Today's Date: ___/___/_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Gender: M/F/_

Address: _____ City _____ State ____ Zip_____

Race: _____ Ethnicity: _____ Language: _____ Birth Date: ____/____/____

Occupation: _____ Marital Status: _____ Employer:-_____ Primary Care Provider:-_____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ SSN: _____ Driver's License: _____

Person Responsible for account: _____ Relationship: _____

Address: _____ City _____ State ____ Zip_____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ SSN: _____ Driver's License: _____

Emergency contact Name: _____ Phone 1: (___) ___-____ Phone 2: (___) ___-____

IF YOU ARE INSURED BY MEDICARE, PLEASE SIGN THE FOLLOWING:

I request that payment of authorized Medicare benefits be made on my behalf to LifeHealth, P.C dba *Doctors' Kidney care* for any services or items furnished me by that physician/staff. I authorize any holder of medical information about me to release any information needed to determine their benefits payable for related services.

Signature of beneficiary or person signing for beneficiary _____ Date Signed____/____/_____

INSURANCE POLICY INFORMATION

Insurance Company(Primary): _____ Policy number: _____

Policy holder's name: _____ Birth Date: __/__/____ Employer: _____

Group number: _____ Relationship of patient to policy holder: _____

Insurance Company(Secondary): _____ Policy number: _____

Policy holder's name: _____ Birth Date: __/__/____ Employer: _____

Group number: _____ Relationship of patient to policy holder: _____

CONSENT FOR TREATMENT: - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize LifeHealth, P.C. dba *Doctors Kidney Care* to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to LifeHealth, P.C. dba *Doctors Kidney Care* of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the LifeHealth, P.C. dba *Doctors Kidney Care* charges for these services. I under-stand that I am financially responsible to LifeHealth, P.C. dba *Doctors Kidney Care* for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by LifeHealth, P.C. dba *Doctors' Kidney Care.* I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the Skate of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

Signature of beneficiary or person signing for beneficiary _____ Date Signed____/____/_____

LifeHealth, P.C Dba Doctors' Kidney Care's Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: we may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE? This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

Policy regarding the protection of personal information. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Changes To This Notice. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Privacy Officer at (205) 226-5925, 817 Princeton Ave SW, POB 2, Suite 210, Birmingham, AL 35211. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses Of Medical Information. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that **I have received the Notice of Privacy Practices and Notice of Individual Rights**

_____ ___/___/_____

Patient or Patient's Personal Representative Date

LIFHEALTH, P.C dba DOCTORS' KIDNEY CARE

PATIENT CONTACT INFORMATION SHEET

PATIENT NAME: _____ Birth Date: _____

Any physician, staff, employee or representative of LifeHealth, P.C DBA Doctors' Kidney Care has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number
	Primary Care Physician	
	Cardiologist	

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to LifeHealth, P.C or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

FINANCIAL POLICY ACKNOWLEDGEMENT
(MEDICARE PATIENTS)

Patient Name: _____ **Date:** _____
(Please Print)

OUR FINANCIAL POLICY	
	Medicare does NOT cover all medical goods and services. It is the patient's responsibility to provide us with current insurance information at each visit. If we believe that Medicare will not cover the medical goods and services provided by Doctors' Kidney Care, we will provide you written notice (known as an Advance Beneficiary Notice, "ABN"). The ABN will detail the non-covered services and your financial obligation for those services.
Initial	
	You are responsible for all and any applicable co-payments, coinsurance, and unmet deductibles. Although you are covered by Medicare, you may be responsible for a co-payment, coinsurance, and/or deductible. You will also be responsible for any past due balances that may be remaining on your account. Doctors' Kidney Care requires that all monies be paid on date of service.
Initial	
	Payment Methods and Returned Check Fee. Doctors' Kidney Care accepts MasterCard, Visa, personal checks, and cash. If the bank returns your check as "un-payable," you will be charged a $25.00 service charge, which will be due, along with the amount of the returned check, within three (3) business days. Your account will be placed on a "cash-only basis."
Initial	
	Prompt Payment of Mailed Invoices. In the event that you receive a statement in the mail from us for payment, it is your responsibility to pay that amount within 14 days. Amounts for which you are liable may be identified as ***"patient balance due"*** on the invoice. Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments.
Initial	
	Accounts Placed for Collection. If you fail to make payments due within sixty (60) days following receipt of an invoice then (i) interest shall accrue on the outstanding balance at the rate of 1% percent per month (or, if less, the highest interest rate permitted by law), and (ii) your account may be sent to an attorney or third-party collection agency for collection. In the event that your account is sent for collection, you will be responsible for costs and reasonable attorneys' fees incurred by Doctors' Kidney Care in connection with the collection of the outstanding balance.
Initial	

ACKNOWLEDGEMENT

I HAVE READ AND UNDERSTAND the Financial Policy of Doctors' Kidney Care and agree to be bound by it. I understand that Medicare does not cover all medical goods and services as well as my responsibilities with respect to Medicare as explained above. I understand that I am ultimately responsible for payment for medical goods and services provided to me by Doctors' Kidney Care. I hereby grant Doctors' Kidney Care the right to bill and collect from Medicare for medical goods and services provided to me.

X_____ _____
Responsible party/Guarantor Name Relationship

X_____ _____
Responsible party/Guarantor signature Date

Pharmacy Name: _____ Phone _____ Fax_____

Address: _____ City: _____ State_____ Zip_____

Current Medications:

1		11	
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

Health History: - List all you medical problems

	No	Yes		No	Yes
Anemia			Hyperlipidemia		
Arthritis			Hypertension		
Asthma/COPD			Kidney cyst		
Atrial Fibrillation(A.fib)			Kidney failure		
Congestive Heart Failure(CHF)			Kidney Stones		
Cancer			Lupus		
Coronary Artery Disease			Polycystic Kidney Disease		
Diabetes Type 2			Protein in Urine		
Diabetes Type I			Recurrent Urinary infection		
Blood in Urine			Stroke		
Hepatitis A			Thyroid disorder		
Hepatitis B			Transplant		
Hepatitis C			Vitamin D Deficiency		

Family Medical History:

Problem	Yes	No	List the family members
Kidney Disease			
Protein in Urine			
Blood in Urine			
Dialysis			
Kidney stones			
Diabetes Type 1			
Diabetes Type 2			
Hypertension			
Lupus			
Polycystic Kidney disease			
Cancer			
Deafness			
Others			

Surgical History

Surgeries	Year

HEALTH HABITS AND PERSONAL SAFETY				
All questions contained in this questionnaire are optional and will be kept strictly confidential.				
Personal	Do you live alone? ❑ Yes ❑ No If no, who lives with you?			
	Do you have a power of attorney or legal guardian? ❑ Yes ❑ No Do you have an Advance Directive or Living Will? ❑ Yes ❑ No			
Children	Do you have children? ❑ Yes ❑ No Number of daughters_____ Sons_____			
Alcohol	Do you drink alcohol? ❑ Yes ❑ No How many drinks per week?			
Tobacco	❑ Never smoker ❑ Current every day smoker ❑ Former smoker How long have you smoked? When did you quit?			
	❑ Cigarettes — pks./day ❑ Chew - #/day ❑ Pipe - #/day ❑ Cigars - #/day			
Transfusion	Have you ever had a blood transfusion? ❑ Yes ❑ No If so, when?			
Drugs	Recreational or street drug usage? ❑ Yes ❑ No			
Salt	Rank salt intake	❑ High	❑ Med	❑ Low
NSAI DS	Have you taken any of the following: ❑ Ibuprofen ❑ Aleve ❑ Advil ❑ Aspirin ❑ Motrin ❑ Celebrex ❑ Oth_____			

Do you have any allergies? If Yes, please list: _____

_____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization
I authorize_____ (healthcare provider) to use and disclose the protected health information described below to **Doctors' Kidney Care** (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:

a. ❑ to _____

OR

b. ❑ all past, present, and future periods

3. Extent of Authorization

a. ❑ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ❑ I authorize the release of my complete health record with the exception of the following information:

- ❑ Mental health records
- ❑ Communicable diseases (including HIV and AIDS)
- ❑ Alcohol/drug abuse treatment
- ❑ Other (please specify):

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until(date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date