North Texas Kidney Disease Associates
What to Expect From Us

1. Office hours are Monday – Friday, 8:30 AM to 5:00 PM. We do not close the office during lunch hours.

2. Our physicians are on-call every evening and weekend. Our answering service will direct any after-hours calls to the on-call physician. Please call 911 for any urgent or life threatening issues.

3. Our standard form of communicating with our patients/care givers is via:
    - in-office appointments,
    - by phone/fax,
    - by secure messages on our patient portal.

    We encourage our patients/care givers to sign up on our patient portal. The patient portal allows patients/care givers the ability to:
    - request appointments,
    - refill prescriptions,
    - download or print records,
    - send a message or file to your physician.

4. Upon each office visit with your physician, you may receive a Clinical Visit Summary and you may request any copies of test results you wish to keep. We will also send a letter to all your care team providers summarizing your visit and send any test results available. This helps keep your care team abreast of any changes in your treatment plan.

5. Other visits to our office may be with a nurse or technician to fulfill orders. We recommend having blood tests prior to each face-to-face office visit with your physician, depending upon your treatment plan, for a more comprehensive consultation. Your physician's nurse may contact you after your appointment to give you test results or changes to your treatment per your physician's orders. We are happy to send orders with our patients to have blood tests drawn at the patient's convenience.

6. We will make your follow up appointment before you leave our office as well as send you an appointment reminder two days before your next scheduled visit. You have the opportunity to tell us whether you wish to receive reminders via phone calls, emails or both.

7. Please visit our web site at **www.northtexaskidney.com** for additional information.

Please retain this page for your records and future reference. Also, please fill out the attached registration forms and remember to bring your completed forms to your appointment.

We look forward to seeing you!

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NORTH TEXAS KIDNEY
DISEASE ASSOCIATES

PATIENT REGISTRATION INFORMATION

DATE_____ ❑ MALE ❑ FEMALE ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

SOC. SEC. # _____ BIRTHDATE_____

NAME_____ EMAIL _____

ADDRESS_____ EMPLOYER_____

_____ BUSINESS ADDRESS _____

CITY _____ _____

STATE _____ ZIP_____ CITY _____ STATE _____ ZIP_____

HOME PHONE_____ WORK PHONE _____

CELL PHONE _____ OCCUPATION _____

Who referred you to our office? ❑ DOCTOR ❑ SELF ❑ FAMILY/FRIEND ❑ INTERNET ❑ NEWSPAPER/YELLOW PAGES

Primary Care Physician _____ PHONE _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY _____

GROUP # _____ SUBSCRIBER ID # _____

PERSON RESPONSIBLE FOR ACCOUNT_____

RELATIONSHIP TO PATIENT ❑ SELF ❑ SPOUSE ❑ PARENT ❑ OTHER _____

SOC. SEC. # _____ BIRTHDATE_____

ADDRESS_____ EMPLOYER_____

_____ BUSINESS ADDRESS _____

CITY _____ _____

STATE _____ ZIP_____ CITY _____ STATE _____ ZIP_____

HOME PHONE_____ WORK PHONE _____

CELL PHONE _____ OCCUPATION _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

GROUP # _____ SUBSCRIBER ID # _____

PERSON RESPONSIBLE FOR ACCOUNT_____

RELATIONSHIP TO PATIENT ❑ SELF ❑ SPOUSE ❑ PARENT ❑ OTHER _____

ASSIGNMENT & RELEASE

I hereby authorize payment directly to **NORTH TEXAS KIDNEY DISEASE ASSOCIATES** all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all fees/charges, whether or not paid by insurance, for all services rendered on my behalf or my dependents.

I authorize the above noted establishment and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY _____ DATE_____

NORTH TEXAS KIDNEY
DISEASE ASSOCIATES

PATIENT NAME _____ AGE _____ BIRTH DATE _____

Reason for your visit? _____

Who referred you to our office? ❑ DOCTOR ❑ SELF ❑ FAMILY/FRIEND ❑ INTERNET ❑ INSURANCE COMPANY
❑ HOSPITAL ❑ NEWSPAPER/YELLOW PAGES ❑ OTHER:

If doctor referred, please name: _____ Phone _____

What are your current symptoms today? _____

_____

PLEASE LIST YOUR CURRENT MEDICATIONS/SUPPLEMENTS

DRUG NAME	MG	FREQUENCY

(IF YOU HAVE MORE, PLEASE PROVIDE A THOROUGH LIST)

DO YOU HAVE ANY ALLERGIES? Substance or Medication

_____
_____
_____
_____
_____

PHARMACY NAME & LOCATION:

