Midwest Nephrology Associates, Inc.

Gary Singer, M.D, Daniel Young, M.D., Furqan Raja, M.D., Ramez Sunna, M.D. Andrea Latta, APRN

Consent to Obtain External Prescription History

I, _____, whose signature appears below,
authorize Midwest Nephrology Associates, Inc to view
my external prescription history via the RxHub service.
I understand that prescription history from multiple other unaffiliated
medical providers, insurance companies, and pharmacy benefit
managers may be viewable by my providers and staff here, and it may
include prescriptions back in time for several years.
MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____

Signature Date

Acknowledgement

Midwest Nephrology utilizes nurse practitioners. These providers see patients for hospital follow up visits and follow up patients in cooperation with our physicians. You may be asked to schedule an appointment with our nurse practitioner or be offered a visit with her for an acute problem.

Signature_____

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Demographics: Please mark one of the following boxes for each listed below.

Marital Status: [] Married [] Divorced [] Widowed [] Single [] Partner [] Legally Separated

Social Security Number _____-_____-_____
EMAIL: _____
Phone number(s): _____
Address: _____

EMERGENCY CONTACT # 1: _____ (RELATION)_____

Phone Number: Home: ( ) _____ Cell: ( ) _____

Date: _____ Patient's Signature: _____

PATIENT AUTHORIZATION OF INSURANCE PAYMENT AND RELEASE

I hereby give lifetime authorization for payment of insurance benefits to be made payable directly to Midwest Nephrology Associate and any assisting physicians for the services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all the cost of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payments of benefits. I further agree that a photocopy, or electronic image, of this agreement should be as valid as the original.

Date: _____ Patient's Signature: _____

FINANCIAL AND ADMINISTRATIVE POLICY
Midwest Nephrology Associates

Please provide current insurance identification card (s) and valid identification on each visit.

Your Health Plan	Patient Responsibility	Midwest Nephrology Responsibility
Medicare	Pay your deductible and co-insurance (20% of the allowable) when billed.	We will file Medicare for you. If you have supplemental insurance, we will file for you.
Medicare and a secondary insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
Medicare and Medicaid	No payment due at time of service.	We will file Medicare and Medicaid for you.
Medicaid	Pay the office visit copay.	We will file Medicaid for you.
Insurances we participate with	Pay your copay at the time of service. Py the coinsurance or deductible when billed.	We will file your insurance for you.
Non-Contracted Plans: insurances we are not participating with	Pay known copay at time of service. Any amount determined to be owed after claim processing should be paid when billed.	We will file your insurance for you.
Self-Pay	Pay the visit installment at time of service in accordance with Self Pay Policy.	None We will accept payment plans for hospital patients.
Non-Covered Charges	All charges not covered by your insurance carrier will require payment in full at the time of billing.	We will file your health plan claim for you.

Other Fees:
Returned check - $30 No Show Repeat Fee - $50

APPOINTMENTS: If you need to cancel or reschedule your appointment, we ask you to kindly give us 24 hours' notice. We reserve the right to charge a $50 no show fee after a 1 no show appointment.

AGREEMENT TO PAYMENT POLICY

I have reviewed and been given an opportunity to ask questions about the Financial and Administrative Policy and agree to the terms of payment due.

_____ _____
Signature Date

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules, and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to Midwest Nephrology Associates all my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Midwest Nephrology Associates for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with Midwest Nephrology Associates, I am not responsible for the amounts the practice has agreed to write off per the contract. If my insurance does not have a contract with Midwest Nephrology Associates, I agree to be responsible for any amounts not paid by my insurance plan. If I default on payment of my account, I understand I am responsible for all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. This does not apply to patients enrolled in traditional Medicare or Medicaid.

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have reviewed and had an opportunity to ask questions concerning the Notice of Privacy Practices of Midwest Nephrology Associates.
Please find at https://www.mykidneydocs.org/patient-resources

_____ _____

Patient's Name Printed Patient's Date of Birth

_____ _____

Patient's Signature Date

_____ _____

Responsible Party Signature Relationship to Patient

Midwest Nephrology Associates

CONSENT FOR MEDICAL CARE AND TREATMENT

CONSENT FOR ALTERNATE COMMUNICATION

I understand that I may have a medical condition that could require examination, diagnosis, and treatment. I do hereby voluntarily consent to such examination, diagnosis and treatment, services, and procedures that may be recommended under the general and specific instructions of the physicians of Midwest Nephrology Associates, their assistants, or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Midwest Nephrology Associates have made no guarantees to me as to the result of examination, diagnosis, or treatment.

Midwest Nephrology Associates 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 and patient medical information. We understand that because of the patient's schedules and our office schedules, personal communication may sometimes be difficult. Midwest Nephrology Associates would not, under any circumstances, leave messages regarding sensitive medical information with unauthorized third parties. 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 Midwest Nephrology Associates 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.

_____ I consent _____ I do not consent
If the physician/physician's staff cannot reach the patient at the home, cell, or business telephone, it is the policy of Midwest Nephrology Associates that a message will be left with the person that answers the telephone to advise the patient to return the phone call unless you indicate you do not consent.

_____ I consent _____ I do not consent
It is the policy of Midwest Nephrology Associates 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. **Information regarding my medical condition, including laboratory and diagnostic test results, can be given to (name of designated person) _____.**
_____ I consent _____ I do not consent
It is the policy of Midwest Nephrology Associates to obtain from hospitals and physicians your records and test results which pertain to the care provided in this practice.

_____ I consent _____ I do not consent
It is the policy of Midwest Nephrology Associates to send appointment reminders to our patients, either by telephone, e-mail, or reminder cards unless you indicate you do not consent.

_____ I consent _____ I do not consent

Signature of Patient _____ Date _____

(*This consent can be revoked at any time with your written request.)*

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.

_____ _____
Witness

Please check all that apply to you (in the last 3 months):

- ☐ Fevers
- ☐ Chills
- ☐ Night Sweats
- ☐ Weight Changes
- ☐ Rash
- ☐ Itching
- ☐ Headache
- ☐ Vision Changes
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Edema
- ☐ Gasping, Shortness of Breath that awakens you at night
- ☐ Nausea
- ☐ Blood in Your Urine
- ☐ Vomiting
- ☐ Pain When You Urinate
- ☐ Foamy or Bubbly Urine
- ☐ Joint Pains
- ☐ Muscle Aches
- ☐ Stroke
- ☐ Seizure
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Anemia (Low Blood Cell Count)
- ☐ Prior Blood Transfusion
- ☐ Depression
- ☐ Anxiety
- ☐ Metallic Taste in Your Mouth
- ☐ Nosebleeds
- ☐ Fatigue/ tiredness
- ☐ None of These Apply