

Kidney Care Group, Inc., dba Loganville Dialysis
3977 Atlanta Highway Suite 104 Loganville, GA 30052

Last Name: _____ First Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (____) - ____ - ____ Cell/Work: (____) - ____ - ____ ext: ____

Social Security #: _____ - _____ - _____ DOB: ____/____/____ Age: _____

Height _____ Weight _____ Sex: Male Female Marital Status _____

Emergency Contact Person: _____ Phone#: (____) - ____ - ____

1st Day of Dialysis here: ____ - ____ - ____ 1st Day of Dialysis ever: ____ - ____ - ____

Did you have a kidney transplant: Yes No

Can we leave a message for you on either your home or work/cell number? Yes No

List any drug allergies:

Medicare Patients Only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Kidney Care Group, Inc., dba Loganville Dialysis for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits or the benefits payable for related services.

Medicare Patient Signature: _____ **Date:** ____ - ____ - ____

Insurance Information

Primary Insurance: _____

Group#: _____ Policy# _____

Policy Holder: _____

Relationship to insured: _____

Policy Holders DOB: ____ - ____ - ____ Male Female

Secondary Insurance: _____

Group#: _____ Policy# _____

Policy Holder: _____

Relationship to insured: _____

Policy Holders DOB: ____ - ____ - ____ Male Female

Signature: _____

Date: ____ - ____ - ____

Kidney Care Group, Inc, dba Loganville Dialysis
ACKNOWLEDGEMENT FORM

Upon My Admission To Kidney Care Group I Acknowledge That The Staff Has Reviewed With Me The Forms Listed Below:

Patient Rights
Patient Responsibilities
Clinic Rules
Grievance Procedure
HIPPA Privacy Rights

In Addition I Acknowledge That I Have Received A Copy Of The Kidney Care Group Patient Handbook Which Contains The Following Information:

Billing/Financial Information
SE Kidney Council Information
Emergency Preparedness Guidelines
Important Phone Numbers

Kidney Care Group, Inc, dba Loganville Dialysis.
PAYMENT INFORMATION

Kidney Care Group, A Provider Of Dialysis Services, Participates In The Federally Funded Medicare Program And The State Funded Medicaid Program. Also, We Bill To Private Insurance Companies.

Your Financial Obligation Will Be Discussed With You By Our Social Worker. The Information You Give To Her Will Be Confidential. The Social Worker Will Assist You In Applying For Benefits If You Are Entitled To Medicare, Medicaid, Or Both.

At Any Time You Should Have Questions or Concerns Regarding Your benefits Or Billing, We Will Refer To The Social worker Or Billing Department Who will Assist You In Solving Your Problem.

Patient Signature

Date

Witness Signature

Date

**Kidney Care Group, Inc. dba Loganville Dialysis
ASSIGNMENT OF BENEFITS**

Patient Name:		SS#:	
DOB:			

I _____ certify that the information given by me for payment under Title XVIII of the Social Security Administration is true and correct. I authorize any holder of healthcare or other information concerning me to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim.

I certify that Kidney Care Group and its agents have my permission to submit medical claims on my behalf for all payers, including but not limited to **Medicare, Medicaid, Commercial Providers, And HMO/PPO/POS Providers**. I request that payment of authorized benefits be paid to Loganville Dialysis. This assignment of benefits shall apply until such time that written notification from me, or my authorized representative (If any) states otherwise.

Patient Signature / Guarantor (Guardian) Signature

Date

Witness Signature

Date

Kidney Care Group, Inc, dba Loganville Dialysis CLINIC RULES

Failure To Comply With The Rules Listed Below Can Result In Your Discharge From This Facility:

