Michigan Kidney Consultants P.C.

PATIENT REGISTRATION

Patient Name _____ **Gender:** Male ☐ Female ☐
Last *First*

Social Security # _____ **Date of Birth** _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Preferred Language: English ☐ Other ☐ *(Please specify)* _____

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Prefer Not to Say

Address _____
Street *City* *State* *ZIP*

Home Ph _____ **Cell Ph** _____ **Alt Ph** _____

Email _____

Do you have an Advanced Care Directive *(Living Will)* in place? Yes ☐ No ☐

Emergency Contact _____ **Phone** _____

If Patient is a minor, Responsible Party _____
Name *Relationship*

Address _____
Street *City* *State* *ZIP*

Social Security # _____

I understand that I am responsible for all charges for services rendered on my behalf. I understand that I am responsible for the payment of all co-pays and deductibles. I understand that any services not covered by my insurance will become my responsibility.

Signature _____ **Date** _____

Michigan Kidney complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: language assistance services, free of charge, are available to you. If you need these services, contact Gayle Robichaud 248-290-3111 ext 1713

Michigan Kidney Consultants P.C.

Name: _____

DOB: _____

Notice of Privacy Practices Acknowledgement

Federal law requires that we offer and provide you with a copy of our Notice of Privacy Practices if requested and document that we do so. If you would like a copy, simply tell the receptionist.

I acknowledge that I have been offered a copy of the Michigan Kidney Consultants Notice of Privacy Practices.

PLEASE SIGN HERE: _____

If you wish to authorize us to release medical information about you to any friends or relatives, please list them below.

Name	Relationship
_____	_____
_____	_____
_____	_____

Is it OKAY to call you at work? Yes ☐ No ☐

Please choose the type of message we may leave on your home or cell voicemail:

Short ☐ Detailed ☐ None ☐

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Michigan Kidney Consultants P.C.

Name: _____

DOB: _____

Patient History

Please print

Medical

Please check the box if you have you ever been diagnosed with any of the following medical conditions.

- ☐ Acute kidney injury
- ☐ Anemia
- ☐ Anxiety
- ☐ Atrial fibrillation
- ☐ Cancer (type: _____)
- ☐ CHF
- ☐ Chronic Kidney Disease
- ☐ Clotting disorder
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Diabetic nephropathy
- ☐ ESRD
- ☐ Gout
- ☐ Hematuria
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Hyperkalemia
- ☐ Hyperlipidemia
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyponatremia
- ☐ Hypothyroidism
- ☐ Kidney stone
- ☐ Myocardial infarction
- ☐ Nephrotic syndrome
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Polycystic kidney
- ☐ Proteinuria
- ☐ Pyelonephritis
- ☐ Renal cyst
- ☐ Sleep apnea
- ☐ Stroke
- ☐ TIA
- ☐ UTI
- ☐ Vertigo

☐ Other _____

Surgical

Please check the box if you have you ever been diagnosed with any of the following medical conditions.

- ☐ Abdominal surgery
- ☐ Appendectomy
- ☐ Bladder
- ☐ CABG
- ☐ Cardiac stent
- ☐ Cataracts
- ☐ Colonoscopy
- ☐ Cystectomy (urinary bladder removal)
- ☐ Dialysis access
- ☐ Gallbladder
- ☐ Gastric bypass
- ☐ Gastric sleeve
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Kidney biopsy
- ☐ Kidney removal
- ☐ Kidney stone surgery
- ☐ Kidney transplant
  - ☐ deceased donor
  - ☐ living related donor
  - ☐ living unrelated donor
  - ☐ unknown donor type
- ☐ Knee replacement
- ☐ Lithotripsy
- ☐ Parathyroid surgery
- ☐ Thyroid surgery
- ☐ Tonsillectomy
- ☐ Valve replacement

☐ Other _____

Family

Please check the box for the listed BLOOD relatives that have/had any of the following conditions:

Relationship	Alive	Deceased	No known problems	Anemia	Autoimmune disease	Cancer	Diabetes	Hypertension	Kidney Disease	Stroke	Heart disease	Dementia	Gout	Polycystic Kidney disease
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat. Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat. Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat. Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat. Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat. GM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat. GF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat. GM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat. GF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social

Tobacco Use: ☐ Current ☐ Former ☐ Never **Type:** ☐ Chew ☐ Cigarettes ☐ Cigars ☐ Pipe

Start Date: _____ **Quit Date:** _____ **Packs/day:** _____ **Years:** _____

Alcohol Use: ☐ Current ☐ Former ☐ Never **Type:** ☐ Beer ☐ Liquor ☐ Wine

Frequency: ☐ Daily ☐ Weekly ☐ Occasional ☐ Rare **Quantity per frequency:** _____

Substance Use: ☐ Current ☐ Former ☐ Never **Type:** _____

Frequency: ☐ Daily ☐ Weekly ☐ Occasional ☐ Rare **Uses per frequency:** _____

Personal

Living Arrangement: ☐ Alone ☐ Assisted Living ☐ Family ☐ In Home Caregiver ☐ Spouse ☐ S/O

Employment Status: ☐ Employed ☐ Retired ☐ Unemployed

Current / Former Occupation: _____

Michigan Kidney Consultants P.C.

