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 yourappointment:

- **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

DALLAS RENAL GROUP
Leaders in Kidney Care

PATIENT REGISTRATION

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

*Last Name:_______________________________*First Name:______________________________Middle Initial: ________

*Address: ____ City:___________________________________

State:_______ Zip code:_________ Home Phone: _________________________ Cell Phone: _____________________

Email Address ____ *Social Security #: ____________________

*Date of Birth:____________Age:______ *Sex:______ *Race _________________ Driver's Lic. #: ___________________

Preferred Language ______________ Hispanic (circle one) Yes No *Employer Name ________________________

Work Phone #: _________________________ Pharmacy Name ____

Pharmacy Phone ________________________Pharmacy Address ____

Emergency Contact Name:____Emergency phone #: ___________________

Primary Care Physician Name:____________________________________PCP office telephone #: ____________________

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: ___________________

*Employer Name:____Phone #: _________________________________

INSURANCE INFORMATION: (OR COPY OF INSURANCE CARD)

Primary:__________________________________Address: ____

Phone #:_________________________________ ID #:___________________________Group #: ____________________

Subscriber:____Relationship: ________________________________

Secondary:________________________________Address: ____

Phone #:___________________________________ID #:____________________________Group #: ___________________

Subscriber:____Relationship: ________________________________

Copay $____Deductible $____

Disclosures, Consents & Financial Responsibility Agreement

Patient Name:______________________________ **Date of Birth**: ____________

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 know my insurance benefits and whether or not the services I am to receive are covered benefit. I understand and agree that I will be responsible for any co-pay or balance due.

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 inwriting.

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 expense to me and I understand this and agree to be financially responsible and make full payment.

Patient signature:______________________________ **Date**: ______________________

Guarantor signature:____________________________**Date**: ______________________

(If different from patient)

Guarantor name (please print): ____

DALLAS RENAL GROUP
Leaders in Kidney Care

Individual Patient's Authorization

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

I_________________________give my authorization to use or disclose my protected
(Patient's Name)
health information to the following individual(s) or group(s).

THIS SHOULD BE NAMES OF RELATIVE OR FRIENDS WE MAY DISCUSS YOUR HEALTH ISSUES WITH. YOU SHOULD LIST AT LEAST ONE PERSON WHO HELPS YOU WHEN YOU ARE ILL.

________________________________ ________________________________

________________________________ ________________________________

I authorize Dallas Renal Group or their representative to leave messages via the following: **Please number in order of preference.** If you don't want to be contacted by one of the following, do not place a number by it.

_______ Home answering machine

_______ Work voice mail

_______ Cell phone

_______Text message

_______ EMAIL ____

I understand that I may revoke this authorization at any time and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Name (Print): ____

Signature: ____

Date: ____

This must be completed for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, or insurance.

REVIEW OF SYSTEMS

PATIENT NAME:_______________________________________**DATE:**________________________________
ALLERGIES:
____
____

Reviewof 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

Ears/Nose/Throat: Hearing loss Earache Nasal drainage Sore throat

Cardio/Peripheral Vascular: Chest pain Difficulty breathing Fatigue Palpitations Edema Claudication Numbness

Respiratory: Shortness of breath Cough Wheezing Asthma

Gastrointestinal: Abdominal pain Reflux Nausea Vomiting

Genitourinary: Incontinence Hematuria/blood in urine Dysuria Frequency Kidney stones

Musculoskeletal: Joint pain Back problems Arthritis Muscle weakness

Skin: Skin lesions Rash Itching Hives

Neurologic: Fainting Focal Weakness Numbness Seizures

Psychiatric: Psychiatric history anxiety depression memory loss

Endocrine: Diabetes Hot and cold intolerance Thyroid disease

Hematologic: Anemia Bleeding Blood clotting problems Swollen glands

Sleep: Snoring Excessive daytime sleepiness Witnessed apnea

Others: Hepatitis type __________ HIV _______ High potassium Low potassium

Cancer: ____

Past Medial History: Please circle any that apply.

High Cholesterol	Gout	Obesity	Hypertension (high blood pressure)
Dementia	Coronary artery disease		Atrial fibrillation
GI Bleeding	Congestive Heart failure		COPD
Osteoarthrosis	Stroke	Seizures	Abdominal Aortic Aneurysm
Kidney transplant	Urinary tract infections		

PATIENT NAME:____DATE: ________________________________

Problems not mentioned in 2 sections above: ____

____

Check any surgeries and list year.

__Appendectomy_______ ___Kidney biopsy_______ ___Tonsillectomy__________Prostate _______

__Gallbladder_____ _ ___Hysterectomy________ ___Pacemaker_________

__Breast biopsy_______ ___Mastectomy_______ ___Coronary artery bypass _________

___Other: ____

Family History: please list family member and disease.

Kidney disease: ____

Diabetes: ____

Hypertension: ____

Heart disease: ____

Cancer: ____

Other: ____

Social History: please circle and list explanation.

Marital Status: Married Single Divorced Separated Partnered Spouse Deceased

Employed: Full-time Part-time Retired

Current or Previous Occupation: _______________________

Education: High school diploma GED Some College College graduate

Tobacco use: Non-smoker Previous Smoker Smoker per day: 1-9 10-19 20-39 40+

Alcohol use: None Occasional Everyday: ___________________________________

Drug use: Never Previous:____________________Current: _______________________

Caffeine consumption: Never Some Cups per day: _____

Filled out by:_______________________________________ Relationship: ____________________

Dallas Renal Group
Leaders in Kidney Care

Patient Name:______________________________ Date of Birth: ______________________

Allergies/ Reactions: ____

____

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.			

Date: ___________________________

Notice of Privacy Practices for Protected Health Information (PHI)

THIS FORM DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Dallas Renal Group (DRG) is required by federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. 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.

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 from about the medical care we provided you.
- Use or disclosure of your PHI in order to conduct certain business and operational activities, such as 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 the Practice. 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;
- 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. 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
- Health Information Exchange(HIE) Opt-Out: You have the right to opt-out of disclosure of your medical

records to or via an electronic health information exchange (For example, Surescripts, Commonwell, CareQuality). However, information that is sent to or via an HIE prior to processing your opt-out may continue to be maintained by and be accessible through the HIE. You must opt out of disclosures to or via an HIE through each of your individual treating providers who may participate in any given HIE.

- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated medical records. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. 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 the Practice, (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 our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information 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.

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. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

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 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. 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.

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.

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 relating 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 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.

Website

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

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 the Practice (as previously provided in this Notice under "Your Health Information Rights.")

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 Practice's Office Manager, 972-274-5555, or in writing to us at:

Kathy Williamson Dallas Renal Group
3571 W. Wheatland Rd Ste. 101
Dallas, TX 75237

Please note that all complaints must be submitted in writing to the Manager at the above address.

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. 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

More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

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.
We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Patient Name (Printed):

Patient Signature:

Date of Signing Consent Form:

DALLAS RENAL GROUP
Leaders in Kidney Care

Medication History Consent Form

Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you authorize Dallas Renal Group to obtain and review your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Dallas Renal Group to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (Printed): ______________________________________

Patient Signature: ____

Date of Signing Consent Form: ________________________________