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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.

Patient Name: ____ DOB: _______________________

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	☐ African American ☐ Asian ☐ American Indian or Alaska Native ☐ Caucasian ☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Decline to Answer
ETHNICITY	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ 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?

☐ No ☐ 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: ________________________

RENAL ASSOCIATES
of West Michigan, P.C.

MEDICATION LIST **Please bring a list/bottles of your current medications**		
DRUG/SUPPLEMENT/VITAMIN NAME	STRENGTH (mg)	FREQUENCY

NSAID HISTORY Are you currently, or have you taken any of the following medications in the past?		
☐ Advil/Co-Advil	☐ Disalcid	☐ Mefenamic/Ponstel
☐ Aleve/Anaprox/Naprosyn/Naproxen	☐ Empirin/Genprin	☐ Meloxicam/Mobic
☐ Ansaid	☐ Etodolac/Lodine	☐ Midol-IB/Pamprin-IB
☐ Arthrotec/Cataflam/Diclofenac/Voltaren	☐ Feldene/Piroxicam	☐ Ponstel
☐ Aspirin/Easprin/Ecotrin/Zorprin	☐ Fenoprofen/Nalfon	☐ Relafen
☐ Baclofen/Kemstro/Lioresal	☐ Flurbiprofen	☐ Robaxin
☐ Bextra	☐ Halfprin/Iburin	☐ Salsitab
☐ Butazolidin	☐ Ibuprofen/Motrin/Rufen/Trendar/Medipren	☐ Sulindac/Clinoril
☐ Celebrex/Celecoxib	☐ Indocin/Indomethacin/Rheumacin	☐ Tolectin
☐ DayPro	☐ Magnaprin	☐ Toradol
☐ Diflunisal/Dolobid	☐ Meclomen	☐ Trilisate

Tylenol and Extra Strength Tylenol are the medication of choice for pain management for people with Kidney problems.

Patient Name: ______________________________________ DOB: ______________________

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

Patient Name: ____ DOB: _______________________

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

MEDICAL HISTORY (continued from previous page)			
Name	**Date Diagnosed**	**Name**	**Date Diagnosed**
OTHER			
☐ Anxiety/Depression		☐ NSAID use	
☐ Deafness		☐ Obesity	
☐ Hyperlipidemia		☐ Vitamin D Deficiency	
Other:			

SURGICAL HISTORY			
Name	**Date of Surgery**	**Name**	**Date of Surgery**
☐ Adrenal Surgery		☐ Hemodialysis Catheter	
☐ Amputation Type:		☐ Hernia Repair	
☐ Any metal in body, where?		☐ Hysterectomy	
☐ Aortic Valve Repair		☐ Kidney Ablation	
☐ Appendectomy		☐ Kidney Artery Angioplasty	
☐ AV Fistula		☐ Kidney Biopsy	
☐ AV Graft		☐ Lithotripsy	
☐ Bladder Surgery, Type:		☐ Liver Transplant	
☐ Cancer Surgery, Type:		☐ Mitral Valve Repair	
☐ Carotid Artery Angioplasty		☐ Mitral Valve Replacement	
☐ Carotid Endarterectomy		☐ Nephrectomy: ☐ left side ☐ right side	
☐ Cholecystectomy		☐ Orthopedic Surgery	
☐ Colon Surgery		☐ Pacemaker	
☐ Coronary Artery Angioplasty/Stent		☐ Pancreas Transplant	
☐ Cystoscopy		☐ Parathyroid Surgery	
☐ Eye Surgery		☐ Peritoneal Catheter	
☐ Gastric Bypass		☐ Thyroid Surgery	
☐ Heart Bypass Surgery-CABG		☐ Ureteral Stent	
☐ Heart Transplant		☐ Vascular Surgery	
☐ Heart/Cardiac Catheterization		Other:	
		☐ **Renal Transplant:** ☐ Living-related or unrelated ☐ cadaveric ☐ left or right side Facility where transplant was performed:	

SOCIAL HISTORY

Smoking Status:

☐ Current, every day smoker: packs smoked per day __________ Year started: __________

☐ Current, some day smoker: packs smoked per day __________ Year started: __________

☐ Former smoker: Year started: __________ Years smoked: __________ Packs smoked per day: __________

☐ Never smoked ☐ Unknown

☐ Heavy tobacco user: Year started: __________ ☐ Light tobacco user: Year started: __________

Alcohol Use:

☐ No history of alcohol use ☐ Rehabilitation: Year of treatment received for alcohol abuse: __________

☐ Currently consume alcohol (provide quantity and frequency): ___________________________

☐ Former Drinker: Sober since: __________ Previous quantity and frequency: ___________________________

☐ Recovering alcoholic: Sober since: __________ Previous quantity and frequency: ___________________________

Illicit Drug Use:

☐ No history of illicit drug use ☐ Rehabilitation: Year of treatment received for drug abuse: __________

☐ Current use: Type of drug: _______________, frequency: _______________ Dates/Years of use: __________

☐ Previous use: Type of drug: _______________, frequency: _______________ Dates/Years of use: __________

Claustrophobic: ☐ Yes ☐ No

Education: ☐ less than 8th grade ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 2 year college ☐ 4 year college ☐ post graduate

Employment status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Employer: ______________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

FAMILY HISTORY

Adopted, Family History Unknown ☐

	Living	Deceased	Age at Death	Cause of Death
Father	☐	☐		
Mother	☐	☐		

Please indicate if a family member has/had any of the following:

	Father	Mother	Brother	Sister	Children	Other (identify)
Diabetes, Type I:	☐	☐	☐	☐	☐	☐
Diabetes, Type II:	☐	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐	☐
Heart Disease (identify type):	☐	☐	☐	☐	☐	☐
Kidney Disease (identify type):	☐	☐	☐	☐	☐	☐
Kidney Failure	☐	☐	☐	☐	☐	☐
Dialysis (identify cause):	☐	☐	☐	☐	☐	☐
Cancer (identify type):	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