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KIDNEY DISEASE  
ACUTE AND CHRONIC DIALYSIS  
TRANSPLANT MEDICINE  
HYPERTENSION

AMELIA K. KLOCKE, B.S.  
PRACTICE ADMINISTRATOR

**Welcome to Renal Associates of West Michigan, P.C. (RAWM)! Our goal is to provide the best care possible in a professional and friendly environment.**

Please review the following summary of our billing and payment policy:

**Payment:**

Payment is expected at the time of service unless other arrangements have been made. You are responsible for all fees associated with your care.

**Insurance Information:**

If we are billing your insurance, please provide the receptionist with your insurance information, including any updates or changes as they occur. A copy of your insurance card(s) and driver's license are required at every visit to ensure proper billing processes.

**Co-Pays:**

For physician visits, your co-pay will be collected at the time of service.

You will be billed for any co-pay/deductible associated with hospital care, transplant management, and dialysis and/or access intervention procedures.

**Insurance Coverage:**

Insurance coverage does not guarantee full payment for services provided. You will be billed for any fees determined by your insurance plan to be your responsibility. If you would like information regarding your payment responsibility for any of the services mentioned above, including physician office visits, please contact our billing office at (616) 752-6235, option 4. Our knowledgeable staff will be happy to answer your questions.

**Please arrive 20 minutes prior to your appointment to ensure that we can provide the best Renal care to you.**

If we can assist you in any way, please do not hesitate to ask, and we thank you for choosing RAWM for your medical care.



**To Our Valued Patients:**

Thank you for selecting our physician as your nephrology provider. An important part of your care plan is information regarding financial responsibility as it relates to your nephrology care. We would like to share with you our collection procedures regarding co-pay and co-insurance collection.

Contracted providers with your insurance company are contractually obligated to collect a portion of the payment from you. These portions could be any of three different types of payment:

**Co-Pays**

Network physicians with your payor are obligated to collect the co-pay at the time of service. Co-pays are associated with physician visits and are payable at the time of service.

**Co-Insurance**

In addition to co-pays, some payors have a co-insurance amount that is due as part of the service delivered. The amount of co-insurance due is based upon the individual policy for each patient.

**Yearly Deductible**

Some patients have a set yearly deductible in addition to co-pays, or co-insurance. This is an amount set by your insurance carrier. Charges that are applied to your deductible will be billed to you. We will not be able to determine the deductible amount due prior to your service. If you have questions regarding your deductible, you will need to direct those to your insurance carrier.

**Patient Portal**

Our portal gives patients secure and convenient access to their health information. Patients can use the Patient Portal to view, download, and transmit their health information, send secure messages to their provider and even pay their bill.

We are committed to providing high quality care to our patients and strive to provide the best communication possible regarding our billing procedures.

Thank you for your cooperation in this matter. If you have any questions concerning this procedure, please do not hesitate to call our bill department at (616) 752-6235, option 4.

*Renal Associates of West Michigan, P.C.*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



**Patient History**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PATIENT ADDRESS:** \_\_\_\_\_ **PATIENT PHONE:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER:** \_\_\_\_\_ **EMAIL ADDRESS:** \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ **EMERGENCY CONTACT PHONE:** \_\_\_\_\_

**PREFERRED LANGUAGE:** \_\_\_\_\_ **INTERPRETER NEEDED?**  YES  NO

**PHARMACY NAMES/CROSSROADS:** \_\_\_\_\_

**PRIMARY CARE PHYSICIAN (PCP):** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PCP ADDRESS:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**PREFERRED LABORATORY/CROSSROADS:** \_\_\_\_\_

**PREFERRED IMAGING FACILITY/CROSSROADS:** \_\_\_\_\_

**Do you see other providers/specialists? If yes, please write their names and specialty below:**

\_\_\_\_\_

\_\_\_\_\_

RACE/ETHNICITY	
RACE	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer
ETHNICITY	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Decline to Answer
MEDICATION ALLERGIES	
Please list names of medications with specific allergy or reaction that you have experienced.	
DRUG NAME	ALLERGY or REACTION
Have you ever experienced a reaction when given X-ray dye or IV Contrast?	
<input type="checkbox"/> No <input type="checkbox"/> Yes, please identify reaction:	
FOOD ALLERGIES	
Please list the foods with the specific allergy or reaction that you have experienced.	
FOOD	ALLERGY or REACTION



