The Nephrology Clinic, P.C.
3351 Eastbrook Drive, Ste 100 • Fort Collins, CO 80525
Phone: 970-493-7733 (877-388-1382) / Fax: 970-493-8745
www.thenephrologyclinic.com

We would like to take this opportunity to welcome you to our office. As a way to begin our relationship with you, we have prepared this packet to help you better understand our policies and procedures.

Office Hours: Our normal office hours are from 8:30 AM to 5:00 PM, Monday through Friday. Outside of these hours, your call will be answered by our answering service.

New Patient Appointment: A Patient Information and History Form are included in this packet. **Please complete these documents prior to your appointment.** If you need help completing the forms, please arrive for your appointment at least 30 minutes early and our staff will be happy to assist you. Make sure to list all of your current medication, specifying dosage and frequency. This information should be available on your prescription bottle.

Due to the high volume of referrals, we receive, we have had to adopt a strict appointment policy. If the patient is a no-show to a new patient appointment, we will not be able to re-schedule them in any of our offices. The same applies for cancellations with less than 48-hour notice. Please let us know ASAP if your schedule changes. Your initial appointment will take approximately 1 ½ hours. It may be helpful to bring along a family member or someone who knows you and can help provide background information and support. **Please be prepared to give us a urine sample upon your arrival.**

Follow up Appointments: In addition to seeing a nephrologist for follow up appointments, you will also see one of our advanced practice providers. These providers have extensive training and experience in the management of chronic kidney disease, and they work closely with your primary nephrologist to ensure your treatment plan is appropriate, and can make adjustments according to changes in your medical status.

Insurance and Billing: Please verify with your insurance company that we are a participating provider with your plan. Always bring your insurance cards to all appointments. Insurance coverage is an estimate, therefore patients are ultimately responsible for all fees and finance charges incurred. As a courtesy, we will submit claims to your supplemental insurance company if needed.

Copayments must be made when you check in for your appointment. If you are seen at one of our outreach clinics, we will mail you a statement. Checks sent in for payment will be electronically deposited within 24 hours of receipt.

Self-Pay Patients: Payment in full is required at time of service unless other arrangements are made in advance. A discount is given when your bill is paid in full at the time of your visit. Please contact our billing department at 970-221-3589 for our current self-pay fee schedule.

Electronic Communication (e-mail): Because e-mail has many risks, the only electronic communication our office uses is the secure messaging system through My Health Connection sponsored by the UCHealth system.

Collection Policy: Clinic statements will be sent to you if necessary. Any delinquent unpaid balance will be sent to an agency for collection. We realize that financial difficulties may affect timely payment of your account. If such problems arise, please contact our billing department at 970-221-3589.