1. Kidney Care Group Is A Smoke Free Facility. No Smoking Allowed.
2. Visitors Are Not Allowed In the Actual treatment Area Without Permission From The Charge Nurse.
3. Solicitation In The Clinic Is Prohibited.
4. No Weapons Of Any Kind Will Be Permitted On The Clinic Property.
5. No Alcoholic Beverages Or Illegal Drugs Are Allowed In The Facility.
6. Conduct Such As Foul Language, Fighting, Sexual Harassment, Verbal Abuse, Or Physical Threats Toward Any Patient, Staff, Or Visitor Will Not Be Tolerated And Will Be Grounds For Dismissal From The Facility.
7. No Eating Or Drinking Will Be Allowed In the Treatment Area.
8. Earphones Must Be Worn At All times With Radios and Televisions.
9. Please Remove All personal Items After Each Treatment Day. The Facility Is Not Responsible For Lost Or Stolen Items.
10. A Courtesy Phone Will Be Available In The Patient Waiting Area. Please Limit Calls To 5 Minutes. **If you have a cell phone, please keep ring volume on a low volume or preferably vibrate mode.**
11. If You Are Having Problems With Your Treatment Schedule, Please Advise The Charge Nurse Or Nurse Manager. Changes And Alterations Can And Will Be Made If Possible To Accommodate You.
12. If You Are Going To Be Late Or Cannot Come In For Your Scheduled Treatment Please Call The Unit As Soon As Possible. **Habitual Tardiness Will Result In Moving You To Another Shift Or Treatment Schedule.**
13. Please Keep The Dialysis Center Informed Of Any Changes In Address, Phone Number, Employer Or Insurance. Please Bring All Medicare, Medicaid, Or Insurer's Letters to the Social Worker.
14. Loganville Dialysis Reserves The Right For Patients Who Refuse To Follow The Facilities Policies To Be Given 30 Days Written Notice That The Responsibility Of Care Will Be Terminated And That The Patient Must Find Another Center To Continue His/ Her Treatments. A List Of Centers Will Be Provided.
15. **We Reserve The Right To Change Or Alter Our Policies At Any Time. Written Notification Will Be Posted on the Patient's Bulletin Board Regarding Any Changes.**
16. Patients must follow their physician recommended treatment regimen, which is imperative to their care as failure to do so could cause increased morbidity and mortality.
17. Failure to repeatedly dismiss the recommended treatment regimen will result in dismissal from Kidney Care Group.

Patient Signature

Date

Kidney Care Group, Inc., dba Loganville Dialysis Patient Rights & Responsibilities

As a patient of Kidney Care Group you have the following rights & responsibilities to yourself, the facility, and the dialysis staff:

Rights

1. You have the right to receive high quality health care that meets recognized professional goals, and includes a full detailed explanation of any treatments/medications that will be administered to you.
2. You have the right to part of the health care team, along with a social worker, nurse, dietitian, and doctor.
3. You have the right to expect that staff members in training will be directly supervised.
4. You have the right to be fully informed of all services available at Loganville Dialysis and any related charges, if any.
5. You have the right to receive a full explanation of the nature of the necessity for recommended treatment/appointments, including the risk of side effects and other treatment options available before giving consent to those options.
6. You have the right to receive information from your nephrologists in words that you can understand. This should include information about your medical conditions, treatment choices, test results, and possible problems.
7. You have the right to be informed of any possible side effects of medications you are taking, and be informed about current dialysis treatments for kidney disease and dialysis techniques.
8. You have the right to be treated with respect, dignity, and consideration. You have the right to suggest a change in the type of treatment. You have the right to expect that the patient to staff ratio at your facility conforms to state regulations.
9. You have the right to expect your kidney doctor and other members of your health team to listen to you when you suggest changes in your dialysis treatment.
10. You have the right to refuse treatment to the fullest extent permitted by law and to be informed of the medical consequences of refusing treatment.
11. You have the right to expect privacy when receiving medical care, expect examinations and discussions about your care to be held in private, and expect that your personal medical information will be kept confidential.
12. You have the right to expect medical care without regard to your race, color, gender, sexual preference, religion, or national origin.
13. You have the right to receive a full explanation of all treatment options for kidney disease, including their advantages, and disadvantages.

14. You have the right to receive a full explanation of the kidney transplant process including all transplant options, and select the transplant center at which you desire to receive a transplant after consultation with the nephrologists.
15. You have the right to be informed of new advances in home care and have the opportunity to make change to that treatment option, receive educational materials about new procedures.
16. You have the right to receive information about dialysis centers that offer self care.
17. You have the right to receive emergency medical care without unnecessary delay, be informed by the dialysis facility about their emergency plan in case of a disaster (i.e. snow storm, fire, loss of power). Be informed of the facility's plan of action in case of medical emergencies.
18. You have the right to expect that the dialysis facility will employ skilled staff and provide safe, clean, comfortable, and professional surroundings.
19. You have the right to expect the facility to make every effort to make you comfortable and give you your treatment on time according to a schedule that meets special needs whenever possible.
20. You have a right to make a complaint to your facility management and request that they try to resolve a problem.
21. You have the right to file a complaint with the ESRD Network in the region, and/or your state health department in an attempt to resolve a problem.
22. You have the right to make decisions about your healthcare based on information given to you by your kidney doctor.
23. You have the right to be informed by your kidney doctor of the possible results of refusing drugs, treatments, or procedures, indicate your refusal in writing, and complete an advance directive stating your wishes.
24. You have the right to request consultation with another doctor for any kidney or non-kidney related medical problem.
25. You have the right to receive a full explanation of any research program in which you may be able to participate, know the study will not be conducted without your informed consent or that of the person acting on your behalf, and refuse or withdraw from the research study at any time.
26. You have the right to receive a full explanation of all charges by the facility and doctor, be informed about your financial responsibilities after Medicare or Medicaid and/or health care insurance coverage.
27. You have the right to obtain assistance with completing insurance forms, and obtain information about how you can pay your bill and about programs available to help you.

