DALLAS RENAL GROUP
Leaders in Kidney Care

Dear Patient,

Thank you for choosing Dallas Renal Group! We have attached your new patient paperwork that needs to be filled out prior to your appointment.

Please bring the following to your appointment:

- **New Patient Paperwork**
- **Picture ID**
- **Insurance card**
- **All your medications, including any over the counter medications.**

If you forget the paperwork packet, please arrive 15 minutes prior to your appointment time, so that you may fill it out.

Thank you in advance for your assistance.

Dallas Renal Group

Phone: (972) 274-5555

Fax: (972) 274-5663

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Leaders in Kidney Care

Today's Date: _____

PATIENT REGISTRATION

PATIENT INFORMATION: (Please use full legal name, no nickname)

*Last Name:_____ *First Name: _____ Middle Initial: ___

*Date of Birth: _____/_____/_____ *Cell Phone:_____ Home Phone:_____

*Email: _____ Preferred (circle one): Cell Email

*Address: _____

City: _____ State: _____ Zip code: _____

*Social Security #:_____ Driver's Lic. #:_____

*Sex: _____ Race:_____ *Preferred Language: _____ Hispanic (circle one): Yes No

Employment Type (circle one): Full-time Part-time Student Temp/Contract Retired Unemployed

Employer Name: _____Work Phone #:_____

*Current/Former Occupation: _____ Work Address: _____

*Primary Care Physician (PCP) Name: _____Telephone #:_____

*Pharmacy Name: _____ Pharmacy Phone: _____

*Pharmacy Address: _____

*Emergency Contact Name: _____ *Relationship:_____

*Emergency phone #: _____

Please tell us how you heard about us: Referred by: _____

GUARANTOR INFORMATION: (If different from patient)

*Last Name: _____ *First Name: _____ Middle Initial: ___

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

*Relationship:_____

INSURANCE INFORMATION: (OR COPY OF THE INSURANCE CARD)

***Primary**: Name:_____ Address: _____
Phone #: _____ ID #: _____Group #:_____
Subscriber:_____ Relationship: _____

***Secondary**: Name:_____ Address: _____
Phone #: _____ ID #: _____Group #:_____
Subscriber:_____ Relationship: _____

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REVIEW OF SYSTEMS

Name: _____ **Date:**_____

Allergies:_____

_____

Review of Systems: Please circle all that apply.

Constitutional: Fever Chills Weight Loss/Gain Night Sweats Weakness Fatigue Loss of Appetite Nausea

Eyes: Blurriness Pain Discharge Itchiness Changes in Vision Glaucoma Blindness Glasses/Contacts

Ears/Nose/Throat: Hearing Aid L/R Hearing loss Earache Ringing in the ears Nasal Drainage Sore Throat

Cardio/Peripheral Vascular: Chest Pain Difficulty Breathing Fatigue Palpitations Edema Claudication Numbness

Respiratory: Shortness of Breath Cough Wheezing Asthma Oxygen Tank ___L/min

Gastrointestinal: Abdominal Pain Reflux Nausea Vomiting Hemorrhoids Constipation

Genitourinary: Incontinence Frequent Hematuria/Blood in Urine Dysuria/Painful Urination Kidney Stones

Male: Erectile Dysfunction Female: Vaginal Discharge

Musculoskeletal: Joint pain Back Problems Arthritis Muscle Aches Paralysis Extremity Swelling

Skin: Skin Lesions Rash Itching Hives

Neurologic: Fainting Focal Weakness Numbness/Tingling Seizures Dizziness Balance Problems

Psychiatric: Psychiatric History Anxiety Depression Memory Loss Substance abuse

Endocrine: Diabetes Hot and Cold Intolerance Thyroid Disease

Hematologic: Anemia Bleeding Blood Clotting Problems Swollen Glands Bruising

Sleep: Snoring Excessive Daytime Sleepiness Witnessed Apnea

Others: Hepatitis Type_____ HIV High Potassium Low Potassium

***Cancer**: _____ (Please write N/A if not applicable)

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Past Medical History: Please circle all that apply.

