REGISTRATION

(PLEASE PRINT)

BlueGrass Renal Care
Quality is Never An Accident
www.bluegrassrenalcare.com
Phone: 859-263-1717 / Fax: 888-502-7513

Date _____ Home Phone (___) _____ Cell Phone (___) _____

PATIENT INFORMATION

Name _____ (Last Name / First Name / Middle Initial) SS/HIC/Patient ID # _____

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (___) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (___) _____

PRIMARY INSURANCE

Person Responsible for Account _____ (Last Name / First Name / Middle Initial)

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (___) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (___) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (___) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (___) _____

Business Address _____ Soc. Sec. # _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Signature of Patient, Guardian or Personal Representative

_____ Date

_____ Please Print Name of Patient, Guardian or Personal Representative

_____ Relationship to Patient

BlueGrass Renal Care, PSC

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could possibly require diagnosis and treatment. I do hereby voluntarily consent to such treatment, services, and procedures that may be recommended under the general and specific instructions of the physicians of Dallas Nephrology Associates, his/her assistants, or his/her designee. I acknowledge that the practice of medicine is not an exact science and that the physicians of BlueGrass Renal Care, PSC have made no guarantees to me as to the result of treatments or examination.

BlueGrass Renal Care, PSC recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition. We also want to provide our patients timely communication as to laboratory/diagnostic test results, etc. We understand that because of the patient's schedules and our office schedules, this may sometimes be difficult. Blue Grass Renal Care, PSC would not, under any circumstances, leave messages regarding sensitive medical information. Acknowledging that it may be difficult for the physician/physician's staff to personally communicate with the patient regarding laboratory/diagnostic test results, etc., it is the policy of BlueGrass Renal Care, PSC to leave this information on the patient's telephone answering machine unless you tell us that you do not want us to leave a message.

☐ I agree ☐ I do not agree

If the physician/physician's staff cannot reach the patient at the home, cell or business telephone, it is the policy of BlueGrass Renal Care, PSC that a message will be left with the person that answers the telephone to advise the patient to return the phone call.

☐ I agree ☐ I do not agree

It is the policy of BlueGrass Renal Care, PSC not to release confidential medical information to patient's family members unless the patient consents to this. 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 agree ☐ I do not agree

It is the policy of BlueGrass Renal Care, PSC to participate in clinical research designed to improve quality of patient care; this may necessitate the review of the patient's medical records by research staff.

☐ I agree ☐ I do not agree

It is the policy of BlueGrass Renal Care, PSC to send appointment reminders to our patients, either by telephone, e-mail or reminder cards.

☐ I agree ☐ I do not agree

Signature of Patient _____ Date _____

If you have a personal representative who has legal authority to act on your behalf, please provide us with that name and contact information.

_____ _____

Personal Representative/Relationship to you Telephone No.

HIPPA Notice of Privacy Practices

BlueGrass Renal Care, PSC
3229 Summit Square Place, STE. 240
LEXINGTON, KY 40509
(859) 263-1717

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, or staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This included the coordination or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors: and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician's practice has taken action in reliance on the use or disclosures indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; physcotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have you physician amend your protected health information. If we deny tour requests for amendments, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain top us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____Signature_____Date_____

I was offered a copy of this form for my personal records and have refused a copy_____pt. initials

BlueGrass Renal Care, PSC
Quality Kidney Care
208 Bevins Lane, Suite B, Georgetown, KY 40324 Phone: 502-867-0411
3229 Summit Square Place, Suite 240, Lexington, KY 40509 Phone: 859-263-1717

Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, and Mastercard.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. File an insurance claim on your behalf.

If You Have...	You Are Responsible For...	Our Staff Will...
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your $131 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit. If you have Regular Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation	If we have verified the claim with your carrier No payment is necessary at the time of the visit. If we are not able to verify your claim Payment in full is requested at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures. You must provide us with adjuster's name and number, claim number, fax
Worker's Compensation (Out of State)	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
Occupational Injury	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

FINANCIAL, NO SHOW AND LATE CANCELLATION POLICY FOR BLUEGRASS RENAL CARE, PSC

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial and no show/cancellation policy is important to our professional relationship.