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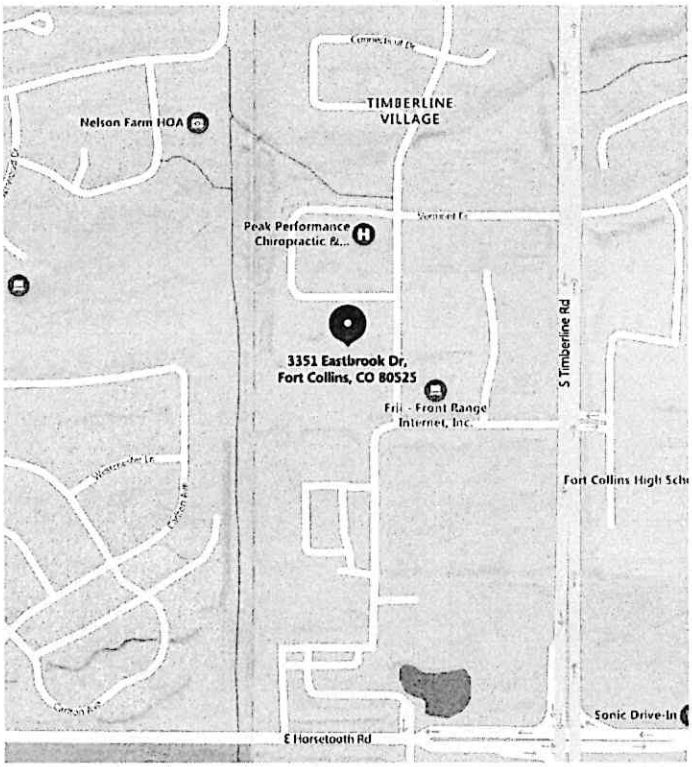
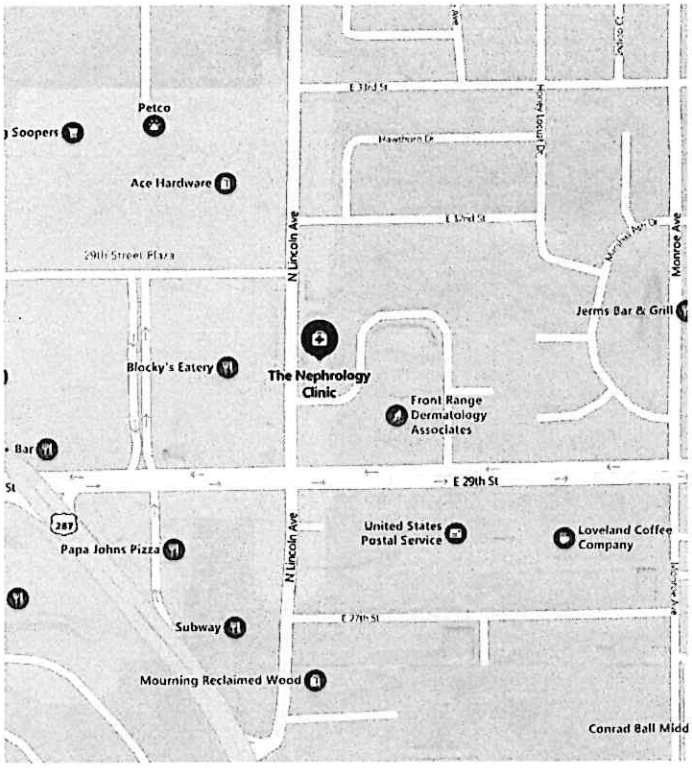
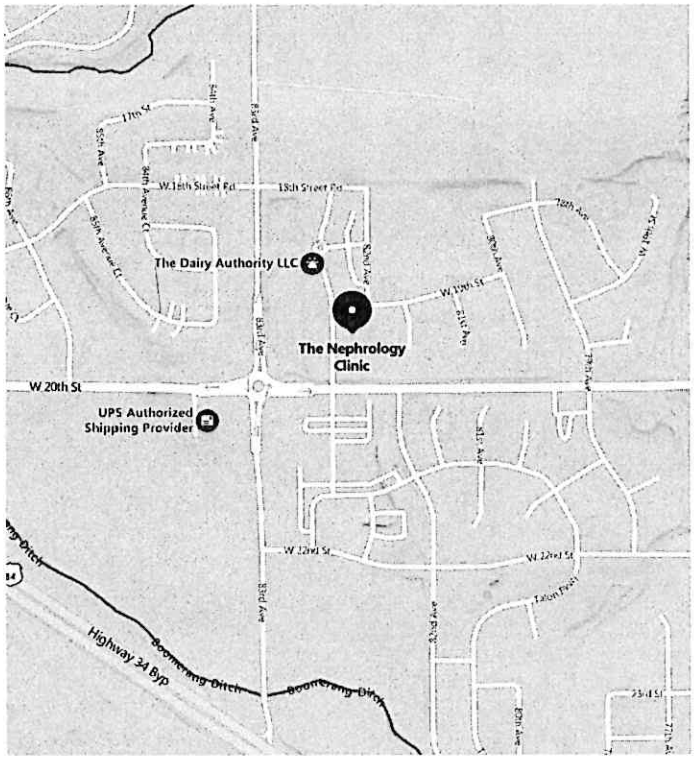
Ft. Collins Office
3351 Eastbrook Drive, Ste 100



