. In the event that you are not covered by a healthcare plan, full payment is required on date of visit.
_____ Initial	Payment Methods and Returned Check Fee. DaVita Kidney Specialist of Fredericksburg accepts MasterCard/Visa, personal checks, and cash. If the bank returns your check as "un-payable," you will be charged a $25.00 service charge, which will be due, along with the amount of the returned check, within three (3) business days. Your account will be placed on a "cash-only basis."
_____ Initial	Prompt Payment of Mailed Invoices. In the event that you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 14 days. Amounts for which you are liable may be identified as "*patient balance due*" on the invoice. Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments.
_____ Initial	Accounts Placed for Collection. If you fail to make payments due within sixty (60) days following receipt of an invoice then (i) interest shall accrue on the outstanding balance at the rate of 1½ percent per month (or, if less, the highest interest rate permitted by law), and (ii) your account may be sent to an attorney or third-party collection agency for collection. In the event that your account is sent for collection, you will be responsible for costs and reasonable attorneys' fees incurred by DaVita Kidney Specialist of Fredericksburg in connection with the collection of the outstanding balance.
_____ Initial	Non-covered Services. While the filing of insurance claims is a courtesy that we extend to our patients, not all services provided by DaVita Kidney Specialist of Fredericksburg may be covered by every healthcare plan. Any service determined not to be covered by your plan will be your responsibility. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

ACKNOWLEDGEMENT

I HAVE READ AND UNDERSTAND the Financial Policy of DaVita Kidney Specialist of Fredericksburg and agree to be bound by it. I understand that healthcare insurance does not cover all medical goods and services and my responsibilities with respect to healthcare insurance as explained above. I understand that I am ultimately responsible for payment for medical goods and services provided to me by DaVita Kidney Specialist of Fredericksburg. I hereby grant DaVita Kidney Specialist of Fredericksburg the right to bill and collect from my healthcare insurance plan for medical goods and services provided to me.
If the patient is a minor (younger than 18 years old), the parent or guardian must sign below.

X_____ _____
Responsible party/Guarantor Relationship

X_____ _____
Responsible party/Guarantor signature Date