Rocky Mountain Kidney Care

New Patient Registration Form

Welcome to Rocky Mountain Kidney Care, a new, higher quality patient experience for patients with kidney disease!

We look forward to working with you. To help us serve you better, we would like to help prepare in advance for your visit with us.

Please print and complete the included forms. It is very helpful for us to get this information **prior** to your appointment. You may return these forms in the following ways:

For appointments at our Aurora office at 1444 South Potomac

- Return to 1444 South Potomac, Suite 215, Aurora, CO 80012
- Fax back to 855-712-9183

For appointments at our Lone Tree office at 9777 South Yosemite

- Return to 9777 South Yosemite, Suite 110, Lone Tree, CO 80124
- Fax back to 720-696-0892

If you are unable to mail or fax forms in advance of your appointment, please bring the completed forms with you for your visit. Providing the packet to our practice ahead of your visit will allow our team to gather additional records so our doctors can provide you the most comprehensive consult on your visit day.

What to expect on the day of your appointment:

- Be ready to submit a urine sample for your provider's review in clinic
- Bring all your medications in bottles (including vitamins, herbs, etc.) with you
- Bring a list of your other providers so we can communicate with your whole care team
- Should you need to cancel your appointment, please notify us as soon as possible.
- Questions? Call us
    - Aurora location 720-500-3439
    - Lone Tree location 720-696-0852

You may request an appointment via a teleconference if you prefer. Give us a call if you are interested in this option.

Warmly,

Your Healthcare Team

Rocky Mountain Kidney Care

New Patient Registration Form

Demographic Information

Patient Name:_____ Date of Birth: ____/_____/_____

Preferred Name:_____ Social Security #:_____

Address: _____ City: _____ State: _____ZIP:_____

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

Email: _____ May we leave messages? ___Yes ___No

Prefer Communication By: _____Home phone _____Mobile Phone _____Email _____Text

Birth Gender: ____Male ____Female Identifies As: ____Male ____Female ____ Neither

Race: ____African Amer ___Amer Indian ____Asian ___ Caucasian ____Other_____

Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino Preferred Language: _____

Emergency Contact: _____ Emergency Contact #:(_____) _____-_____

Do you have a Living Will? ____Yes _____No Advanced Directive? ____Yes _____No

Primary Care Provider? (name/address) _____

Who Referred You? _____

Please list any other providers you see_____

Do you consent to phone calls? ___Yes ___No Consent to text messages? ___Yes ____No

Authorization to download patient's medication history automatically from pharmacy? _ Yes__No

Authorize discussion of health records to family/friends:

Name:_____ Relationship:_____ Phone: _____

Pharmacy and Lab Info

Preferred Pharmacy: _____

Pharmacy Address:_____ Pharmacy Phone: (____) _____-_____

Preferred Laboratory: _____

Laboratory Address:_____ Laboratory Phone: (____) _____-_____

Preferred Imaging:_____

Imaging Address:_____ Imaging Phone: (____) _____-_____

Billing Information

Primary Insurance:_____ ID #_____ Group#_____

Secondary Insurance:_____ID#_____Group#_____

Rocky Mountain Kidney Care

1) **Consent for rendering medical care**. I voluntarily give my consent to Rocky Mountain Kidney Care, its providers, staff, and affiliates (hereafter "the Clinic"), to render health care typical to outpatient services including history taking, diagnostic procedures including labs and radiology imaging, medications both oral and injectable, both in-person and via alternative means such as telehealth. I understand that the Clinic and its designees will provide care to the best of their ability, and that despite this, medical care is not an exact science and therefore no guarantees are made regarding treatment or services and their outcomes in the Clinic.
2) **Financial agreement.** I understand that this agreement is a contact which obligates me to pall all charges for my treatment, whether through insurance company (whether private, nonprofit or governmental such as Medicaid or Medicare) reimbursement for services, out-of-pocket payments, or a combination of both. I understand that the Clinic has predetermined charges consistent with area norms and the services it provides. I acknowledge that it frequently is not possible to predetermine which exact services are indicated and their specific cost at the Clinic is acting in good faith to offer the best medical care possible, and certain costs are either unpredictable or unknown. I am aware that I have a right to request a non-binding estimate of charges for the services to be rendered.
3) **Specimen handling.** I understand that specimens as a byproduct of my care may be produces and will be retained, managed and disposed of by the Clinic in accordance with the law.
4) **Financial assistance.** If I cannot pay my bill, I understand that I may be able to inquire about and qualify for financial assistance.
5) **Nonpayment.** I understand that after a good faith effort to notify in compliance with the law, the Clinic may employ third party services for the collection of delinquent debts due to my nonpayment for services rendered.
6) **Communication consent.** I understand that by providing my telephone number or email, I give my consent to the Clinic and its assigns to receive communications for the purposes of scheduling, follow-up, and or payment of bills.
7) **Preauthorization.** I understand it is my duty to obtain preauthorization for services where required by my insurance coverage plan.
8) **Assignment for payment.** I authorize and direct payment for health care services be paid on my behalf of the Clinic.
9) **_____ (initials) Acknowledgement of privacy practices.** I acknowledge that the Clinic has provided me a copy of its Notice of privacy practices which is also available on its website, rockymountainkidney.com, and that this does not affect the care I receive at the Clinic.

I acknowledge that I have read this document, I understand its contents, and I have access to a copy for my records. I am the patient or authorized person to sign this consent.

My signature is my consent to the above terms:

Signature: _____ **Date: _____**
Patient/parent/legal guardian (or person authorized to give consent)

Name of Patient: _____

If signed by person other than patient, provide:

Name:	Relationship to patient:	ID/Driver's license number:
Witness name:	Witness signature:	Date: