Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

Welcome

We are delighted to have you as a patient of Knoxville Kidney Center, PLLC. This letter is to share some information with you that will prepare you for your first visit to our office. You have been referred to see one of our Specialist, and if the appointment time for your Pre-visit or Dr. visit will not work for you, please call to reschedule. If you do not call to reschedule and do not make your appointment there will be a $50.00 non-refundable charge.

Questionnaire

Please complete the enclosed information sheets and bring them with you on the day of your pre-visit appointment. It is very important that each sheet is completely filled out, as this information is necessary for the Dr. Also, please be sure to sign the records release form, and other forms enclosed so that the doctor will have all necessary information at the time of your appointment.

What to expect on your first visit

If possible, you should arrive 15 minutes prior to your appointment to allow us time to copy your insurance cards and prepare your chart. **Please bring in your updated medication list with you,** we do not need the bottles. At all of your visits, please be prepared to provide a urine specimen. Please do not become alarmed if someone is called before you, our office provides different services other than physician appointments.

Referrals

Many patients are now required to obtain a referral or authorization from their primary care physician (PCP) before receiving treatment or services from a specialist. It is important that you get a referral or authorization from your PCP before coming in for your appointment if your insurance requires this. If your insurance requires an insurance referral number please phone your PCP and request that it be faxed to @ 865-692-3463.

Financial Policy

Please contact your insurance company directly if you have questions regarding what your insurance will cover, your deductible or co-payments. Our patient account representatives will file your insurance claims as a courtesy. We ask that you provide your insurance cards at the time of registration. Please review and complete enclosed Statement of Financial Policy form.

Thank you,

Knoxville Kidney Center, PLLC

Knoxville Kidney Center PLLC
320 Park 40 North Blvd., Ste A • Knoxville, TN • 37923 • Telephone (865) 692-3462 • Fax (865) 692-3463

Patient Information Form

Date: _____

Full Name _____
Last First Middle

Address _____
Street

_____
City State Zip

Phone: Home: _____

Work: _____

Cell: _____

Social Security Number: _____

Date of Birth: _____

Marital Status (circle one) S M D W Spouse's Name _____

Email for Patient Portal: _____

Sex (circle one) M F Other

Race (circle one) African American, Caucasian, Asian, Hispanic, American Indian, Other

_____ _____
Primary Physician Primary Physician Phone Number

_____ _____
Referring Physician Referring Physician Phone Number

_____ _____
Pharmacy Name Pharmacy Phone Number

_____ _____
Nursing Home Name Nursing Home Phone Number

_____ _____
Home Health or Visiting Nurse Contact Name and Phone Number

_____ _____
Employer Name Employer Address

Knoxville Kidney Center PLLC
320 Park 40 North Blvd., Ste A • Knoxville, TN • 37923 • Telephone (865) 692-3462 • Fax (865) 692-3463

Other family members seen here: _____
Name/Relationship

Emergency Contact: _____
Name/Relationship/Contact Number

Insurance Information

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____Relationship: _____

Subscriber SS#: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Subscriber Name: _____Relationship: _____

Subscriber SS#: _____ Subscriber Date of Birth: _____

Notification of Test Results

When calling to report test results, procedures scheduled or other medical information, I authorize Knoxville Kidney Center PLLC and/or office staff to leave a voice message on my answering machine or voice mail system at any of the following telephone numbers (circle one) **Home Work Cell**

I also authorize Knoxville Kidney Center PLLC and/or office staff to notify my spouse or the person named below about my test results if I am not available to receive test results myself:

Name: _____ Contact Number: _____

Please note: Persons not named above will not be given any information.

Release of Liability

In the event any testing is prescribed/recommended for and treatment of patient's condition and said test is not performed, by patient choice or patient cancellation; The patient will release Knoxville Kidney Center PLLC and staff from all medical liability for any consequences that may arise as a result of the procedure not being performed, and which could directly impact the patient's diagnosis and/or treatment of the patient's condition.

Patient Signature/Date: _____

Knoxville Kidney Center, PLLC **Adult Nephrology & Hypertension**
320 Park 40 North Blvd. Suite A, Knoxville, TN 37923 Phone (865) 692-3462 Fax (865) 692-3463

History and Review of Systems

Patient's Name _____ Date_____
SS # _____ Date of Birth _____
Address _____ Phone _____
_____

Renal History	Yes	No	Comments
1) Any kidney x-rays such as ultrasound, IVP or CAT Scan? When? Where?			
2) Do you have blood in urine?			
3) Do you have protein in urine?			
4) History of kidney infection?			
5) History of kidney stones?			
6) Trouble with leg swelling?			
7) Any kidney or bladder surgery?			
Relevant Current History			
1) High blood pressure?			
2) What type of diabetes and how long have you had diabetes? Eye damage? Nerve damage (numbness, decreased feeling in feet)? Kidney damage?			
Review of Symptoms			
Pulmonary History of asthma? History of COPD?			

Review of Symptoms	Yes	No	Comments
Cardiovascular			
Any prior heart surgery?			
Any prior cardiac catheterization?			
Cardiologist's name?			
Musculoskeletal Gout?			
Skin			
Skin cancer?			
Neurologic TIA or mini-stroke?			
Stroke; location weakness? Date?			
History of seizures?			
Endocrine			
Thyroid problems?			
Cholesterol problems?			
Osteoporosis?			
Blood or Cancer Problems			
History of anemia or low blood counts?			
Do you take a blood thinner?			
Do you have a history of cancer?			
Urological			
Are you currently under the care of a urologist?			
Urologist's name?			

