KIDNEYCARE of OREGON

Registration Form (Please print)

Date_____ Telephone_____ Cell_____ Email_____

Patient Name (last name)_____ First Name_____ M.I._____

Address_____ City_____ State_____ Zip_____

Race ☐ American Indian or Alaska Native ☐ Black or African-American ☐ Asian
☐ White or Caucasian ☐ Native Hawaiian or Other Pacific Islander ☐ Undetermined_____

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Preferred Language (if other than English)_____

Sex ☐ Male ☐ Female Age_____ Birthdate_____ Social Security Number_____

☐ Single ☐ Married ☐ Divorced ☐ Widow(er) ☐ Occupation_____

Employer_____ Business Phone_____

Spouse's Name_____ Spouse's Birthdate_____

Spouse Employed By_____ Business Phone_____

Primary Insurance_____ Policy Holder_____

Group Number_____ ID Number_____

Secondary Insurance_____ Policy Holder_____

Referred By_____ PCP_____

Emergency Contact (Name/Phone Number)_____ #_____

I understand that I am financially responsible for all charges for the services rendered to me. I agree to be personally responsible for the balance of my account should the insurance not pay my claim in full. I authorize the release of medical information necessary to process my claim and request payment of benefits to be made directly to KidneyCare of Oregon. Furthermore, I authorize KidneyCare of Oregon to send my medical evaluation(s) to my referring physicians.

Date_____ Signed_____

I have received a copy of KidneyCare of Oregon's *Notice of Privacy Policies*.

Date_____ Signed_____

KIDNEYCARE of OREGON

Name_____

To better coordinate your care our doctors need a list of your prescription medications, over the counter supplements, over the counter pain medications (ie: ibuprofen, Tylenol, Aleve, etc.) all injectable medications, inhalers and how you take them, even if you only take occasionally. If you have any questions or cannot fill our this list just bring your medications to your appointment with you. Thanks!

Medication	Strength (mg)	How often do you take it?	Which Doctor prescribed?

If you have additional medications, please continue on back.

KIDNEYCARE of OREGON

Authorization of Release of Information

Date_____Physician_____

Patient Name_____Date of Birth_____

I,_____the undersigned, hereby authorize KidneyCare of Oregon, its representatives, physicians, and staff to share the designated (see below) medical information to the following individual(s). The individual(s) listed below are involved in my care and have authorization to speak with the staff on the phone and at the physician's office.

Medical Information to Be Released

Consisting of: ____Drug/Alcohol ____General Records ____Genetics ____HIV ____Mental Health ____ Other_____

(Initial the above information to be used and/or disclosed. By initialing you are allowing protected health information to be exchanged to the below designated entity)

Please list below the individuals you are giving us permission to share your medical information with:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

I understand that authorization to anyone other than myself is voluntary and I can revoke authorization at any time.

Authorized by:_____ _____Date_____

Signature of Patient/POA Printed Name

KIDNEYCARE of OREGON

Authorization to Use/Disclose Health Information

I authorize_____to use and disclose a copy of the specific health and medical information described below regarding:

Printed name of patient_____ Date of Birth_____

Consisting of: ____Drug/Alcohol ____General Records ____Genetics ____HIV ____Mental Health ____Patient Portal

____Other_____

(Initial the above information to be used and/or disclosed. By initialing you are allowing protected health information to be exchanged to the below designated entity)

To: **KidneyCare of Oregon Fax: 541.868.9606**
3355 Riverbend Dr., Suite 200, Springfield, OR 97477

For the purpose of: **Cont. of Care/Transfer to OR**
*(Describe **each** purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to provide a statement of purpose.)*

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of:

1. Creating health information about you to be disclosed to a third party; or
2. For the purpose of research

You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Jennifer Dring, 3355 RiverBend Dr. Suite 200, Springfield, OR 97477, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization. Records will be released within 30 days of receipt of this Authorization.

This Authorization will expire on the earlier of_____(date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By_____Date_____
Patient

OR

By_____Date_____
Patient's Representative

Description of Representative's Authority_____