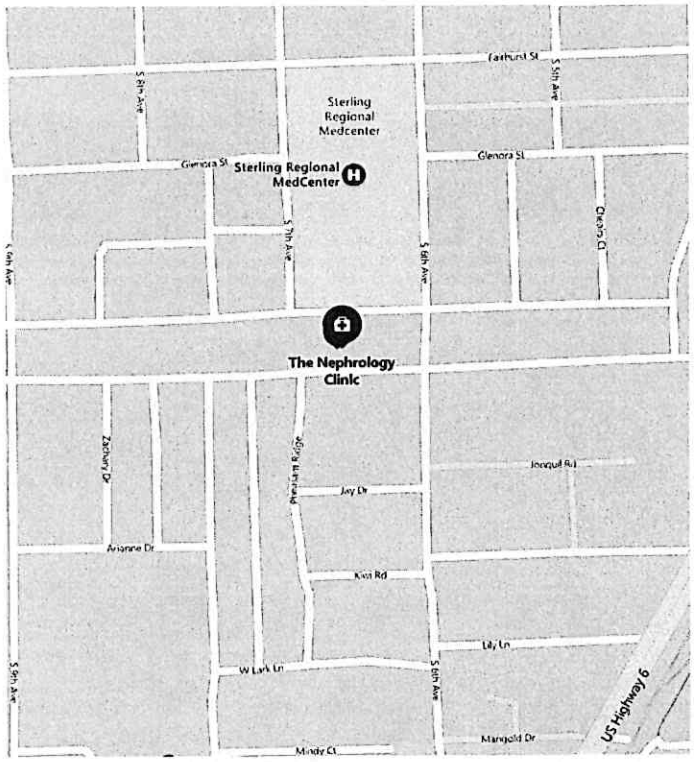
Loveland Office
2988 Ginnala Dr.



Greeley Office
8229 W. 20th St.



Sterling Office
620 Iris Dr.



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Patient:_____ Date of Birth:_____

Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I have been offered/have received a copy of Provider's Notice of Privacy Practices with effective date noted below.

_____ _____

Signature of Patient/Responsible Party **Date**

Consent for Treatment and Responsibility for Payment

I consent to be diagnosed and treated by the providers of The Nephrology Clinic PC and authorize my insurance to be billed and medical benefits be paid on my behalf directly to The Nephrology Clinic. I further consent The Nephrology Clinic to release any medical information necessary to pay my healthcare claim. I understand that The Nephrology Clinic uses electronic communication through HIPAA compliant forms and The Nephrology Clinic may bill my insurance for the use of this communication.

_____ _____

Signature of Patient/Responsible Party **Date**

Consent to Release Information

As a patient of The Nephrology Clinic, PC I give authorization to the following person(s) to have access to my medical record and to speak to the staff on my behalf (It is not necessary to list other doctors):

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone:_____ Relationship: _____

_____ _____

Signature of Patient/Responsible Party **Date**

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Date of Visit: _____

Last Name	First Name	MI	Birth Date	Age

Address	City	State	Zip

Primary Phone Number	Type: (circle) Home Cell Work	May we leave messages about your care at this number? YES NO	Alternate Phone

Social Security #	Marital Status S M W D	Gender Male Female	Family Physician Name and Phone Number

Email Address	If employed, list Employer Name and Phone Number

Pharmacy Name, Address and Phone Number

Emergency Contact Name	Primary Phone	Cell Phone	Relationship to Patient

Primary Insurance

Insurance Name	

ID or Policy Number	Group No.

Subscribers Name

Subscribers Birth Date	Gender Male Female

Insurance Address

Insurance Phone

Patient's Relation to Subscriber
Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance

Insurance Name	

ID or Policy Number	Group No.

Subscribers Name

Subscribers Birth Date	Gender Male Female

Insurance Address

Insurance Phone

Patient's Relation to Subscriber
Self ☐ Spouse ☐ Child ☐ Other ☐

Copays must be paid when you check-in for your appointment.
You are responsible for all deductibles and coinsurance in accordance with your insurance.

