We are implementing an Electronic Health Record and need to update the new system. Please complete the following and return to the receptionist.

Name_____

Date of Birth_____

Social Security Number_____

Address_____ Zip Code_____

Phone Home_____Cell_____Work_____

May we leave messages on your phones? YES NO (circle one)

Email Address_____ May we email you? YES NO

Sex_____Race_____Ethnicity_____Language_____Maritial Status_____

Primary care Physician/Referring Physician_____

Pharmacy_____ Zip Code_____ Drug Allergies_____

Insurance_____**PLEASE GIVE CARDS TO RECEPTIONIST TO COPY****

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians.
* ***Initial & Date***_____
CONSENT TO OBTAIN PRESCRIPTION HISTORY:
I give my full consent for Kidney Care Consultants to obtain any and all records pertaining to my prescription history.
Initial &
Date_____
RELEASE OF INFORMATION/HIPPA NOTICE OF PRIVACY PRACTICES
By signing this form, you are granting consent to KCC to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 502-595-7744. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.
Initial & Date_____
MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.
Initial &
Date_____

Patient Signature_____Date_____

Printed Name_____