Responsibilities:

1. You have the responsibility to learn as much as you can about your kidney disease and how it is treated.
2. You have the responsibility to talk about your health care team concerns regarding your treatment.
3. You have the responsibility to treat other patients and staff members with respect with respect, dignity, and consideration.
4. You have the responsibility to never threaten others, act in a violent manner or cause any physical harm.
5. You have the responsibility to supply all information needed to plan and carry out a treatment program that will give you the best results.
6. You have the responsibility to find out about other services and referrals that are recommended by your health care team.
7. You have the responsibility to make every effort to be on time for your scheduled dialysis, and to tell the dialysis facility ahead of time if you are unable to attend your next treatment date, and understand that your treatment time may be shortened if you arrive late.
8. You have the responsibility to follow the policies and procedures that have been developed to provide safety and quality of care to all patients.
9. You have the responsibility to make every effort to pay your bills for care from the dialysis facility and doctor(s), obtain Medicare Part B coverage or co-insurance through a private carrier.
10. You have the responsibility to inform the business office of all health insurance programs and policies from which you receive direct payment for services in the treatment of kidney disease.
11. You have the responsibility to pay the dialysis facility and doctor when you receive payments from your Health Insurance Company or medical policies.

The above listed Loganville Dialysis Patient Rights & Responsibilities have been reviewed by me and any questions or concerns have been answered to my satisfaction.

Patient Signature

Date

**Kidney Care Group, Inc., dba Loganville Dialysis
MEDICAL RECORDS RELEASE AUTHORIZATION FORM**

Date of Request: _____ - _____ - _____

Patient Name: _____

I, _____, hereby give Kidney Care Group, Inc., dba Loganville Dialysis permission to disclose, receive and deliver any medical information contained in my medical record to:

_____. Such information disclosed, received or delivered may include the complete case history, copy of medical records, information for progression toward care plan and other treatment at Kidney Care Group. This release is valid for one year from the date requested.

Specific information requested:

Demographics/Insurance info	Flow Sheets	Labs (within 30 days)	SW Notes
H&P	EKG	Hep Status	RD Notes
Home Meds	Chest X-ray	MD Progress Notes	Care Plans (long/short term)
MD Orders	2728	RN Notes	PPD

Purpose of release (e.g., patient transfer, transient information request, insurance claim, legal investigation, disability determination)

Signature of Patient or Legal Guardian
(If legal guardian, state relationship-e.g. parent, power of attorney, etc)

Witness

Date

Date

Date Sent: _____ - _____ - _____

**Kidney Care Group, Inc., dba Loganville Dialysis
Consent Form**

1. My Physician Has Advised Me That I Have Chronic Renal Failure. This Means That My Kidneys Are No Longer Able To Perform One Or More Of Their Functions, Including Riding The Body Of Waste Products, Maintaining Normal Concentrations Of Certain Chemicals In The Body, And Regulating The Volume Of Fluids And The Pressure Of The Blood.
2. I Understand That I Will Be Receiving Hemodialysis As A Form Of Treatment That Will Filter The Waste Products And Fluids From The Body And Allow An Acceptable Quality Of Life.
3. I Understand That My Doctor Has Determined How Long, How Frequently, And Under What Conditions I Should Dialyze. I Understand That My Doctor Has Prescribed This Treatment With My Specific Needs In Mind.
4. The Potential Risks And Benefits Of Dialysis Treatment Have Also Been Explained And I Understand That Those Benefits And Risks May Include, But Are Not Limited To, Those Listed Below.

Risks Of Dialysis Treatment Include The Following:

Muscle Cramps	Clotted Access (Requiring Surgical Intervention)
Low Blood Pressure	Headaches
Bleeding (From Access Site)	Infection
Adverse Reaction from Medication	
Adverse Reaction to Products Used During Dialysis	

Benefits Of Dialysis Treatment Include The Following:

Improved Appetite	Extension of Life
Improved Energy Level	Feeling of Well Being

5. I Hereby Consent To Dialysis Treatment Provided By Kidney Care Group. I Understand My Responsibilities As A Patient, Which Include Adherence To The Recommended Dialysis Treatment Prescribed, By My Doctor. I Have Had The Opportunity To Ask And Have Answered Any Questions That I May Have Regarding My Treatment. In Addition I Have Been Encouraged To Ask Any Questions Of The Dialysis Staff Or My Physician About Any Aspect Of My Care And Treatment.

_____ Patient Name (PRINTED)	_____ Date	_____ Patient Name (SIGNATURE)	_____ Date
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_____ Witness Signature	_____ Date	_____ Patient's Medical Record Number
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