Name: _____

DOB: _____

Pharmacy / Medication History Consent

E-Prescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy.

Local Pharmacy

Pharmacy Name: _____

Pharmacy Phone: _____

Address / Location: _____

_____

Mail-In Pharmacy

Pharmacy Name: _____

Pharmacy Phone: _____

Address / Location: _____

_____

Medication history allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: Compliance with prescribed regimens; therapeutic interventions; drug – drug and drug allergy interactions; adverse drug reactions; and duplicative therapy.

Consent:
By signing this consent form, you are agreeing that your provider at Michigan Kidney Consultants, PC may request and use your prescription medication history from other health care providers and/or third-party pharmacy benefit payors for treatment. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Signature _____ Date _____

Michigan Kidney Consultants P.C.

Name: _____

DOB: _____

Patient Medication List

What medications are you allergic to? _____

_____

What medications are you currently taking? *Please include name, strength, and frequency.*

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____
13) _____
14) _____
15) _____

Michigan Kidney Consultants P.C.

Name: _____

DOB: _____

Please list all the following doctors that apply to you:

(First and last name of doctor)

Primary Care:

Phone Number:

Cardiologist:

Phone Number:

Urologist:

Phone Number:

Gastroenterologist:

Phone Number:

Endocrinologist:

Phone Number:

Hematology / Oncology:

Phone Number:

Reason for referral: _____

Michigan Kidney Consultants P.C.

RESPONSIBILITY FOR PAYMENT / ASSIGNMENT OF BENEFITS

I agree to pay Michigan Kidney Consultants, P.C. (the "Practice") for all health care items and services (including all in-person and telemedicine services) provided to me.

I hereby assign to the Practice all of my rights and claims to payment and reimbursement for all of the health care items and services provided to me (including all in-person and telemedicine services), authorize the Practice to bill Medicare, Medicaid and/or any other health insurance program or plan which may have benefits available to pay for the health care items and services provided to me, and authorize payment for such items and services to be made directly to the Practice. This assignment is primary to any assignment given after this date, including any cost relative to attorney fees, and will remain in effect until I revoke it in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand and acknowledge that:

- If requested, I am responsible to obtain authorization from my health insurance plan before service is rendered and if I do not, my benefits may be reduced or lost, but I will still be responsible for paying the Practice for the items and services rendered.
- My insurance coverage may require that some portion of the charges remain my personal responsibility, such as my deductible, co-payment or co-insurance, and that certain payments may be required at the time of, or in advance of, services being provided, and I agree to pay such amounts timely and in full.
- A list of health insurance programs and plans with which the Practice contracts is available upon request.

To the extent the Practice determines, prior to providing any items and services to me, that any of the items or services included in my plan of care are not covered by my health insurance because they are deemed "medically unnecessary" or otherwise, the Practice will use reasonable efforts to notify me of the applicable charges for such items and services, and if I elect to receive such items and services, then I will be responsible to personally pay for them.

I acknowledge and agree that the Practice is entitled to recover the full amount owed for the items and services it provides to me, and I agree to pay collection costs and expenses, including reasonable attorney's fees and court costs, resulting from the collection of my accounts.

CERTIFICATION

I certify that I have read or had this RESPONSIBILITY FOR PAYMENT / ASSIGNMENT OF BENEFITS form (2 pages) read and/or explained to me, that I fully understand the information, consents and authorizations provided above, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily, and that I am the Patient listed in this document or I am duly authorized by the Patient to provide the consents and authorizations described herein and to sign this document.

Patient or Patient Advocate / Representative Initials: _____

References to "I", "me", and "my" in this document refer to the person listed as the Patient, even though a Patient Advocate or representative signs it on behalf of or for the Patient. If this document is signed by a Patient Advocate or representative, then such person represents and warrants to the Practice that he or she has the necessary power and authority to execute this document and to make decisions regarding the health care of the Patient, and agrees to indemnify, defend and hold the Practice harmless in connection with any breach of this representation and warranty. The Practice may and shall treat, rely and enforce all statements made by Patient Advocate or representative to the fullest extent permitted by law.

I acknowledge that I can receive a copy of this form upon request.

_____

Printed Name

_____ _____

Patient Signature or, if Patient is unable to sign, Signature of Patient Advocate / Representative — Date

If Patient is unable to sign, secure signature of Patient Advocate, Representative, Next of Kin and indicate reason why Patient is unable to sign: ___ Minor ___ Disoriented ___ Incompetent ___ Medically Unstable

_____ ☐ *Documents of Relationship to Patient Attached*

Name of Patient Advocate / Representative and Relationship to Patient (Please print)

_____ _____

Witness — Date