KIDNEY CARE SPECIALISTS, LLC.

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Dr. Arthur Tsai, M.D.
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www.KidneyCareOhio.com

Date: _______________________________

To: _______________________________

ENCLOSED IS A PACKET OF FORMS FOR YOU TO FILL OUT AND BRING WITH YOU TO YOUR UPCOMING APPOINTMENT THAT IS SCHEDULED FOR: ____ WITH __________________________ AT OUR ______________________________ OFFICE LOCATION.

PLEASE FILL OUT ALL FORMS (FRONT & BACK) AND HAVE THEM READY FOR YOUR APPOINTMENT.
WE DO REQUIRE A 48 HOUR NOTICE FOR ALL CANCELLED/RESCHEDULED APPOINTMENTS.

YOU WILL NEED TO ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME SO THAT WE MAY PROCESS YOUR PAPER WORK GET EVERYTHING ENTERED INTO THE COMPUTER. IF THERE IS ANYTHING ON THE FORMS THAT YOU DON'T UNDERSTAND, PLEASE LEAVE IT BLANK AND WE WILL BE GLAD TO HELP YOU WHEN YOU ARRIVE. THANK YOU FOR ALLOWING US TO PARTICIPATE IN YOUR CARE!

YOU WILL NEED TO BRING THE FOLLOWING WITH YOU:

1. INSURANCE CARD(S)
2. DRIVER'S LICENSE OR PICTURE ID
3. UPDATED MEDICATION LIST
4. IF WE HAVE NOT ALREADY SEEN YOU IN THE HOSPITAL, WE WILL BE COLLECTING A URINE SAMPLE UPON ARRIVAL AT YOUR APPOINTMENT. PLEASE DO NOT BRING A SAMPLE WITH YOU. WE WILL COLLECT A NEW ONE UPON ARRIVAL. IF YOU ARE BEING SEEN IN THE BEAVERCREEK LOCATION, A URINE SAMPLE IS NOT REQUIRED FOR THE VISIT. WE WILL SEND YOU TO A LAB TO COLLECT ONE BEFORE YOUR NEXT VISIT.

*ENTRANCE FOR THE XENIA OFFICE IS UNDER THE LARGE GREEN AWNING THAT FACES STAN'S DRIVE-THRU
*The Beavercreek office is located within Soin Medical Center, in the Ollie Davis Pavilion.
*Please note, our Kettering office cannot accommodate a stretcher or large wheel chairs.
*Ask us today about creating your CKD EHR MyChart Account for easy access to your medical records.

OFFICE LOCATIONS:

KETTERING	XENIA	BEAVERCREEK	EATON
1362 E Stroop Rd	215 S Allison Ave	3535 Pentagon Blvd, St 210	105 E Wash-Jackson Rd
Kettering, OH 45429	Xenia, OH 45385	Beavercreek, OH 45431	Eaton, OH 45320
PH: 937-643-0015	PH: 937-376-2571	PH: 937-702-4920	PH: 937-643-0015
FX: 937-643-0016	FX: 937-376-2930	FX: 937-702-4924	FX: 937-643-0016

KIDNEY CARE SPECIALISTS, LLC.

Patient Registration

Date: ____________

PATIENTS FULL NAME: ____
FIRST MIDDLE LAST

PATIENTS ADDRESS: ____
STREET APT # CITY STATE ZIP CODE

FAMILY DOCTOR: ______________________ ______________________
NAME PH #

OTHER NAMES USED: ____

PATIENT INFORMATION:

Date of Birth: ______________________
Home Phone: ______________________
Cell Phone: ______________________
Occupation: ______________________
Employer: ______________________
Business Phone: ______________________
Social Security Number: ______________________
Email: ______________________

PARENT/GUARANTOR INFORMATION:

Name: ______________________
Relationship to Patient: ______________________
Address: ______________________
Date of Birth: ______________________
Employer: ______________________
Business Phone: ______________________
Social Security Number: ______________________
Email: ______________________

Male: _____ Female: _____ Single: ____ Married: ____ Widowed: ____ Divorced: ____ Separated: ____

Language: ____________________ Ethnicity: ____________________ Race: ____________________

PREFERRED PHARMACY: ______________________ PHONE #: ______________________

REFERRING DOCTOR: ____
NAME ADDRESS PH #

DO YOU HAVE INSURANCE? _____ Yes _____ No
IF YOU DO NOT HAVE INSURANCE, HAVE YOU APPLIED FOR MEDICAID? _____ Yes _____ No

PRIMARY INSURANCE COMPANY: ____
Policy Number: ______________________ Group Number: ______________________
Name of card holder: ____
Relationship to patient: ____

SECONDARY INSURANCE COMPANY: ____
Policy Number: ______________________ Group Number: ______________________
Name of card holder: ____
Relationship to patient: ____

EMERGENCY CONTACT: ______________________ PHONE: ______________________

KIDNEY CARE SPECIALISTS, LLC.

Patient Authorizations and Billing Policy

AUTHORIZATIONS

- I hereby consent to authorize all treatments that may be considered advisable or necessary in judgment by my provider, at my discretion. This consent for treatment and following authorization to bill my insurance company, will remain in effect until I notify Kidney Care Specialists of my withdraw from the practice in writing.
- I authorize Kidney Care Specialists to bill any claims for services to my insurance company. Regardless of benefits, I am responsible for any services rendered that are not covered by insurance.
- I authorize the secure release of my medical information to my insurance company and its agents if needed to determine the eligibility of these benefits and to my referring/family physician via paper or electronic means.
- I authorize Kidney Care Specialists to utilize the “Care Everywhere” tab in Epic to obtain my medical information.
- I authorize Kidney Care Specialists to take and use my photo for my chart cover only.

