PATIENT REGISTRATION FORM ROCKY MOUNTAIN PEDIATRIC KIDNEY CENTER

PATIENT INFORMATION (Please print)

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address: _____

City, State, Zip: _____

Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ DOB: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Social Security Number: _____ - _____- _____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last) _____ (First) _____ (MI) _____

Date of birth: MM ____/DD ____/YYYY_____ Sex: ☐ Female ☐ Male

Social Security Number: _____-_____-_____ Phone number: _____

Address: _____

City, State: _____ ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

Referring Physician

Practice Name:_____ **Physician Name**_____

Phone number:_____ **Fax number:**_____

Address _____

City, State:_____ **ZIP:**_____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks 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 signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level 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 consent forms 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.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

Rocky Mountain Pediatric Kidney Center

FINANCIAL POLICY & PATIENT RESPONSIBILITIES

We would like to thank you for entrusting Rocky Mountain Pediatric Kidney Center with your child's care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and we do require a signature to document that you have read and understand this policy. You will be given a copy for your records, and if you have any questions or concerns please let us know and we will do our best to answer all of your requests.

MISSED APPOINTMENT / LATE CANCELLATION

Our office will call to confirm your child's appointment two (2) business days prior to the appointment date. We understand that schedules can change on a moment's notice; we do ask that you keep us informed as soon as you know you are unable to keep your scheduled appointment and/or check-in time. In order to maintain our schedule, we do appreciate at least 24 hour notice for cancellations or rescheduling of appointments.

CHECK IN - NEW PATIENTS

For your first appointment your paperwork check-in time will need to be 30 minutes prior to your physician appointment. Your initial appointment with us will require quite a bit of paperwork in order to begin your child's care with us. Once this is completed, you will need time for our Nurse to meet with you and collect vital signs, possibly medical history, and occasionally lab samples will need to be collected all before seeing your physician.

CHECK IN - ESTABLISHED PATIENTS

For all future appointments, your check-in time will need to be 15 minutes prior to your physician appointment time. This time will be spent with our Nurse collecting vital signs, update medical history and occasionally lab samples before seeing your physician.

PLEASE NOTE: If you are more than 15 minutes late for your expected check-in time, we may need to reschedule your appointment. We will do our best to fit you into our schedule if at all possible, but due to the nature of the practice, it may be necessary to reschedule you to another day to ensure the proper care of all of our patients.

PAYMENT

For patients with a co-pay plan, payment is expected at the time of service. When you check in for your appointment, we will collect the amount indicated on your card unless instructed otherwise. We accept credit cards, checks and cash. All insurance carriers have a fee schedule from which they will reimburse. Any uncovered services, including: deductibles and coinsurance are your responsibility and will be billed to you by our office.

INSURANCE

We will bill directly to your insurance as a courtesy to you. However, it is your responsibility to understand your benefits, and eligibility. You are ultimately responsible for payment if your visit is not covered or authorized. If you need further information, please your insurance carrier directly using the customer service phone number on the back of your card. It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing our physicians, you will need to obtain one through your primary care doctor office. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

Guardian/Responsible Party Signature:_____ Date:_____

HCA PHYSICIAN SERVICES

ROCKY MOUNTAIN KIDNEY CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient Name:	Birth Date:	Social Security No. ***(Optional)-.***

Sender's Name:	Recipient's Name: ROCKY MTN PEDIATRIC KIDNEY CENTER
Address:	Address: 2055 HIGH STREET; SUITE 270

City:	State:	Zip:	City:	State:	Zip:
			DENVER	**CO**	80205

Phone:	Fax:	Phone:	Fax:
		303-301-9010	303-830-3165

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: Event:

Purpose of disclosure: ☐ Continuity of Care ☐ Transfer of Care ☐ Personal Use ☐ Other _____

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in Medical Record		☐ Operative Report		☐ Labor/Delivery Summary	
☐ Admission form		☐ Lab/Pap Results		☐ OB Nursing Assess	
☐ Visit Notes		☐ Special Test/Therapy		☐ Postpartum Flow Sheet	
☐ Physician orders		☐ Radiology Report		☐ Nursing Information	
☐ Prenatal Records		☐ Consult Report		☐ Rhythm Strips	
☐ Clinical Tests		☐ Transfer Forms		☐ Other:	
☐ Medication Sheets		☐ ER Information			

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ☐ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing? ☐

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**

Print Name of Patient's Representative:	**Relationship to Patient:**