DFW KIDNEY CARE CLINIC

Thank you for choosing DFW Kidney Care Clinic! Attached is the new patient paperwork that needs to be completed prior to your appointment.

You also need to bring the following:

- **New Patient Paperwork**
- **Picture ID**
- **Insurance Card(s)**
- **ALL your medications, including any over the counter medications.**

If you are unable to complete the paperwork packet, please arrive at least 15 minutes prior to appointment time so that this can be completed.

Thank you in advance!

DFW Kidney Care Clinic

Phone: 817-912-5900

Fax: 817-912-5902

www.DFWKCC.com

DFW KIDNEY CARE CLINIC

PATIENT REGISTRATION

Patient Information: (*Please use legal name, no nickname)*

Last Name: _____First Name: _____ Middle Initial:

Address: _____

City: _____ State: _____Zip Code: _____

Cell Phone: _____Home Phone: _____Work Phone: _____

Social Security Number: _____Driver's License: _____

Date of Birth: _____Age: ____Sex:_____Marital Status: _____

Employer Name & Address: _____

._____

Emergency Contact Name: _____Phone number: _____

Primary Care Physician: _____ Phone number: _____

Pharmacy: _____ Phone Number: _____

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(S))*

Primary: _____Address: _____

Phone #: _____ID:____Group #_____ Subscriber: _____

_____Relationship: _____

***NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES** *(on website for review)*

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Patient Name_____ **DOB:**_____

Allergies to medications, foods, x-ray dye:

_____ _____

_____ _____

_____ _____

Pharmacy: _____ **Phone#:**_____

MEDICATIONS/OVER THE COUNTER MEDICATIONS/SUPPLEMENTS/HERBS*: (Bring all to your appointment)*

Medication	Dosage	Frequency

RELEASE OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____

Social Security #: _____Patients Phone #:_____

I request and authorize all the physicians and healthcare entities to release the medical record of the above-named patient to DFW Kidney Care Clinic (www.DFWKCC.com). This request and authorization apply to the entire medical record.

Reason for Release: Patient Care

_____Signature of patient or authorized representative Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative)

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, DFW Kidney Care Clinic originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by DFWKCC for treatment, payment, and health care operations. I acknowledge that I have been provided with DFWKCC Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that DFWKCC reserves the right to change its Notice of Privacy Practices at any time and that I will be provided a copy of the revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that DFWKCC is not required to agree to the restrictions requested but if it does, it is bound by such restrictions. I understand that I may revoke this consent in writing, except to the extent that DFWKCC has already acted in reliance thereon.
By signing this form, I consent to DFWKCC use and disclosure of my health information for treatment, payment, and health care operations.

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could require examination, diagnosis and treatment and other medical services which may include x-rays, laboratory procedures, tests, and medications. I do hereby voluntarily consent to such examination, diagnosis, treatment, and other medical services, and procedures that may be recommended under the general and specific instructions of the physicians of DFW Kidney Care Clinic (DFWKCC), their assistants, nurses, or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of DFWKCC have made no guarantees to me as to the result of examination, diagnosis, treatment, or other medical services.

DFWKCC recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition. We also want to provide our patients with timely communication as to laboratory/diagnostic test results from either DFWKCC in house laboratory or any other laboratory and other patient medical information. We understand that because of the patient's schedules and our office schedules, personal communication may sometimes be difficult. DFWKCC policy is not to leave messages regarding sensitive medical information with unauthorized third parties. However, acknowledging that it may be difficult for the physician/physician's staff to personally communicate with the patient regarding laboratory/diagnostic test results, or patient medical information, it is the policy of DFWKCC to leave such information on the patient's telephone answering machine unless you indicate that you do not consent to leaving such messages on your answering machine.

If the physician/physician's staff cannot reach the patient at home, cell, or business telephone, it is the policy of DFWKCC that a message will be left with the person that answers the telephone to advise the patient to return the phone call.

It is the policy of DFWKCC not to release confidential medical information to patient's family members unless the patient consents to the release. We will not discuss your medical condition or release diagnostic test results to anyone without your consent.

It is the policy of DFWKCC to participate in or support clinical research designed to use patient data to improve diagnosis and treatment of medical illnesses and to identify potential study subjects for clinical research; such research support may include the review or disclosure of a patient's medical records.

It is the policy of DFWKCC to send appointment reminders to our patients, either by telephone, e-mail, text, or reminder cards.

At some of its medical offices, DFWKCC collaborates with nursing and medical school teaching programs enabling students as well as physicians in residency and fellowship programs to observe patient care, and if permitted by a physician based upon their level of training and experience to assist the office medical personnel in the delivery of medical services under the supervision and direction of a DFWKCC physician. DFWKCC physicians allow future students and those involved in current teaching programs to accompany them at some of its medical offices and on hospital and dialysis rounding with patient consent and appropriate permission from those facilities.

PATIENT INFORMED CONSENT FOR TELEMEDICINE SERVICES

DFW Kidney Care Clinic has implemented an electronic health record (EHR) in part to meet the U.S. Department Health and Human Services initiative to improve health information technology, toward the goal of improving quality of health care. Our EHR integrates your clinical record with appointments, registration, and billing and makes this information available to the clinicians who are involved in your health care. In connection with its electronic communication systems, DFWKCC has also implemented and has in place privacy and security policies and procedures to minimize risk of inadvertent or unauthorized disclosure, corruption and/or loss or distortion of data,

but as with all record keeping systems, whether paper or digital, some risks remain of loss, inadvertent disclosure or errors in the recorded data.

I have read and understand the information provided regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine including electronic transfer of medical data to other medical practitioners participating in my medical care. I hereby authorize DFWKCC to use telemedicine during my diagnosis and treatment and consent to the electronic communication of my personal health care information to other entities for treatment, payment, or health care operations.

INFORMED CONSENT FOR PRESCRIPTIONS

DFWKCC continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians, and pharmacists. DFWKCC electronic health record (EHR) provides secure access for patients with prescription coverage in the United States. Prescription eligibility, benefit, formulary, and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings.

I consent to electronic prescriptions and acknowledge that DFWKCC will use electronic connectivity between payers, physicians, and pharmacists.

PATIENT PORTAL CONSENT

DFWKCC is offering the patient portal as a convenience to you. The patient portal is a secure web portal that allows you, as a patient, to view your medical chart and to access our online bill pay via the internet. It also allows you to communicate with our office via secure messaging. You may request appointments, schedule changes, and medication refills (not including controlled substances). DFWKCC reserves the right to suspend or terminate the patient portal at any time and for any reason. I understand that the patient portal will be offered at no charge and acknowledge that communications over the internet using the portal is secure. I also agree with the policy defined herein for suspension or termination of portal access.

All the foregoing consents are continuing in nature during the entire course of my care unless specifically revoked by me.
(Any individual consent or this entire consent can be revoked at any time upon receipt of your written request.)

Print Name of Patient_____ Date_____

Signature of Patient _____ Date _____

If you have a Personal Representative /Guardian who has been given authority to act on your behalf, please provide us with that name and contact information.

_____

Personal Representative/Guardian Telephone No.

_____

Date