Past Medical History: (Please list problems and any recent hospitalizations.)

_____

_____

_____

Past Surgical History: (Please list surgeries and dates.)

_____

_____

_____

Family Medical History	Yes	No	Comments
Anyone with kidney stones?			
Anyone with kidney disease, such as protein or blood in urine or kidney failure?			
Anyone with high blood pressure?			
Anyone with heart or blood vessel disease?			
Anyone with cancer?			
Social History			
Do you work?			
Do you use tobacco?			
Do you use alcohol?			
Do you use drugs?			
Drug Allergy			

Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

Patient Name:

Medication Allergies?

Please list all medications currently taking, including over the counter, vitamins, injections and herbal supplements.

Medication	Strength (milligrams, etc.)	How often

Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

Acknowledgement of receipt of "Notice of Privacy Practices" (HIPPA)

By signing this form, I acknowledge receipt of the "Notice of Privacy Practices" or that I have been offered a copy and declined receipt. The Notice of Privacy Practices provides information about how Knoxville Kidney Center PLLC may use and disclose my protected health information.

Signed: _____ Date:_____

For Knoxville Kidney Center PLLC use only:

Inability to obtain acknowledgement signature

To be completed **ONLY** if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith effort made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

Knoxville Kidney Center PLLC Representative:_____

Date: _____

Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

Authorization to Release Medical Records

I request that my original file, or a copy of my file only in the event of unforeseen patient care needs, including all my medical records and information (including, but not limited to, information on my physical condition, hospital stays, medications and HIV or communicable disease) to be released to **Knoxville Kidney Center PLLC** at:

Knoxville Kidney Center PLLC
320 Park 40 North Blvd., Suite A
Knoxville, TN 37923
Telephone (865) 692-3462
Facsimile (865) 692-3463

Print Patient Name _____

Patient Date of Birth _____

Patient Signature _____

Date _____

Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

Statement of Financial Policy

Knoxville Kidney Center, PLLC is a provider for many insurance plans. We will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we do expect payment of any applicable deductibles, co-payments or co-insurance amounts at the time of service. Also, any services that your insurance will not cover are your responsibility for payment. By signing this document, you hereby assign, transfer and set over Knoxville Kidney Center, PLLC your rights, title, and interest for medical reimbursement benefits under your insurance policy for services rendered by our practice. This assignment will remain in effect until revoked by you in writing. A photocopy of this agreement is to be considered as valid as an original.

If your insurance requires prior authorization for any of your services here at our office, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred that are not paid by your insurance carrier. If your insurance subsequently authorizes today's services, your payment will be refunded to you upon receipt of the insurance payment. For procedures ordered by our physicians at the time of your visit, our office will contact your insurance carrier to obtain authorizations if needed.

If we are not a participating provider for your insurance plan, we will still bill your insurance directly once you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us for 30 days until your insurance has paid, however, if your insurance company has not paid after 30 days you will be required to submit full payment for services.

If you do not have insurance, payment is expected at the time of service. We accept all major credit cards for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged with our billing department prior to or at the time of your office visit. All self-pay patients will be required to review and sign a Self-Pay Agreement form. Please be advised that our contracted laboratory services for send out labs will have a separate billing department and will have additional charges.

Please bring your current insurance card with you for **EVERY** visit. **It is your responsibility to inform us in a timely manner of any changes to your billing information. If an insurance company denies payment for incomplete, wrong information or timely filing, it is your responsibility to make a payment in full** and be **reimbursed by your insurance company.** If your insurance company **REQUIRES** a **REFERRAL FORM OR AUTHORIZATION**, it is your responsibility to obtain this from your primary care provider **BEFORE** your appointment at our clinic.

We charge what is usual and customary for our area. You are responsible for payment regardless of an insurance company's arbitrary determination of usual and customary rates. However, please note, our practice participates in many managed health care plans with which we honor contracted fee arrangements.

I have read and understand Knoxville Kidney Center, PLLC's financial policy.

Print Patient Name: _____

Patient Signature/Date: _____

Responsible Party Signature/Date (if other than patient): _____

Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

Quality of Life Survey

Name _____

Patient # _____ Visit Date _____ CKD Stage _____

This survey includes a variety of questions about your health and your life. We are interested in how you feel about these issues.

Effects of Kidney Disease on Your Daily Life

How true or false is each of the following statements for you? (Mark an "X" in a box on each line.)

		Definitely true ⇓	Mostly true ⇓	Don't know ⇓	Mostly false ⇓	Definitely false ⇓
1.	My kidney disease interferes too much with my life.	☐1	☐2	☐3	☐4	☐5
2.	Too much of my time is spent dealing with my kidney disease.	☐1	☐2	☐3	☐4	☐5
3.	I feel frustrated dealing with my kidney disease.	☐1	☐2	☐3	☐4	☐5
4.	I feel like a burden on my family.	☐1	☐2	☐3	☐4	☐5

Thank you for completing these questions!

 Version 3.0 Version Date: 03/16/2018

FOR INTERNAL USE ONLY

Knoxville Kidney Center PLLC

320 Park 40 North Blvd., Ste. A • Knoxville, TN • 37923 • Telephone: (865) 692-3462 • Fax: (865) 692-3463

From Cedar Bluff Road: Turn onto Parkwest Blvd. as though you are going to Parkwest Medical Center. You will pass a Cracker Barrel and the Days Inn on your left. Turn right onto Park 40 North Blvd. directly across the street from the Days Inn (the first street on the right). We are located in the 2nd parking lot (2nd drive-way) on the left.

Please call if you need further directions.