High Cholesterol	Gout	Obesity	Hypertension (high BP)	Dementia	Afib
Coronary Artery Disease	COPD	GI Bleeding	Congestive Heart failure	Osteoarthrosis	Frequent UTI
Kidney Transplant	Stroke	Seizures	Abdominal Aortic Aneurysm	Cancer	Kidney stones

Problems not mentioned in the 2 sections above:

_____

_____

Surgical History: Check any surgeries and list the year.

Surgery	Year	Surgery	Year
Appendectomy	_____	Coronary artery bypass	_____
Kidney biopsy	_____	Kidney disease:	_____
Tonsillectomy	_____	Cancer:	_____
Gallbladder	_____	Hypertension:	_____
Hysterectomy	_____	Heart disease:	_____
Prostate	_____	Pacemaker:	_____
Breast biopsy	_____	Other:	_____
Mastectomy	_____	Other:	_____

Have you had any imaging (MRI, CT, Ultrasound, etc.) done within the last 6 months?

No **If yes, when/what: _____**

Have you ever had chemotherapy or immunotherapy?

No **If yes, when/what: _____**

Do you have any metallic implants?

No **If yes, when/what: _____**

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Family History: Please circle all that apply and list the relationship.

Kidney Disease _____ **Heart Disease** _____ **Diabetes** _____ **Cancer** _____

Social History: Please circle and list explanations.

Marital Status: Married Single Divorced Separated Partnered Widowed

Who Lives With You (circle all that apply): Alone Spouse Children Parents Friend Other_____

Education: High School Diploma GED Some College College Graduate

Tobacco use: Non-smoker Previous Smoker Smoker: _____ cigarettes per day

Alcohol use: None Occasional: _____ Everyday: _____

Drug use: Never Previous:_____ Current:_____

Caffeine consumption: Never Some: _____ cups per day

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Date: _____

Medication History (Include prescription, over the counter, and/or vitamin supplements):

Patient Name:_____ Date of Birth: _____

Name of Medication	Strength	How Often	What is the medication for?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

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PRESCRIPTION HISTORY AND PRISMA CONSENT

Purpose of Prescription History and PRISMA Review:
A detailed prescription history provides valuable insights into medications prescribed by other healthcare providers involved in my medical care. This information will be utilized to improve the accuracy of my medication list in the medical chart, ensuring that there are no discrepancies in medication names or dosages. Dallas Renal Group also utilizes a health information search engine and exchange system, PRISMA, to obtain and store patient records—such as laboratory results and imaging studies—from external providers and hospitals, in order to support a more complete and chronological understanding of the patient's medical history.

Terms of Consent for Prescription History and PRISMA Review:
I, the undersigned, understand that accurate medication information is crucial for my medical care. To enhance the accuracy and precision of my medication records and minimize the risk of adverse reactions or false information, I hereby authorize Dallas Renal Group, with its physicians, employees, and staff, to obtain and review my prescription history, labs, and imaging from various sources, including but not limited to healthcare providers, pharmacies, health exchanges, and benefit payers (e.g., insurance companies). I acknowledge that Dallas Renal Group may use health information exchange systems like PRISMA to electronically transmit, receive and/or access, and store my prescription, labs and imaging history. I understand that this consent will be valid and remain in effect as long as I attend or receive services from Dallas Renal Group, unless revoked by me in writing provided to and agreed upon by Dallas Renal Group’s main office.

By signing this consent form, I have provided my prescription, labs, and imaging history to the best of my knowledge and I grant Dallas Renal Group permission to request, view, and use health information search engines like PRISMA for my external prescription, labs, and imaging history for treatment purposes. I acknowledge that I have had the opportunity to ask any questions related to this consent and all queries have been satisfactorily addressed.

