Southwest Kidney Care, LLC

Patient Informed Consent

- I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Southwest Kidney Care, LLC and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Southwest Kidney Care, LLC.

- I understand that Southwest Kidney Care, LLC will file all my insurance claims, provided I inform them of the correct policy information and that I have a current referral or prior authorization from my primary care provider as required by my insurance carrier

- I understand that I am financially responsible for all services provided.
- I authorize payment of medical benefits to Southwest Kidney Care, LLC or their designee for services rendered.
- I have received a copy of the Notice of Privacy Practices. **Initial:** _____

- I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment. **Initial:** _____

Appointment Confirmation

I give Southwest Kidney Care, LLC permission to confirm my appointment and/or I authorize representatives of Southwest Kidney Care, LLC to leave appointment information on my home or mobile telephone numbers. **Initial:** _____

I give Southwest Kidney Care, LLC permission to send correspondence via email. **Initial:** _____

I give Southwest Kidney Care, LLC permission to send text messages to my mobile phone. **Initial:** _____

_____

Patient or Authorized Representative Signature Date

_____

Patient or Authorized Representative Name

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_____

Patient or Authorized Representative Signature Date

_____

Patient or Authorized Representative Name

Southwest Kidney Care

Patient Medication List

Patient Name:_____**DOB:**_____

Preferred Pharmacy Name/Address_____

Phone: _____

Are you allergic to any medications? ____**YES** ____ **NO**

Please list:_____

_____

Please provide the names of all medications you are currently taking. This includes any over the counter medications or supplements. Include the Medication Name, Medication Dose/Strength (i.e. mg, mcg, mEq, etc.), and frequency of use (i.e. daily, twice daily, at bedtime, etc.)

If you are unsure about any of your medications, please bring all of your medication bottles in with you when you come to your appointment.

Medication	Dose/Strength	Frequency
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____
4)_____	_____	_____
5)_____	_____	_____
6)_____	_____	_____
7)_____	_____	_____
8)_____	_____	_____
9)_____	_____	_____
10)_____	_____	_____
11)_____	_____	_____

Southwest Kidney Care

Patient Medication List

	Medication	Dose/Strength	Frequency
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			
21)			
22)			
23)			
24)			
25)			

Southwest Kidney Care

Patient History

Please complete the following sections to the best of your knowledge and as completely as possible. If none are applicable, please fill in with "N/A" or "Unknown".

Past Medical/Surgical History:

Family Medical History:

Social History: