KIDNEY ASSOCIATES OF TEXAS

Excellence in kidney care

McKinney | 5830 Collin McKinney Pkwy, Suite 302, McKinney, TX 75070
Sherman | 204 Medical Drive, Suite 210, Sherman, TX 75092
Phone: 972-521-6000 | Fax: 972-521-6012 | Email: kaotexas2016@hotmail.com | Website: kaotexas.com

Patient information

PATIENT DETAILS

Name _____ **SSN** _____

Address _____

City _____ **State** _____ **ZIP** _____

Date of birth _____ **Age** _____ **Phone** _____

Alternate phone _____ **Sex** _____

Marital status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Employer _____ **Employer address** _____

Primary care physician _____ **Phone** _____

Referring physician _____ **Phone** _____

Employment: [ ] Full time [ ] Part time [ ] Retired [ ] Self employed [ ] Student

EMERGENCY CONTACT AND PHARMACY

Contact name _____ **Phone** _____ **Relationship** _____

Pharmacy _____ **Location** _____ **Phone** _____

INSURANCE SUBSCRIBER

Name _____ **Relationship** _____

Address _____

City _____ **State** _____ **ZIP** _____

Date of birth _____ **Phone** _____

Please bring your insurance card and driver license to your visit.

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Health history

Patient name _____ **Date of birth** _____

MEDICAL HISTORY - CHECK ALL THAT APPLY

[ ] High blood pressure
[ ] Heart failure
[ ] Heart disease
[ ] Retinopathy
[ ] Coronary stent / bypass
[ ] Hepatitis
[ ] Prostate disease
[ ] High cholesterol
[ ] Lupus
[ ] Anemia
[ ] Chronic kidney disease
[ ] Diabetes: Type 1 / Type 2
[ ] Hearing problems
[ ] COPD / asthma
[ ] Stomach ulcers
[ ] Gout
[ ] Seizures
[ ] Rheumatoid arthritis
[ ] Osteoporosis
[ ] Other: _____
[ ] Kidney stones
[ ] Stroke / TIA
[ ] Blindness / cataracts
[ ] Irregular heartbeat
[ ] Cancer
[ ] Recurrent UTI
[ ] Thyroid disease
[ ] Osteoarthritis
[ ] Anxiety

SURGICAL HISTORY

[ ] None [ ] Appendectomy [ ] Dialysis access (AVF/AVG) [ ] Bypass surgery

[ ] Transplant [ ] Cataract [ ] Gallbladder [ ] Hip / knee [ ] Hysterectomy

Other surgery _____

FAMILY AND SOCIAL HISTORY

Father: [ ] Living [ ] Deceased History: [ ] Diabetes [ ] Heart disease [ ] Kidney disease [ ] Stroke

Mother: [ ] Living [ ] Deceased History: [ ] Diabetes [ ] Heart disease [ ] Kidney disease [ ] Stroke

Smoking: [ ] Never [ ] Current [ ] Former Packs/day: _____ Years: _____

Alcohol: [ ] No [ ] Yes [ ] Social [ ] Heavy Drug use: [ ] No [ ] Yes

CURRENT SYMPTOMS

[ ] Burning urination
[ ] Foamy urine
[ ] Chest pain
[ ] Persistent cough
[ ] Nausea / vomiting
[ ] Fever / chills
[ ] Weak urine stream
[ ] Frequent urination
[ ] Shortness of breath
[ ] Dizziness
[ ] Abdominal pain
[ ] Weight change
[ ] Blood in urine
[ ] Swelling
[ ] Palpitations
[ ] Headaches
[ ] Diarrhea / constipation
[ ] Excess fatigue

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Consents, disclosures & financial responsibility

Patient name _____ **Date of birth** _____

CONSENT FOR MEDICAL CARE AND TREATMENT

I voluntarily consent to evaluation, examination, diagnosis and treatment by Kidney Associates of Texas and its physicians, advanced practice providers, nurses and other authorized staff. This may include laboratory testing, imaging, medications, prescriptions and other medically appropriate services. I understand that medicine is not an exact science and no guarantee has been made regarding the outcome of care.