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



<b>RENAL (KIDNEY)-HYPERTENSION-DIABETES</b>			
Do you have a history of kidney disease? <input type="checkbox"/> No <input type="checkbox"/> Yes (check all that apply from below list)			
Name	Date Diagnosed	Name	Date Diagnosed
<input type="checkbox"/> Acute Renal Failure		<input type="checkbox"/> Kidney Cyst(s)	
<input type="checkbox"/> Anemia - Chronic		<input type="checkbox"/> Lupus Nephritis	
<input type="checkbox"/> Anemia – Iron Deficient		<input type="checkbox"/> Membranous Nephropathy	
<input type="checkbox"/> Chronic Kidney Disease		<input type="checkbox"/> Nephrolithiasis	
<input type="checkbox"/> End-Stage Kidney Disease		<input type="checkbox"/> Nephrotic Syndrome	
<input type="checkbox"/> Glomerulonephritis		<input type="checkbox"/> Polycystic Kidney Disease	
<input type="checkbox"/> Hypertension/High Blood Pressure		<input type="checkbox"/> Proteinuria	
<input type="checkbox"/> IgA Nephropathy		<input type="checkbox"/> Renal Tumor	
<input type="checkbox"/> Interstitial Nephritis			
<b>ENDOCRINE</b>			
<input type="checkbox"/> Adrenal Gland Tumor		<input type="checkbox"/> Hyperaldosteronism	
<input type="checkbox"/> Diabetes Mellitus, Type 1		<input type="checkbox"/> Hyperparathyroidism	
<input type="checkbox"/> Diabetes Mellitus, Type 2		<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> Diabetic Nephropathy		<input type="checkbox"/> Hypoaldosteronism	
<input type="checkbox"/> Diabetic Peripheral Neuropathy		<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> Diabetic Retinopathy			
<b>ELECTROLYTE IMBALANCE</b>			
<input type="checkbox"/> Hypercalcemia		<input type="checkbox"/> Hypokalemia	
<input type="checkbox"/> Hyperkalemia		<input type="checkbox"/> Hypomagnesemia	
<input type="checkbox"/> Hypermagnesemia		<input type="checkbox"/> Hyponatremia	
<input type="checkbox"/> Hypernatremia		<input type="checkbox"/> Hypophosphatemia	
<input type="checkbox"/> Hyperphosphatemia		<input type="checkbox"/> Metabolic disorder	
<input type="checkbox"/> Hypocalcemia			
<b>HEART</b>			
<input type="checkbox"/> Anticoagulant use		<input type="checkbox"/> Congestive Heart Failure	
<input type="checkbox"/> Arrhythmias		<input type="checkbox"/> Coronary Artery Disease	
<input type="checkbox"/> Bradycardia		<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Cardiomyopathy		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Carotid Artery Stenosis		<input type="checkbox"/> Tachycardia	
<input type="checkbox"/> Congenital Heart Disease		<input type="checkbox"/> Valve Disorder	
<b>VASCULAR</b>			
<input type="checkbox"/> CVA/TIA/Stroke		<input type="checkbox"/> Peripheral Neuropathy	

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



<b>MEDICAL HISTORY (continued from previous page)</b>			
<b>Name</b>	<b>Date Diagnosed</b>	<b>Name</b>	<b>Date Diagnosed</b>
<b>VASCULAR (cont).</b>			
<input type="checkbox"/> DVT/Clotting Disorder		<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Peripheral Artery Disease		<input type="checkbox"/> Venous Insufficiency/Stasis/ Varicose Veins	
<b>PULMONARY/LUNGS</b>			
<input type="checkbox"/> Asthma		<input type="checkbox"/> Sarcoidosis	
<input type="checkbox"/> COPD/Emphysema		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Obstructive Sleep Apnea		<input type="checkbox"/> Valley Fever	
<input type="checkbox"/> Pulmonary Hypertension			
<b>GASTROINTESTINAL</b>			
<input type="checkbox"/> Cirrhosis		<input type="checkbox"/> GERD	
<input type="checkbox"/> Colitis		<input type="checkbox"/> GI Bleed	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Peptic Ulcers	
<b>GENITOURINARY/UROLOGIC</b>			
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Hematuria	
<input type="checkbox"/> Bladder Incontinent		<input type="checkbox"/> Hydronephrosis	
<input type="checkbox"/> Cystitis		<input type="checkbox"/> Recurrent UTI's	
<b>RHEUMATOLOGY</b>			
<input type="checkbox"/> Erythematosis		<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Sjogren's Syndrome	
<input type="checkbox"/> Gout		<input type="checkbox"/> Systemic Lupus	
<input type="checkbox"/> HIV		<input type="checkbox"/> Wegner's Granulomatosis	
<input type="checkbox"/> Rheumatoid Arthritis			
<b>SKELETAL</b>			
<input type="checkbox"/> Degenerative Joint Disease		<input type="checkbox"/> Osteopenia	
<input type="checkbox"/> Kyphosis		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Osteoarthritis		<input type="checkbox"/> Scoliosis	
<b>CANCER</b>			
<input type="checkbox"/> Bladder		<input type="checkbox"/> Pancreatic	
<input type="checkbox"/> Breast		<input type="checkbox"/> Prostate	
<input type="checkbox"/> Colon		<input type="checkbox"/> Renal	
<input type="checkbox"/> Lung		<input type="checkbox"/> Other	
<input type="checkbox"/> Ovarian/Uterus/Cervix			