The following information outlines your responsibility related to payment and appointment reservation for professional services. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

1. At each visit, we will ask to see your insurance card and picture ID. Please provise two phone contact numbers and an email address:
   Phone 1: (____)____-_____ Phone 2: (____)____-_____Email:_____
2. At each visit, we will verify your benefits with your insurance company. It is ultimately the responsibility of the patient to know whether their plan is in network for our practice. The patient needs to be aware of what their plan benefits are and what is covered.
3. At each visit, we will require payment of the following:

   a. Any plan co-pays
   b. Any previous old balances
   c. Current deductible –most insurances are verified in real time. We will inform you of any deductibles that are your financial obligation and request payment of all or part of that deductible at that visit.
   d. Non-covered and Out of Network medical services that are considered by your insurance company to be non-covered, out of network or not medically necessary will be your responsibility.
   e. Self-pay patients will be required to pay for services at time of visit.

4. No show and late cancelled appointments:

   a. Effective September 1, 2018, any established patient who fails to show or cancel/reschedule appointment and has not contacted our office with at least 48 hour notice will be considered a No Show and charged an initial $50 fee.
   b. Any established patient who fails to show or cancels/reschedules an appointment without 48 hour notice a second time will be charged $75 fee.
   c. If a third No Show or cancellation/reschedule with no 48 hour notice should occur, the patient may be subject to dismissal from BlueGrass Renal Care, PSC
   d. The fee is charged to the patient, not the insurance company, and is due before scheduling patients' next appointment.

I have read and understand the Financial, No Show and Late Cancellation Policy and agree to its terms.

_____ _____

Signature (Patient/Legal Guardian) **Relationship to Patient**

_____ _____

Printed Name **Date**

Payment Policy

1. SELF PAY IS DUE AT TIME OF SERVICE. IF NOT PAID IN FULL A PAYMENT PLAN MUST BE SET UPBEFORE MAKING YOUR NEXT APPOINTMENT AND A DOWN PAYMENT IS ***REQUIRED***. Monthly payment plans with us are available to fulfill your obligation under that plan, including paying all monthly installments when due. Failure to make prompt payment on your account could also result in discharge as a patient from our practice and be turned over to a 3rd party collection agency.
2. WE ACCEPT MOST MAJOR INSURANCE COMPANIES.
3. RETURNED CHECK FEE IS **$50.**
4. IF A PATIENT DOES NOT SHOW FOR THE APPOINTMENT AND DOES NOT CONTACT THE OFFICE WITH IN **48 HRS.** PRIOR TO THE APPOINTMENT, A FEE OF AT LEAST $50. THIS WILL NEED TO BE PAID BEFORE ANY FUTURE APPOINTMENTS WILL BE MADE AND WILL BE CHARGED TO THE PATIENT NOT THE INSURANCE COMPANY.
5. IF YOU MISS 3 CONSECUTIVE APPOINTMENTS AND HAVE NOT CONTACTED THE OFFICE THIS WOULD UNFORTUNATELY PROMPT **A DISMISSAL** FROM OUR PRACTICE. PLEASE CALL THE OFFICE AND WE WILL SUPPLY YOU WITH CONTACT INFORMATION ON OTHER PHYSICIANS.

I have read, understand, and agree to the Bluegrass Renal Care Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co payments and deductibles, are my responsibility. I understand that Bluegrass Renal Care, PSC reserves the right to turn any patient over to a 3rd party collections agency to collect any amounts not paid in conformity with this policy. I also understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and co-payments, in addition to payment for any services of treatment not covered by my insurance carrier. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Bluegrass Renal Care.