Race (circle one) Asian African American/Black Caucasian/White American Indian/Alaskan Native Native Hawaiian/Pacific Island

Ethnicity (circle one) Hispanic or Latino Non-Hispanic or Latino Unknown or Decline to Answer

Last Name	First Name	MI	Age	Birth Date

Appointment Date:	Provider Name:	PCP:

REVIEW OF SYMPTOMS

Please circle any symptoms you are currently experiencing.

General: Recent weight loss, recent weight gain, weakness, fatigue, fever, chills

Skin: Rashes, blisters, skin wound, itching

Head: Headache, migraines, head injury

Eyes: Visual loss, pain, redness, double vision, excessive tearing

Ears: Hearing loss, ringing in ears, earaches, ear infections, drainage from ears

Nose & Sinuses: Nasal stuffiness, nasal discharge, nosebleeds

Mouth & Throat: Bleeding gums, loss of teeth, sore throat, difficulty swallowing, metallic taste in mouth

Neck: Lumps in neck, "swollen glands", goiter

Breasts: Lumps, pain or discomfort, nipple discharge

Respiratory: Cough, coughing up blood, wheezing, asthma, difficulty breathing, shortness of breath at rest, shortness of breath with exertion, waking up short of breath

Cardiac: Chest pain, palpitations

Gastrointestinal: Heartburn, nausea, vomiting, vomiting of blood, diarrhea, constipation, rectal bleeding, abdominal pain, liver troubles

Genitourinary: Blood in urine, foamy or frothy urine, frequent urination, delays in starting urination (hesitation), urinary urgency, pain/burning with urination, incontinence, infection, waking up at night to urinate

Neurological: Fainting, dizziness, seizures, tremors, involuntary movements, slurred speech, strokes, poor coordination, weakness, frequent falls while walking

Endocrine: Thyroid trouble, excessive sweating, excessive thirst, excessive hunger

Psychiatric: Nervousness, tension, depression, any history of psychiatric problems

What is your current occupation?	
Highest Level of education completed?	
Who lives with you?	

Please list any blood relatives that have had the following

Disease	**Relationship to you**
Kidney Disease	
High Blood Pressure	
Heart Disease and / or Stroke	
Diabetes	

Last Name	First Name	MI	Age	Birth Date

Family History	State of Health	Current Age	Age of Death	Cause of Death
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

PAST MEDICAL HISTORY

	Circle Yes or No	
Rheumatic Fever	Yes	No
Diabetes I	Yes	No
Diabetes II	Yes	No
Stroke	Yes	No
Osteoarthritis	Yes	No
Kidney Stones	Yes	No
Cancer	Yes	No
Type of Cancer:		
COPD/Emphysema	Yes	No
Obstructive Sleep Apnea	Yes	No
Vascular Disease		
Abdominal Aortic Aneurysm	Yes	No
Peripheral Vascular Disease	Yes	No
Deep Vein Thrombosis	Yes	No
Pulmonary Embolism	Yes	No

	Circle Yes or No	
Asthma	Yes	No
Prostate Disease	Yes	No
Migraines	Yes	No
Coronary Artery Disease	Yes	No
Heart Attack	Yes	No
Atrial Fibrillation	Yes	No
Congestive Heart Failure	Yes	No
Hypertension	Yes	No
Hay Fever / Seasonal Allergies	Yes	No
Thyroid Disease		
Hyperthyroidism	Yes	No
Hypothyroidism	Yes	No

SURGICAL HISTORY

Surgery Date	Surgery Type

HEALTH HABITS

	Circle Yes or No		History of use in years and frequency
Alcohol	Yes	No	
Tobacco Use	Yes	No	
Marijuana (medical or recreational)	Yes	No	
Drugs	Yes	No	

Last Name	First Name	MI	Age	Birth Date

MEDICATION ALLERGIES

☐ *Check box if none*

	Medication Allergies	Reaction
1		
2		
3		
4		

	Medication Allergies	Reaction
5		
6		
7		
8		

CURRENT MEDICATIONS and/or SUPPLEMENTS

Please bring a list of your medications or fill out the form below.

	Medication Name	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
28			
19			
20			