FORT WORTH RENAL GROUP

PATIENT INFORMATION

Last Name: _____First Name: _____MI: _____

Date of Birth: _____ Age: _____ Sex: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone:(____) _____Cell Phone:(____) _____

Social Security #: _____ Marital Status: _____

Race: ☐ Asian ☐ Black ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Two or More Races
☐ White ☐ Refused to Report

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or ☐ Refused to Report

Preferred Language: _____Written Language: _____
Interpreter Needed: ☐ Yes ☐ No

Do you have any communication difficulties/special needs: ☐ Visually Impaired ☐ Hearing Impaired
☐ Special Needs

Preferred Communication Method: ☐ No Preference ☐ Mail ☐ Phone ☐ My Chart
By checking one of the boxes for Preferred Communication Method, I agree to receive correspondence from Fort Worth Renal Group

Primary Care Physician Name: _____ Phone #: _____

Pharmacy Name: _____Phone #: _____

Emergency Contact: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Power of Attorney: _____Phone #: _____

Employer Name: _____Phone #: _____

FINANCIALLY RESPONSIBLE PARTY – GUARANTOR:

☐ Same as Patient Information (*If different, please complete section below*)

Last Name: _____First Name: _____MI: _____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone:(____) _____Cell Phone:(____) _____

Employer Name: _____Phone #: _____

INSURANCE INFORMATION:

Primary Insurance: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscribers DOB: _____

Relationship to Subscriber: _____ Employer Name: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Subscriber's Name: _____ Subscribers DOB: _____

Relationship to Subscriber: _____ Employer Name: _____

FINANCIAL AND PAYMENT GUIDELINES:

Payment is due at the time of service. This includes all co-pays, deductibles, and co-insurance.

- I authorize direct payment of my insurance benefits to Fort Worth Renal Group for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- I am responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out of Network services not paid by the health insurance company will be the responsibility of the patient.
- Fort Worth Renal Group or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.
- I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to ant telephone number provided during my registration process.

Lab / X-Ray / Diagnostic Services:

- I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles, and co-insurance due for these services if they are not reimbursed by my insurance.

RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS:

- I authorize the release of all medical records to specialist and/or consulting physicians if applicable to my care and condition.
- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier, any information needed for this or any related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or the party who accepts assignments. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Fort Worth Renal Group.

ACKNOWLEDGMENT:

I have read, fully understand and agree to the above release of medical information to others, financial and payment guideline, release of information & assignment of benefits. I also certify that all of the information provided is complete and accurate.

Patient Name: _____ Signature: _____ Date: _____

Acknowledgment of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have certain rights to privacy regarding their protected health information. By signing below, you, the patient, acknowledge the following regarding the management of your protected health information. Your protected health information will be used to:

- Conduct, plan, and direct treatment by the physicians employed by Fort Worth Renal Group and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waived your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Fort Worth Renal Group has previously released relying on this consent.

1. Do we have permission to leave a detailed message regarding any appointments, treatments or test results at any of the following numbers we have on file for you:
   Home: ___Yes ___No **Cell**: ___Yes ___No **Work**: ___Yes ___No

2. Do we have permission to leave a call back number at any of the following numbers we have on file for you:
   Home: ___Yes ___No **Cell**: ___Yes ___No **Work**: ___Yes ___No

3. Do we have permission to mail detailed information regarding appointments, treatments or test results to your home address:
   ___Yes ___No

4. Do we have permission to email detailed information regarding appointments, treatments or test results to the email address you have provided us with:
   ___Yes ___No ___N/A

Please list anyone you give us permission to discuss your medical records with:

1. Name: _____Relationship: _____ Phone Number: _____
2. Name: _____Relationship: _____ Phone Number: _____

Patient Name: _____ Signature: _____ Date: _____

Authorization to Release Health Care Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Patient Name: _____ D.O.B.: _____ SSN: _____

I request and authorize to release the medical records of the patient named above to:
Fort Worth Renal Group
1902 Windsor Place, Suite 102
Fort Worth, TX 76110
682-207-1700
This request and authorization applies to:

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

___All health information ___History/Physical Exam ___Past/Present Medications ___Lab Results ___Physician's Orders ___Patient Allergies ___Operation Reports ___Consultation Reports ___Progress Note ___Discharge Summary ___Diagnostic Test Reports ___Billing Information ___Other

Your initials are required to release the following information:
___Mental Health Records (excluding psychotherapy notes) ___Genetic Information (including Genetic Test Results)
___Drug, Alcohol, or Substance Abuse Records ___HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month____ Day____ Year____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

Patient Name: _____ Signature: _____ Date: _____

Consent for Care and Treatment

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s),

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By singing below, you are indication that:

- You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.
- You consent to treatment at this office or any other satellite office under common ownership.
- You have the right at any time to discontinue services.
- You have the right to discuss the treatment plan with you physician about the purpose, potential risk, and benefits of any test ordered for you.
- If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.
- I voluntarily request a physician and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice.
- I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consents prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name: _____ Signature: _____ Date: _____

FORT WORTH RENAL GROUP

Physician List

Physician	Phone & Fax Number
_____ Cardiologist	_____
_____ Pulmonologist	_____
_____ Endocrinologist	_____
_____ Neurologist	_____
_____ Gastroenterologist	_____
_____ Hematologist	_____
_____ Urologist	_____
_____ Other	_____

FORT WORTH RENAL GROUP

Medication List

Medication	Dose (e.g. mg/pill)	How many times per day?

FORT WORTH RENAL GROUP

Patient Name: _____ Date of Birth: _____

Medical History Questionnaire

Allergy symptoms	☐ Current ☐ Past	High cholesterol	☐ Current ☐ Past
Anemia	☐ Current ☐ Past	History of blood transfusion	☐ Current ☐ Past
Anxiety	☐ Current ☐ Past	HIV	☐ Current ☐ Past
Arthritis	☐ Current ☐ Past	Hypertension	☐ Current ☐ Past
Asthma	☐ Current ☐ Past	Kidney Disease	☐ Current ☐ Past
Coronary Artery Disease	☐ Current ☐ Past	Liver Disease	☐ Current ☐ Past
Cancer	☐ Current ☐ Past	Meningitis	☐ Current ☐ Past
Cataract	☐ Current ☐ Past	Mitral Valve Disease	☐ Current ☐ Past
Clotting Disorder	☐ Current ☐ Past	Myocardial Infarct	☐ Current ☐ Past
Congestive Heart Failure	☐ Current ☐ Past	Osteoporosis	☐ Current ☐ Past
COPD	☐ Current ☐ Past	Seizures	☐ Current ☐ Past
Depression	☐ Current ☐ Past	Sickle cell	☐ Current ☐ Past
Diabetes	☐ Current ☐ Past	Sleep apnea	☐ Current ☐ Past
Emphysema	☐ Current ☐ Past	Stroke	☐ Current ☐ Past
Gastric Ulcers	☐ Current ☐ Past	Substance abuse	☐ Current ☐ Past
GERD	☐ Current ☐ Past	Thyroid Disease	☐ Current ☐ Past
Glaucoma	☐ Current ☐ Past	Tuberculosis	☐ Current ☐ Past

Surgical Procedure

Appendectomy	Year_____	Comments/Location: _____
Biopsy (location)	Year_____	Comments/Location: _____
Brain surgery	Year_____	Comments/Location: _____
Breast surgery	Year_____	Comments/Location: _____
Colon surgery	Year_____	Comments/Location: _____
Coronary artery bypass graft	Year_____	Comments/Location: _____
Cosmetic surgery	Year_____	Comments/Location: _____
C-section	Year_____	Comments/Location: _____
Eye surgery	Year_____	Comments/Location: _____
Fracture surgery	Year_____	Comments/Location: _____
Gallbladder surgery	Year_____	Comments/Location: _____
Hernia repair	Year_____	Comments/Location: _____
Hysterectomy	Year_____	Comments/Location: _____
Joint replacement	Year_____	Comments/Location: _____
Prostate surgery	Year_____	Comments/Location: _____
Spine surgery	Year_____	Comments/Location: _____
Tubal ligation	Year_____	Comments/Location: _____
Valve replacement	Year_____	Comments/Location: _____
Vasectomy	Year_____	Comments/Location: _____
Other:	Year_____	Comments/Location: _____

Patient Name: _____ Date of Birth: _____

Social History (please check all that apply)

Tobacco: ☐ Never ☐ Past ☐ Active ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Snuff ☐ Dip ☐ Chewing

Start _____ Stop _____ Packs per day _____

Alcohol: ☐ Never ☐ Past ☐ Active ☐ Liquor ☐ Wine ☐ Beer ☐ AA ☐ Alcohol Rehab

Drinks per: _____Day _____Week _____Month

Illicit Drugs: ☐ Never ☐ Past ☐ Active ☐ Cocaine ☐ Marijuana ☐ Heroine ☐ Amphetamine ☐ Barbiturate ☐ LSD
☐ PCP ☐ IV Drug Abuse ☐ Active ☐ Drug Rehab

Family Medical History (please make a check in the boxes that apply):

	Alive / Deceased	Diabetes	Hypertension	Kidney Disease	Heart Disease	Cancer	Stroke
Father							
Mother							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							
Siblings							
Children							

Immunizations (please indicate the year you last had any of the following immunizations)

Flu Vaccine _____ Pneumonia Vaccine _____