Patient Name _____

Signature _____ Date _____

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Leaders in Kidney Care

HIPAA Policy

Notice of Privacy Practices for Protected Health Information (PHI)

THIS FORM DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Dallas Renal Group (DRG) is required by federal and state laws to maintain the privacy of your health information and to provide you notice of our legal duties and privacy practices with respect to your health information. Protected health information (PHI) is the information our practice, DRG, with its physicians, employees, staff, and other personnel create and maintain in the course of providing our services to you. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and meet certain legal requirements related to your care. Such information may include documentation of your symptoms, examinations, test results, diagnosis, treatment protocols, and billing documents for those services. We are permitted by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to use and disclose your PHI without your written authorization for purposes of treatment, payment, and health care operations. Treatment may mean providing, coordinating, and/or managing your healthcare and related services by one or more healthcare providers. Payment may mean obtaining reimbursement for services, confirming insurance coverages, and/or billing and collection activities. Health care operations may mean conducting quality assessments, auditing, customer services, and/or cost management analysis. Other examples are listed below. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

For Example:
. A nurse needs to obtain your treatment information and record it in your medical record.
. A physician determines he/she will need to consult with a specialist. They will share the information with the specialist and obtain his/her input.
. Submitted requests for payment to your health insurance company and response to health insurance company requests for information about the medical care we provided you.
. Use or disclosure of your PHI in order to conduct certain business and operational activities, such as data analysis, quality assessments, employee reviews or training. Information may be shared with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of DRG. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI upon request by phone, by visiting our website or at one of our office locations;
- Receive notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree and is not as required by law. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the DRG's designated medical records. If you would like us to refrain from releasing your health information to a family member or friend who is involved in your care, you may exercise this right by delivering your request, in writing, to DRG's main office at 7999 W Virginia Dr, Ste A, Dallas,

TX 75237

- Appeal a denial of access to your PHI, except in certain circumstances of "unreviewable grounds" under HIPAA;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to DRG's main office. We may deny your request if you ask us to amend information that: (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by DRG, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to DRG's main office;
- If we engage in fundraising activities and contact you to raise funds for DRG, you will have the right to opt-out of any future fundraising or marketing event communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules; and,
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to DRG (except to the extent action has already been taken based on a prior authorization)

As our responsibility, DRG is required to:

- Maintain the privacy of your health information that is as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out of pocket at the time of service and is not as required by law.

Other Uses and Disclosures of your PHI

- **Appointment Reminders and Office Visit**
  We may use or disclose your health information in order to contact you via text or call and remind you of upcoming appointments related to your treatment plan and/or other healthcare services. We may need you to sign in during an office visit and call out your name in the waiting room for your appointment.

- **Communication with Family, Caretakers and Emergency Contacts**
  Per information given on your Medical Records Release Form, we may disclose to a family member, close personal friend or any other person you identify, health information relevant to that person's involvement in your care, payment for care or in the care of an emergency situation.

- **Research**
  We may under limited circumstances disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI without your written authorization. We may also disclose your information if the researchers require only a limited portion of your PHI.

- **Disaster Relief**
  We may use and disclose your PHI to assist in disaster relief efforts so that your family or other persons responsible for your care can be notified of your health status and location.

- **Organ Procurement Organizations**

Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant if you are an organ donor.

- **Food and Drug Administration (FDA)**
  We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects or post-marketing surveillance information to enable product recalls, repairs, or replacements.

- **Workers' Compensation**
  If you are seeking compensation from Workers' Compensation, we may disclose your PHI to the extent necessary to comply with laws related to Workers' Compensation.

- **Public Health**
  We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

- **As Required by Law**
  We may disclose your PHI as required by federal, state or local law, or to appropriate public authorities as allowed by law to report abuse or neglect.

- **Employers**
  We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

- **Law Enforcement**
  We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

- **Health Oversight**
  Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

- **Judicial/Administrative Proceedings**
  We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

- **For Specialized Governmental Functions or Serious Threat**
  We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

- **Correctional Institutions**
  If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

- **Coroners, Medical Examiners, and Funeral Directors**
  We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our patients to funeral directors as necessary for them to carry out their duties.

