



Dear Patient,

Thank you for choosing Austin Kidney Associates, P.A. We are committed to maintaining and improving the health of our patients, and we strive for excellence in the diagnosis, treatment and management of our patients' medical conditions. Our team of highly skilled physicians and nurse practitioners strive to provide the highest quality of kidney care services possible. Our goal is to work with you and your team of physicians to effectively manage your kidney disease.

We offer a wide range of outpatient services at office locations in Central, North and South Austin, Cedar Park, Round Rock, and Kyle. In addition, we are actively involved in the Dell Seton Abdominal Transplant Program and also follow patients who receive their transplants at the St. David's North Austin Medical Center Transplant Program. Our physicians are on staff at most area hospitals to offer hospital-based and emergency care for patients as needed. In addition, we provide care for renal dialysis patients at dialysis centers located in Central, North and South Austin, Leander, Cedar Park, Round Rock, Georgetown, Taylor, and Kyle.

Our physicians have completed extensive training in the specialty of Internal Medicine and subspecialty of Nephrology (care of abnormalities of kidneys function and related systems) and are current on all treatments concerning kidney disorders. All of our physicians are board certified in Internal Medicine and board certified or board eligible in Nephrology.

Our nephrologists direct all aspects of kidney care including the diagnosis and management of the spectrum of kidney diseases including diabetic and hypertensive kidney disease as well as other acute and chronic kidney diseases, kidney failure, electrolyte abnormalities, hypertension, and kidney transplants. We emphasize preventative medicine with patient management plans aimed at reducing the rate of loss of kidney function and avoiding the late complications of kidney disease. Our physicians are experts in the care of dialysis patients as well. Our nurses, nurse practitioners, and staff are committed to helping our patients achieve good health and improve their quality of life. Further, we strive to keep our patients well informed on recent medical research findings and opportunities for patient participation in research studies.

In the event that you require dialysis care, an Austin Kidney Associates' physician may refer you to Austin Access Care, an ambulatory surgery center specializing in dialysis access management. Austin Access Care provides expert care, and uses the latest minimally invasive techniques to treat dysfunctional dialysis accesses in a caring and timely manner, emphasizing a quick return to regular dialysis treatments. Austin Access Care offers numerous treatment options to ensure that you leave this center with a fully functioning access, including fistula declots, fistulagrams, angioplasties, stent insertions, and PermCath insertions and removals. Please note that Austin Access Care is 100% owned by Austin Kidney Associates, P.A., and Austin Kidney Associates, P.A. may receive income as a result of such referral.

In an effort to effectively communicate with our patients, a wide variety of languages are spoken by our physicians. Those languages include: English, Spanish, basic German, Tamil, French, Teluga and Mandarin Chinese.

Our practice accepts most insurance plans in our area including Medicare, Medicaid, HMO's, PPO's and indemnity insurance plans. Please check with your insurance company to verify that we are providers for your plan. If you are part of an HMO or other policy that requires referrals to our office, please coordinate with your primary care physician for a referral prior to your appointment with us. Our billing office staff is always happy to answer your billing or insurance related questions and can be reached at (512) 382-0037 or (512) 451-5800.

Thank you, again, for choosing Austin Kidney Associates.



New Patient Packet

ID	
Date	

Name: _____ Date of Birth: _____ Sex: Male Female
 Address: _____ Social Security #: _____
 _____ Emergency Contact: _____
 _____ Phone: _____ Hm Wk Other
 City, State, Zip: _____ Marital Status: Married Single Divorced Widow
 Primary Phone: _____ Hm Wk Other **Referring Physician:** _____
 Secondary Phone: _____ Hm Wk Other **Primary Physician:** _____
 Primary Language: _____ Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other Declined
 Race: American Indian/Alaska Native Black/African American Native Hawaiian/Pacific Islander Asian White Declined
 Email address: _____ Preferred Pharmacy: _____

Patient Employment

Employed Retired Unemployed Disabled Date Retired: _____ Date Disabled: _____
 Employer: _____ Employer Phone: _____
 Employer Address: _____ City: _____ State: _____ Zip Code: _____

Insurance

Primary Insurance Company: _____ Insured ID: _____ Policy Group: _____
 Check if Same as Patient: Insured party: _____ Relationship to Patient: _____ Social Security #: _____
 Employer: _____ Employer Phone: _____ Date of Birth: _____
 Secondary Insurance Company: _____ Insured ID: _____ Policy Group: _____
 Check if Same as Patient: Insured party: _____ Relationship to Patient: _____ Social Security #: _____
 Employer: _____ Employer Phone: _____ Date of Birth: _____

Guarantor: (where bill is to be mailed)

Check if Same as Patient: Guarantor: _____ Relationship to Patient: _____ Phone number: _____
 Address: _____ City: _____ State: _____ Zip Code: _____

<u>Authorization to Release Medical Information</u>	
<p>I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law. I understand that a photocopy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time. I hereby authorize any physician, whether past or present, following my care to disclose medical information, by mail or fax to:</p> <p style="text-align: center;">Austin Kidney Associates, PA 3000 N. IH-35, Ste. 635 Austin, TX 78705</p>	
Signature _____	Date _____

By my signature below, I hereby certify that the demographic and insurance information is correct or I have made appropriate changes to this form to reflect the correct information.