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



MEDICAL HISTORY (continued from previous page)			
Name	Date Diagnosed	Name	Date Diagnosed
<b>OTHER</b>			
<input type="checkbox"/> Anxiety/Depression		<input type="checkbox"/> NSAID use	
<input type="checkbox"/> Deafness		<input type="checkbox"/> Obesity	
<input type="checkbox"/> Hyperlipidemia		<input type="checkbox"/> Vitamin D Deficiency	
Other:			
SURGICAL HISTORY			
Name	Date of Surgery	Name	Date of Surgery
<input type="checkbox"/> Adrenal Surgery		<input type="checkbox"/> Hemodialysis Catheter	
<input type="checkbox"/> Amputation Type:		<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Any metal in body, where?		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Aortic Valve Repair		<input type="checkbox"/> Kidney Ablation	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Kidney Artery Angioplasty	
<input type="checkbox"/> AV Fistula		<input type="checkbox"/> Kidney Biopsy	
<input type="checkbox"/> AV Graft		<input type="checkbox"/> Lithotripsy	
<input type="checkbox"/> Bladder Surgery, Type:		<input type="checkbox"/> Liver Transplant	
<input type="checkbox"/> Cancer Surgery, Type:		<input type="checkbox"/> Mitral Valve Repair	
<input type="checkbox"/> Carotid Artery Angioplasty		<input type="checkbox"/> Mitral Valve Replacement	
<input type="checkbox"/> Carotid Endarterectomy		<input type="checkbox"/> Nephrectomy: <input type="checkbox"/> left side <input type="checkbox"/> right side	
<input type="checkbox"/> Cholecystectomy		<input type="checkbox"/> Orthopedic Surgery	
<input type="checkbox"/> Colon Surgery		<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Coronary Artery Angioplasty/Stent		<input type="checkbox"/> Pancreas Transplant	
<input type="checkbox"/> Cystoscopy		<input type="checkbox"/> Parathyroid Surgery	
<input type="checkbox"/> Eye Surgery		<input type="checkbox"/> Peritoneal Catheter	
<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Thyroid Surgery	
<input type="checkbox"/> Heart Bypass Surgery-CABG		<input type="checkbox"/> Ureteral Stent	
<input type="checkbox"/> Heart Transplant		<input type="checkbox"/> Vascular Surgery	
<input type="checkbox"/> Heart/Cardiac Catheterization		Other:	
		<input type="checkbox"/> <b>Renal Transplant:</b> <input type="checkbox"/> Living-related or unrelated <input type="checkbox"/> cadaveric <input type="checkbox"/> left or right side  <u>Facility where transplant was performed:</u>	

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



SOCIAL HISTORY						
<b>Smoking Status:</b>						
<input type="checkbox"/> Current, every day smoker: packs smoked per day _____ Year started: _____						
<input type="checkbox"/> Current, some day smoker: packs smoked per day _____ Year started: _____						
<input type="checkbox"/> Former smoker: Year started: _____ Years smoked: _____ Packs smoked per day: _____						
<input type="checkbox"/> Never smoked <input type="checkbox"/> Unknown						
<input type="checkbox"/> Heavy tobacco user: Year started: _____ <input type="checkbox"/> Light tobacco user: Year started: _____						
<b>Alcohol Use:</b>						
<input type="checkbox"/> No history of alcohol use <input type="checkbox"/> Rehabilitation: Year of treatment received for alcohol abuse: _____						
<input type="checkbox"/> Currently consume alcohol (provide quantity and frequency): _____						
<input type="checkbox"/> Former Drinker: Sober since: _____ Previous quantity and frequency: _____						
<input type="checkbox"/> Recovering alcoholic: Sober since: _____ Previous quantity and frequency: _____						
<b>Illicit Drug Use:</b>						
<input type="checkbox"/> No history of illicit drug use <input type="checkbox"/> Rehabilitation: Year of treatment received for drug abuse: _____						
<input type="checkbox"/> Current use: Type of drug: _____, frequency: _____ Dates/Years of use: _____						
<input type="checkbox"/> Previous use: Type of drug: _____, frequency: _____ Dates/Years of use: _____						
Claustrophobic: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Education: <input type="checkbox"/> less than 8th grade <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> post graduate						
Employment status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled Employer: _____						
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner						
FAMILY HISTORY						
Adopted, Family History Unknown <input type="checkbox"/>						
	Living	Deceased	Age at Death	Cause of Death		
Father	<input type="checkbox"/>	<input type="checkbox"/>				
Mother	<input type="checkbox"/>	<input type="checkbox"/>				
Please indicate if a family member has/had any of the following:						
	Father	Mother	Brother	Sister	Children	Other (identify)
Diabetes, Type I:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Type II:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis (identify cause):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>