I authorize my insurance benefits be paid to the treating physician. I authorize my treating physician to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____

Signature (Patient/Legal Guardian) **Relationship to Patient**

_____ _____

Printed Name **Date**

BLUEGRASS RENAL CARE, PSC
HEALTH HISTORY
CONFIDENTIAL

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ DATE OF LAST PHYSICAL EXAM: _____

WHAT IS THE REASON FOR YOUR VISIT? _____

PLEASE √ IF YOU HAVE EVERY HAD ANY OF THE FOLLOWING. USE THE _____ SPACE TO PROVIDE DETAILS AND/OR YEAR OF ONSET

KIDNEY DISEASE

□ CKD: □ Stage 1 □ Stage 2 □ Stage 3 □ Stage 4 □ Stage 5 □ Unknown

□ Transplant: Year: _____

Type: □ Cadaveric □ Living Related □ Living Unrelated

□ Dialysis: Year: _____ Type: □ Hemodialysis □ Peritoneal Dialysis

□ Polycystic kidney disease

□ Acute kidney injury Details: _____

□ Glomerulonephritis

DIABETES

□ Diabetes Type 1
□ Diabetes Type 2
□ Diabetes Type Unknown

HIGH BLOOD PRESSURE

□ Essential
□ Renovascular
□ White Coat
□ Conn's Syndrome

ISCHEMIC HEART DISEASE

□ Heart Attack Yr:_____
□ Angina
□ Angioplasty Yr:_____
□ Coronary Stent Yr: _____
□ CABG Yr:_____

□ **STROKE** Yr:_____

□ **GOUT**

CANCER

□ Lung _____
□ Breast _____
□ Prostate _____
□ Colon _____
□ Melanoma _____
□ Bladder _____
□ Other: _____

□ Lymphoma _____
□ Kidney _____
□ Thyroid _____
□ Leukemia _____
□ Endometrial _____
□ Pancreatic _____

ENT

□ Blindness
□ Cataracts
□ Hearing Problems
□ Glaucoma

CARDIOVASCULAR

□ Atrial fibrillator
□ Pacemaker
□ AICD

□ Valvular heart disease
□ Congestive heart failure
□ Mitral valve prolapse

PATIENT NAME: _____ DATE OF BIRTH: _____

RESPIRATORY

- □ COPD
- □ Chronic bronchitis
- □ Asthma
- □ Emphysema
- □ Pneumonia
- □ Tuberculosis
- □ Sleep apnea

GASTROINTESTINAL

- □ GERD (Gastric reflux)
- □ Stomach/Bowel ulcers
- □ Gall bladder disease
- □ Hepatitis
- □ Inflammatory bowel disease
- □ Irritable bowel syndrome
- □ Gluten intolerance
- □ Lactose intolerance

GENITOURINARY

- □ Enlarged prostate
- □ Kidney stones
- □ Frequent UTIs

OB HISTORY

- □ Preeclampsia
- □ Pregnancy induced hypertension
- □ Gestational diabetes
- □ History of complicated pregnancy

MUSCULOSKELETAL

- □ Osteoarthritis
- □ Osteoporosis

NEUROLOGIC

- □ Multiple sclerosis
- □ Seizures
- □ Parkinson's
- □ Dementia

PSYCHIATRIC

- □ Depression
- □ Anxiety disorder

ENDOCRINE

- □ Hypothyroidism
- □ Hyperthyroidism
- □ Adrenal insufficiency

HEMATOLOGY

- □ Anemia
- □ Sickle cell disease
- □ Sickle cell trait
- □ Blood transfusion
- □ Thalassemia

IMMUNO/ALLERGY

- □ HIV
- □ AIDS
- □ Rheumatoid arthritis
- □ Lupus

SURGERY HISTORY

- □ Appendectomy Year: _____
- □ CABG Year: _____
- □ Carotid endarterectomy Year: _____
- □ Cataract surgery Year: _____
- □ D & C Year: _____
- □ Gall bladder removal Year: _____
- □ Gastric bypass Year: _____
- □ Hemorrhoidectomy Year: _____
- □ Hernia repair Year: _____
- □ Hip replacement Year: _____
  - □ Left □ Right □ Bilateral
- □ Knee replacement Year: _____
  - □ Left □ Right □ Bilateral
- □ Hysterectomy Year: _____
- □ Prostatectomy Year: _____
- □ Nephrectomy Year: _____
- □ Renal transplant Year: _____
- □ Thyroidectomy Year: _____
- □ Tonsillectomy Year: _____
- □ Valve replacement Year: _____
- □ AV fistula Year: _____
- □ AV graft Year: _____
- □ PD catheter Year: _____
- □ Other: _____