I have read the above authorizations, understand my financial obligations, and agree to the above terms.

Patient Signature: ______________________________________ **Date:**______________________________

Patient Name: ____ **Relationship:** _______________________

BILLING POLICY

The following sets forth the general billing policy of Kidney Care Specialists. Please review this and sign where indicated:

- I understand that it is my responsibility to provide the office of Kidney Care Specialists with current and accurate billing information at the time of check in and to notify them of any changes in this information. I understand that the office will also verify my insurance eligibility, deductable and coinsurance amount at the time of service.
- I understand that it is my responsibility to know my specialist co-pay to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to re-pay the NSF amount with cash, money order, cashier’s check, or credit card, plus the original payment.
- I understand that there is a $20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional comprehensive disability forms (such as FMLA) require completion, I understand that the $20 fee (payable prior to completion) is required.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three statements for any balance due after insurance payment. I understand that if I have not made payment prior to the third statement being mailed, that the third statement will be marked as “Final Notice” and may be sent to a collection agency and I will be responsible for the associated collection fees.
- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier, in addition to any co-pays, deductibles, etc…

I have read the above billing policies, understand my financial obligationz, and agree to the above terms.

Patient Signature: ______________________________________ **Date:** ___________________________

Patient Name: ____ **Relationship:** ____________________

KIDNEY CARE SPECIALISTS, LLC.

Authorization to Release Information and Privacy Policy

All persons listed below must be able to provide us with your date of birth when we are communicating by phone before we will give them any of your Protected Health Information. This is our way to identify them as authorized to receive information about you.

1. Please list the person's, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

   NAME _______________________________ RELATIONSHIP _____________________ PHONE ______________________

   NAME _______________________________ RELATIONSHIP _____________________ PHONE ______________________

2. Please list names other than those above, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

   NAME _______________________________ RELATIONSHIP _____________________ PHONE ______________________

   NAME _______________________________ RELATIONSHIP _____________________ PHONE ______________________

3. Please print the address where you would like to have your billing statement and / or correspondence from our office sent if other than your home: ____

4. Please print the telephone number where you want to receive calls about your appointments, labs, x-rays results or other health care information, if other than your home phone number listed on page one: _________________________________

5. Can confidential messages, i.e., appointment reminders, etc. be left on your telephone answering machine or voicemail?
   YES______________ NO_______________

The Department of Health and Human Services has established a "Privacy Rule" to help insure that Protected health Information (PHI) is protected for privacy. The Privacy Rule also created to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry on treatment, payment or health care operations. You have a right to review our privacy notice (provided as a hard copy upon request) to access your medical record, to request restrictions, and to revoke consent in writing. We reserve the right to revise this notice of privacy practices without notifying patients (so long as it continues to comply with the privacy rule).

As our patient, we want you to know that we respect the privacy of your personal medical records and we will do all that we can do to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate, we provide the minimum necessary information about treatment, payment, or health care operations in order to provide health care that is in your best interest.

We may have indirect treatment relationships with you (such as laboratories or outpatient imaging centers that interact with physicians only) and may have to disclose PHI for purposes of treatment, payment, or health care operations. These entities occur most often and require obtaining patient consent. Disclosures are permitted without authorization to public health authorities that are authorized to collect or receive information for certain public health activities and purposes. Those purposes include preventing or controlling disease, injury, or disability and conducting public health surveillance, investigations, or interventions. Kidney Care Specialists, LLC. uses Epic for their Electronic Health Record. We utilize the Care Everywhere feature to connect with most of your current providers.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your PHI. If you chose to give consent in this document, at some future time you may request to refuse all or part of your consent. You may not revoke actions that have already been taken which relied on this consent or a previously signed consent.

By signing below, I confirm that I have read the above information,I understand the Privacy Rule, accept the terms and confisions and further understand that I may receive a full copy upon request at any time.

Patient Signature: ______________________________________ **Date:**_________________________________

Patient Name: ____ **Relationship:** _________________________

KIDNEY CARE SPECIALISTS, LLC.

Patient Authorization to Release Medical Records

1362 E. STROOP ROAD	215 S. ALLISON AVENUE	3535 PENTAGON BLVD, # 210A
KETTERING, OH 45429	XENIA, OH 45385	BEAVERCREEK, OH 45431
PHONE: 937-643-0015	PHONE: 937-376-2571	PHONE: 937-702-4920
FAX: 937-643-0016	FAX: 937-643-0016	FAX: 937-702-4924

Patient Name: ____
FRIST MIDDLE LAST

Address: ____
STREET CITY STATE ZIP

Date of Birth: ________________________ Social Security Number:_____________________________

I GRANT MY PERMISSION FOR THE RELEASE OF INFORMATION FROM MY MEDICAL RECORDS:

TO: KIDNEY CARE SPECIALISTS, LLC.

Dr. Ibrahim Ahmad
Dr. Madhu Kandarpa
Dr. Arthur Tsai
Dr. A. 'Sola Giwa
Dr. Mohammad Katout
Jennifer Bair, CNP
Gretta Weindorf, CNP

TO/FROM: List any doctors having records that could be released to us or whom we can release to:

____

____

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Patient Signature: ______________________________________ **Date:**________________________

Patient Name: ____ **Relationship:** _________________