_____
_____
_____

PHARMACY PHONE: _____

PATIENT CONDITIONS Please check conditions you have or have had in the past

Kidney Disease	❑	Heart Disease	❑	Glaucoma	❑
Hypertension	❑	Hyperlipidemia	❑	Retinopathy	❑
Diabetes	❑	Lung Disease	❑	HIV Positive	❑
Hematuria (blood urine)	❑	Rheumatologic Disease	❑	Infections	❑
Proteinuria (protein in urine)	❑	Gastrointestinal	❑	Psychiatric Disorder	❑
Kidney Stones	❑	Arthritis	❑	Bipolar	❑
Glomerulonephritis (Nephritis)	❑	Cancer	❑	Depression	❑
Urologic Disease	❑	Anemia	❑	Headaches	❑

PLEASE COMMENT ON CONDITIONS CHECKED:

_____
_____

PATIENT SURGERIES Please check any surgeries you have had in the past

Appendectomy	❑	Coronary Artery Bypass	❑	Gastric Bypass/Banding	❑
Cholecystectomy	❑	Angioplasty/Stent	❑	Cataract Surgery	❑
Hernia Repair	❑	Aortic Aneurysm Repair	❑	Retinal Laser Surgery	❑
Transplant	❑	Carotid Endarterectomy	❑	Chemotherapy	❑
Nephrectomy	❑	Aortoiliac Artery Bypass	❑	Radiation Therapy	❑
Fistula or Shunt for Dialysis	❑	Pacemaker/Defibrillator	❑	Stem Cell Transplant	❑
Peritoneal Dialysis Catheter	❑	Hysterectomy	❑	Spinal Surgery	❑
		Mastectomy	❑		

PLEASE COMMENT ON CONDITIONS CHECKED:

_____
_____

PATIENT NAME _____ **AGE** _____ **BIRTH DATE** _____

PATIENT DEMOGRAPHICS Please tell us about yourself

WHAT IS YOUR NATIVE LANGUAGE?

English ❑
Spanish ❑
Chinese ❑
Vietnamese ❑
Other: _____

WHAT IS YOUR NATIONALITY OR ETHNICITY?

Hispanic/Latino ❑
Not Hispanic/Latino ❑

WHAT IS YOUR RACE?

American Indian/Eskimo/Aleut ❑
Asian or Pacific Islander ❑
Black/African American ❑
Caucasian/White ❑
Other: _____

(Includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category)

WHAT IS YOUR LIVING SITUATION?

I live alone ❑
I live with my spouse ❑
I live with my family or relatives ❑
Assisted Living/Retirement Village ❑
Other: _____

WHAT IS YOUR WORK HISTORY?

Work full time. Shift Day / Evening/ Night
Work part time. Shift Day / Evening/ Night
Retired due to: Age / Disability
Not Currently Employed ❑
Currently on Disability ❑
Student: Full Time / Part Time

WHAT IS YOUR MARITAL HISTORY?

Married ❑
Single ❑
Separated ❑
Divorced ❑
Widowed ❑

WHAT IS YOUR TRANSPORTATION SITUATION?

I drive myself ❑
Family or friends drive me ❑
I take public transportation ❑
I take the facility transportation ❑
What is the best time for your appointments? Morning / Afternoon

PLEASE CHECK WHICH SUBSTANCES YOU USE

Smoking ❑
Previous History of Smoking ❑
Chewing Tobacco ❑
Alcohol ❑
Marijuana or drug use ❑
Alternative Vitamins/Meds/Herbs ❑

PLEASE ANSWER THE FOLLOWING:	YES	NO
I take my blood pressure regularly	❑	❑
I weigh myself weekly	❑	❑
Do you have a Physical Disability?	❑	❑
Do you have a Mental Disability?	❑	❑
Ever had a Blood transfusion?	❑	❑

If yes, when: _____

INDICATE IF YOU HAD ANY OF THESE VACCINATIONS:

Pneumococcal ❑
Influenza ❑
Hepatitis B ❑
Hepatitis C ❑
Other: _____

HOW WELL DO YOU CARE FOR YOUR HEALTH?

I care for my own health ❑
My doctor takes care of my health ❑
My spouse or family member takes care of my health ❑
Who: _____

WHO PREPARES YOUR MEALS?

Myself or my spouse ❑
A family member or friend ❑
I eat out at restaurants ❑
Assisted Living/Retirement Village ❑

IS THERE FAMILY HISTORY OF THE FOLLOWING?

	Mother	Father	Sister	Brother
Polycystic Kidney Disease	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑
Diabetes Mellitus	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑

Other: _____

IS THERE CANCER HISTORY OF THE FOLLOWING?

	Mother	Father	Sister	Brother
Breast Cancer	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑
Lung Cancer	❑	❑	❑	❑
Kidney Cancer	❑	❑	❑	❑
Ovarian Cancer	❑		❑	

Other: _____

HAVE YOU HAD ANY OF THESE TESTS?	YEAR?
Colonoscopy	_____
Cystoscopy	_____
Hemoglobin A1c	_____
PSA	_____
Mammogram	_____
Pap Smear	_____

PATIENT NAME _____ **AGE** _____ **BIRTH DATE** _____

PATIENT DEMOGRAPHICS Continued

Who are your social support groups? Please identify a contact.

My family, Contact: _____

My friends, Contact: _____

Religious Group, Contact: _____

Social Group, Contact: _____

Nursing Home/Retirement Village

Contact: _____

May we contact the person you have identified to assist in your care? ❑ Yes ❑ No

I seem to go to the Emergency Room or get admitted to the hospital frequently. Please answer: ❑ Yes ❑ No

If Yes, why: _____

_____

PLEASE LIST ANY HOSPITALIZATIONS	YEAR?

PLEASE LIST YOUR OTHER DOCTORS	PHONE

Please list medications you do not like to take because of unpleasant symptoms:

Medication	Symptom	Reason for taking this

Please answer the following questions:

Do you sometimes forget to take your medicine? ❑ Yes ❑ No

Does someone prepare your medications in advance? ❑ Yes ❑ No

If Yes, who does this for you? _____

Do you stop taking a medicine if it makes you feel worse? ❑ Yes ❑ No

Do you ever cut back or stopped taking your medicine without telling your doctor? ❑ Yes ❑ No

Do you ever forget to refill your medications? ❑ Yes ❑ No

Do you forget to pick up your medicine from the pharmacy? ❑ Yes ❑ No

If Yes, why? _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ **Signature**

_____ **Date**

NORTH TEXAS KIDNEY
DISEASE ASSOCIATES

CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical (labs, injections) or other services under the general and specific instructions of the physicians of North Texas Kidney Disease Associates, and their assistants or designee as is necessary in their judgment. North Texas Kidney Disease Associates has on staff at select locations an advance practice nurse to assist in the delivery of nephrology care. An advance practice nurse is NOT a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat and monitor common acute and chronic diseases, as well as, provide health maintenance care. I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of the treatments or examination by the physicians of North Texas Kidney Disease Associates.

Financial Interest Disclosure

North Texas Kidney Disease Associates physicians, staff and/or their immediate family members may hold ownership or investment interest in the healthcare facilities at which they practice or to which they refer patients for medical diagnosis and treatment. If you have any questions about your treatment options at any healthcare facilities, please feel free to discuss this with your physician in your effort to make an informed decision.

I have read the above and hereby consent to the services of North Texas Kidney Disease Associates.

_____

PATIENT SIGNATURE

_____

DATE

_____

WITNESS

NORTH TEXAS KIDNEY
DISEASE ASSOCIATES

CONSENT FOR RELEASE OF MEDICAL RECORDS

TO: _____
Name of Party Releasing Information

FROM: _____
Patient's Full Name

DOB: _____

PHONE: _____

INFORMATION REQUESTED:

- ❑ Progress Notes
- ❑ Lab/Blood work Reports
- ❑ Radiology Reports
- ❑ Cardiology Reports
- ❑ Medication List
- ❑ Demographic/Insurance information
- ❑ Other:_____
  _____

I HEREBY AUTHORIZE AND REQUEST RELEASE OF THE ABOVE INFORMATION FROM MY MEDICAL RECORDS.

THIS INFORMATION IS TO BE RELEASED TO:

North Texas Kidney Disease Associates
1600 Waters Ridge Drive, Suite A
Lewisville, TX 75057
Phone# _____
Fax# _____

SIGNATURE _____ DATE_____

WITNESS: _____ DATE_____

NORTH TEXAS KIDNEY
DISEASE ASSOCIATES

PATIENT CONTACT QUESTIONAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

Name: _____Phone: _____
Name: _____Phone: _____
Name: _____Phone: _____

II. Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____Phone: _____
Name: _____Phone: _____
Name: _____Phone: _____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, **if other than your home**:

_____
_____
_____

IV Please give the telephone number, if any where you want to receive calls about your appointments, lab and x-ray results, or other health care information, **if other than your home phone number**:
(_____)_____

V. Can confidential messages be left on your home answering machine or voicemail?
❑ Yes ❑No

VI. If you do not have voicemail, can a confidential message be left at your place of employment?
❑ Yes ❑No

VII. Does your mail need to be marked confidential? ❑ Yes ❑No

_____ _ _____
Signature of Patient or Legal Guardian Witness

_____ _ _____
Relationship to Patient Date