TELEMEDICINE / TELEHEALTH INFORMED CONSENT

I consent to receive medically appropriate services through telemedicine or telehealth, including the electronic exchange of health information for my care. I understand that telemedicine uses remote communication rather than an in-person visit and may have limitations, including technology failure, incomplete information, privacy or security risks, and the possibility that an in-person evaluation or other care may be recommended. I may ask questions and may withdraw consent to telemedicine at any time before or during a telemedicine visit. Telemedicine is not for emergencies; for an emergency I should call 911 or seek emergency care.

INSURANCE AND ASSIGNMENT OF BENEFITS

I authorize Kidney Associates of Texas to submit claims and receive payment directly from my health plan for covered services. I authorize disclosure of information reasonably needed to process claims. I agree to provide accurate insurance information and obtain referrals or prior authorizations when my plan requires them. Authorization by a plan is not a guarantee of payment.

FINANCIAL RESPONSIBILITY

I am responsible for applicable copayments, deductibles, coinsurance, noncovered services, and other amounts I may lawfully owe under my plan and applicable law. The practice will bill my insurance when applicable. I may ask for an estimate or explanation of a charge. This agreement does not waive any protection against balance billing or create a charge that law or my plan prohibits.

MISSED APPOINTMENTS

Please cancel at least 24 hours before an appointment. A same-day cancellation may incur a $35 fee. The first no-show will not be charged; beginning with the second no-show, a $50 fee may apply to that and each later no-show. Fees apply only when permitted by law and the patient's plan, are never billed to insurance, and do not apply to Texas Medicaid patients. Staff may waive a fee for an emergency or circumstances beyond the patient's control. This page alone does not authorize a card charge.

COMMUNICATION PREFERENCES

The practice may contact me about appointments, care coordination, billing and test results as permitted by law. Email and voicemail can carry privacy risks. For nonurgent communications, my preferred channel is: [ ] Phone [ ] Voicemail [ ] Email [ ] Mail [ ] Patient portal. I may update this preference by contacting the office. Urgent or clinically sensitive messages may use a more appropriate channel.

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

[ ] I received a copy of the practice Notice of Privacy Practices. [ ] I was offered a copy and declined it. This acknowledgment does not waive my privacy rights or authorize additional uses or disclosures of my health information.

Patient or authorized representative signature _____ **Date** _____

Representative name and relationship (if applicable) _____

By signing, I acknowledge and agree to the applicable consents and terms above. Questions? Call 972-521-6000.

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Medication and allergy list

Patient name _____ **Date of birth** _____

MEDICATION ALLERGIES

[ ] None known [ ] Yes - list medication and reaction below

_____

_____

OVER-THE-COUNTER MEDICINES AND SUPPLEMENTS

Check those you take: [ ] Acetaminophen [ ] Ibuprofen [ ] Naproxen [ ] Meloxicam

[ ] Herbal products [ ] Vitamins / supplements [ ] Other: _____

CURRENT MEDICATIONS

Include prescriptions, over-the-counter medicines and supplements. Bring your bottles or a current list.

Medication name	Strength / dose	Amount taken	How often

If you need more space, attach an additional medication list.

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Card-on-file authorization for no-show fees

First no-show: no fee. Second and later no-shows: $50 each, where permitted.

PATIENT AUTHORIZATION

I authorize Kidney Associates of Texas to save my card through its secure payment processor and charge $50 for my second and each later no-show, only when permitted by law and my health plan. Texas Medicaid patients are not charged missed-appointment fees. This authorization does not cover cancellation fees or other charges. I will receive notice and a receipt for each charge. I may withdraw authorization for future card charges by contacting the office in writing; any lawfully incurred fee remains payable.

Patient name _____

Cardholder name (if different) _____

[ ] I authorize the card-on-file charges described above.

Cardholder signature _____ **Date** _____

OFFICE USE: Processor reference _____ Card last four digits _____

Retain this signed authorization. Remove and destroy the card intake section below after setup.

CUT HERE - DO NOT SCAN OR RETAIN CARD DETAILS

DETACHABLE CARD INTAKE - OFFICE PROCESSING ONLY

Patient: _____ Date: _____

Card number _____

Expiration (MM/YY) _____ **CVV** _____

Billing ZIP _____

Staff: enter card details directly into the secure payment processor and save a card token. Complete any processor-required setup or verification, then immediately cross-shred this entire slip. Never scan, email, fax, or place it in the patient chart.

For electronic intake, send the patient a secure processor-hosted card entry link.