DALLAS RENAL GROUP
Leaders in Kidney Care

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the DRG's Office Manager, 972-274-5555, or in writing to us. Please note that all complaints must be submitted in writing to the Manager at DRG's main office:

Dallas Renal Group 7999 W Virginia Dr, Ste A, Dallas, TX 75237

You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice and we cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints. The address for the Texas Regional Office is:

Office for Civil Rights, U.S. Department of Health and Human Services 701 W. 51st Street, MC W206 Austin, Texas 78751 Phone: 1-888-388-6332 or 512-438-4313 Fax: 512-438-5885

Acknowledgement of Receipt of Notice of Privacy Practices

You may access a copy of this Notice electronically on our website at www.dallasrenalgroup.com

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you at any time. If our information practices change, we will amend our Notice and you may request a written copy of the revised Notice from any of our offices.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to Practice (as previously provided in this Notice under "Your Health Information Rights.") This notice is effective as of the date this form is signed by the patient and we are required to abide by the terms of this Notice.

Please sign below to acknowledge that you have read and received Dallas Renal Group's Notice of Privacy Practices.

Signature_____Date_____

Patient Name_____

DALLAS RENAL GROUP
Leaders in Kidney Care

Financial Policies

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to Dallas Renal Group or the physician individually for services rendered to my dependents or me by the physician or under his-her supervision. I understand that it is my responsibility to ensure that the clinic has valid and/or updated insurance information. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefits. I understand and agree that I will be responsible for any co-pay, deductibles, premiums, and other payments due. I also understand that ultimately I am responsible for any outstanding balance not covered by my insurance.

Medicare/ Medicaid/ insurance benefits:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to the Dallas Renal Group or the physician on my behalf.

Authorization to Release Non-public Personal Information:
I certify that I have received and read a copy of the Dallas Renal Group Patient Information Privacy Policy. I hereby authorize Dallas Renal Group or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to Mail, Call, or E-mail:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize the Dallas Renal Group staff or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Dallas Renal Group to that effect in writing.

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-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Financial responsibility agreement
I understand and agree that I will be financially responsible for any and all charges not paid by my insurance for my visits. This includes medical service or visit, lab testing, and any other screening service or diagnostic ordered by the physician or staff. I understand and agree it is my responsibility and the responsibility of the physician or clinic to know if my insurance will pay for medical service or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, usual and customary limit and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expenses to me. I understand and agree to be financially responsible and make complete payment of all outstanding balances.

Insufficient funds
I understand that in the event of any returned/declined payment made to Dallas Renal Group, I will be responsible for the declined payment charge of $20 in addition to the balance owed.

Signature: _____ Date:_____

Patient (or Guarantor's) Name:_____

DALLAS RENAL GROUP
Leaders in Kidney Care

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth:_____

This form is to confirm your authorization for the use or disclosure of your protected health information for a special purpose. By signing below, you give your authorization for Dallas Renal Group or their representative to use or disclose your protected health information to the individuals or groups listed below. These individuals or groups may be contacted regarding your health issues, and you should list at least one person who assists you when you are ill.

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Dallas Renal Group will make attempts to contact you in the following order of communication methods:

1. Cell Phone: Voicemail/Text Message
2. Home Phone: Answering machine
3. Email
4. Work Phone: Voicemail

If you have a preference for alternative modes of communication, kindly provide a written request specifying your preferred method(s).

I understand that I may revoke this authorization at any time, and such revocation must be done in writing. This authorization will remain valid until written notice of termination is received. Any additions or deletions to this list must also be submitted in writing.

Patient's Name (Print): _____

Signature: _____

Date: _____

Note: This form must be completed for any information to be disclosed to a spouse, family member, organization, or individual assisting you with your medical care, appointments, or insurance

DALLAS RENAL GROUP
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Patient Responsibilities

As a patient, I understand that it is my responsibility to:

- Maintain a civil and respectful attitude with any form of communication to the staff, providers, and other personnel in the medical office.
- Update the staff to the best of my knowledge regarding my medical conditions, medication list, family/social/surgical history, insurance, and payment plan.
- Follow the treatment plan recommended by my healthcare provider to the best of my ability and discuss with my provider any concerns about my treatment plan.
- Be financially responsible for any charges and payments not covered by my insurance

Patient's Name (Print): _____

Signature: _____

Date: _____