Have used medications like Advil, Motrin, Aleve, Meloxicam, Voltaren, Ibuprofen, Celebrex, Diclofenac on chronic basis? ___ Yes ___ No

Have you ever had Kidney stones? ___ Yes ___ No

Have you ever used Herbal Medications? ___ Yes ___ No

Any Exposure to Lead, Mercury, Lithium, Chromium, or Cadmium? ___ Yes ___ No

Male patients any history of enlarged Prostate or Prostate Cancer? ___ Yes ___ No

PATIENT NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY

DO THE FOLLOWING FAMILY MEMBERS HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

KIDNEY DISEASE	□ Father	□ Mother	□ Sibling	□ Child
DIABETES	□ Father	□ Mother	□ Sibling	□ Child
HIGH BLOOD PRESSURE	□ Father	□ Mother	□ Sibling	□ Child
ISCHEMIC HEART DISEASE	□ Father	□ Mother	□ Sibling	□ Child
CANCER	□ Father	□ Mother	□ Sibling	□ Child
STROKE	□ Father	□ Mother	□ Sibling	□ Child
GOUT	□ Father	□ Mother	□ Sibling	□ Child
ADULT POLYCYSTIC KIDNEY DISEASE	□ Father	□ Mother	□ Sibling	□ Child
DEMENTIA	□ Father	□ Mother	□ Sibling	□ Child

FAMILY HISTORY - STATUS

Father: □ Living

□ Deceased Age at death: _____ Cause of Death: _____

□ Unknown

Mother: □ Living

□ Deceased Age at death: _____ Cause of Death: _____

□ Unknown

Other Family History Not Listed Above:

_____

_____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

SOCIAL HISTORY

CURRENT MARITAL STATUS

□ Married □ Separated □ Single □ Widowed □ Divorced

LIVING ARRANAGEMENT

□ Alone
□ Family member
□ Spouse
□ In home caregiver
□ Significant Other
□ Assisted living facility

OCCUPATION

□ Retired
□ Unemployed
□ Student
□ Employed: □ Full Time □ Part Time
Current Occupation: _____

FUNCTIONAL/COGNITIVE

□ No impairment
□ Hearing loss
□ Limited mobility
□ Memory deficit
□ Poor vision or blindness
□ Transportation challenges

SOCIAL HISTORY - HABITS

TOBACCO USE □ Current or Former User □ Never Used □ Unknown

□ Cigarettes □ Chewing tobacco □ Pipes □ Snuff □ Cigars

If a former user, what year did you quit? _____

If a current or former smoker, how often do/did you smoke? □ Every day □ Some days □ Unknown

How many packs per day do/did you smoke? _____

How many total years have you used cigarettes? _____

ALCOHOL USE □ Current or Former User □ Never Used

□ Occasional alcohol □ 1-2 per day □ 3 or more per day

If a former user, what year did you quit? _____

RECREATIONAL DRUG USE □ Current User □ Former User: Year Quit _____ □ Never used

□ Marijuana
□ Amphetamines
□ LSD
□ Heroin
□ Ecstasy
□ Opium
□ Cocaine
□ Barbiturates
□ Other _____

Other Social History Not Listed Above: _____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

- □ Fever
- □ Weight gain
- □ Weight loss
- □ Fatigue
- □ Chills
- □ Weakness

HEENT

- □ Vision impaired
- □ Eye pain
- □ Redness
- □ Color blindness
- □ Double vision
- □ Hearing loss
- □ Ear pain
- □ Sinus problems
- □ Sore throat
- □ Nose bleeds
- □ Headache
- □ Hoarseness
- □ Tinnitus
- □ Vertigo