Patient's Signature _____ Date _____

IF YOUR INSURANCE REQUIRES AN AUTHORIZATION, PLEASE BE SURE YOU HAVE ONE CURRENT ON FILE. OTHERWISE YOU MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

HIPAA Release of Information

Patient's Name _____

Date of Birth: _____

Appointment Information

Please check all of the following message delivery methods that are available in case we can not reach you. Please include your daytime/work telephone number. For each number, please authorize name(s) with which we may arrange or confirm your appointment information.

1. Home Phone # _____
 - a. Can we leave a detailed message on this voicemail? YES / NO
 - b. We may arrange or confirm your appointment with:
Self Only Spouse Mother Father Child Other
Name of child/Other: _____

2. Daytime/Work Phone # _____
 - a. Can we leave a detailed message on this voicemail? YES / NO
 - b. We may arrange or confirm your appointment with:
Self Only Spouse Mother Father Child Other
Name of child/Other: _____

3. Mobile phone # _____
 - a. Can we leave a detailed message on this voicemail? YES / NO
 - b. We may arrange or confirm your appointment with:
Self Only Spouse Mother Father Child Other
Name of child/Other: _____

Medical Information

With whom may we discuss or disclose your medical information?

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

I have received a copy of the Notice of Privacy Practices from Austin Kidney Associates. I will inform Austin Kidney Associates with any changes of the above disclosure information.

Patient's Signature _____ Date _____

Austin Kidney Associates, PA
Office Policy- Please Read Carefully

Payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks, MasterCard Visa, Discover, and American Express. We will charge a return check fee of \$25.00.

We are providers for several PPO and HMO insurance plans and will be happy to file your claim for you. Co-payments are due prior to seeing the physician at the time of service. You are responsible for obtaining any necessary referral or authorization from your primary care physician. You are responsible for any non-covered charges. If your insurance does not make payment within 45 days, you may be asked to call them for the status of the claim.

Frequently, insurance companies may require additional information from the patient before processing a claim. If you receive such information in the mail, please fill out the form and mail it back to your insurance company as quick as possible. Failure to do so will make you responsible for the entire bill regardless of our contract status. We will expect payment of the deductible and coinsurance amounts at the time of service, or proof that your deductible has been met. We allow 60 days for processing of your insurance claims. At the end of that time if your insurance has not paid, the entire balance becomes your responsibility.

Medicare: Austin Kidney Associates, PA will accept assignment for our Medicare patients. If you do not have a Medicare supplement, we expect you to pay your 20 percent and, if not met, your yearly deductible at the time of your visit.

Medicaid: Austin Kidney Associates, PA will file claims to Medicaid on your behalf. You must present a current copy of your Medicaid eligibility letter at each visit.

Assignment of Benefits

I hereby authorize payment of insurance benefits to be paid directly to Austin Kidney Associates, P.A. for any services furnished to me. I authorize Austin Kidney Associates, P.A. to release to the Health Care Financing Administration, the Centers for Medicare and Medicaid Services or any commercial insurance carrier any information needed to determine the benefits or the benefits payable for related services not covered by insurance or prepayment programs. I hereby authorize the release of my medical records to other physicians and insurance companies deemed necessary.

Consent For Treatment

I hereby authorize evaluation and treatment by the physicians of Austin Kidney Associates, PA. I understand that the signature and date on this form will not expire without written notice or in the case that a minor reaches an adult, and that a photocopy of this form is considered valid as the original. I authorize Austin Kidney Associates to check my medication history.

CriticalConnection Central Texas Membership

Austin Kidney Assoc. is a member of CriticalConnection Central Texas, a doctor-owned community medical co-op that permits physicians to more easily share medical information when they are providing care to the same patient. Your medical information will only be released to your physicians, their staff (as necessary), and other physicians authorized to provide you care if your physician is not available (referred to as "covered physicians"). Your health information will only be released with your consent or when otherwise allowed under state or federal law. For example, we may share limited health information with a healthcare provider for emergency service if you are unconscious and unable to provide consent. By my signature below, I represent understanding.

Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Cancellation/No show Policy

We require a 1 business day advance notice for all appointments. Patients who need to cancel a scheduled appointment must call our office before 4:30 p.m. the day prior to the appointment. Failure to properly cancel will result in an administrative fee of \$25.00. This administrative fee is NOT covered by any insurance plan and will be the patient's responsibility.

My signature below represents understanding of the office policies listed in this form.

Patient's Signature _____

Date _____