RESPIRATORY

- □ Shortness of breath
- □ Shortness of breath at rest
- □ Shortness of breath with activity
- □ Pain with breathing
- □ Cough
- □ Wheezing
- □ Blood in sputum
- □ Night sweats

CARDIOVASCULAR

- □ Chest pain
- □ Palpitations
- □ Claudication
- □ Orthopnea
- □ Edema
- □ PND

GASTROINTESTINAL

- □ Abdominal pain
- □ Nausea
- □ Diarrhea
- □ Heartburn
- □ Vomiting
- □ Constipation
- □ Anorexia
- □ Trouble swallowing
- □ Indigestion

GENITOURINARY

- □ Urinary urgency
- □ Urinary burning or pain
- □ Blood in urine
- □ Urinary frequency
- □ Urinary hesitancy
- □ Foamy urine
- □ Incontinence
- □ Nocturia

MUSCULOSKELETAL

- □ Bain pain
- □ Neck pain
- □ Joint pain
- □ Muscle pain
- □ Arm weakness
- □ Leg weakness

SKIN

- □ Rash
- □ Itching
- □ Scaling
- □ Dryness
- □ Color change

NEUROLOGICAL

- □ Numbness
- □ Tremors
- □ Seizures
- □ Tingling
- □ Fainting

PSYCHIATRIC

- □ Depression
- □ Insomnia
- □ Anxiety

ENDOCRINE

- □ Heat intolerance
- □ Cold interolance
- □ Excessive thirst
- □ Excessive urination

HEMATOLOGY

- □ Bleeding gums
- □ Easy bruising

IMMUNO/ALLERGY

- □ Seasonal allergies
- □ Hives

MEDICATION LIST

Please list all medications prescribed by a physician, over-the-counter, and supplements (examples: aspirin, vitamins, fish oil, etc).

NAME OF MEDICATION	STRENGTH	DIRECTIONS FOR TAKING THIS MEDICATION	ARE YOU TAKING IT AS DIRECTED Y/N

BLUEGRASS RENAL CARE, PSC
MEDICAL RECORD REQUEST

Patient Name: **Birth Date:** **Social Security No.:**

CHECK ONE:

☐ **I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT**

☐ **I HEREBY AUTHORIZE**_____**TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO:** _____

ADDRESS: _____

PHONE NUMBER:_____**FAX NUMBER:**_____

Name(s) of person(s)/organization(s) or class(es) of persons/organizations to which disclosure is to be made:

For treatment date(s):_____
Specify date(s) – this line MUST BE completed

For the following purpose(s):_____Expiration Date:_____
If the request is initiated by the patient (or patient representative), insert "at the request of patient;" otherwise, describe purpose of use or disclosure. If the purpose relates to marketing, indicate whether Provider will receive remuneration.

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED

(Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless the records were prepared on behalf of Provider)

- ☐ Patient Demographic Information
- ☐ Emergency Room Records
- ☐ Admission History & Physical
- ☐ Consultation Reports
- ☐ Operative/Procedure Reports
- ☐ Lab Test Results
- ☐ Imaging/Radiology Reports
- ☐ Cardiac Studies
- ☐ Physician Progress Notes
- ☐ Physician Orders
- ☐ Discharge Summary
- ☐ Nursing Notes
- ☐ Billing Records
- ☐ Entire Record (will not include Billing or records not prepared by or on behalf of Provider unless those items also are selected).
- ☐ Records not prepared by or on behalf of provider. Provider cannot be responsible for the completeness or accuracy of such records.
- ☐ Other_____

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program_____; information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition_____; information relating to HIV testing, HIV status, or AIDS _____; psychotherapy notes_____. I understand that such information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. statute 65-5601 et seq., and K.S. A. statute 65-6001 et seq. **By my initials, I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization.**

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it by mailing or hand-delivering written notification to the following person:BlueGrass Renal Care, PSC, Office Manager, 3229 Summit Square Place, Suit 240, Lexington, KY 40509.

_____ _____
Date **Signature of Patient/Patient Representative**

_____ _____
Printed Name of Patient Representative **Description of Personal Representative's Authority**

_____ _____
Date **Signature of Witness**