NORTHWEST Kidney Centers

New Patient Admission
Chronic ESRD Patient Worksheet

(Packet A)

The following tasks must be completed on every new Northwest Kidney Centers patient. If the Primary Nurse is not available, a nurse must AT A MINIMUM complete those tasks marked as a "Core Task" in the timeframe specified.

Note: Those tasks marked as PCT can be completed by a Patient Care Technician at the direction of the nurse.

	Prior to Patient Arrival	**Core Task**
☐	Review all documentation included with referral, document on exam screen (see New Patient Assessment Policy CD-N1044)	X
☐	Enter dialysis orders	X
☐	Enter labs per standing orders	X
☐	Verify lab tests entered in lab portal for 1st treatment	X
☐	Complete Patient History Form	X
☐	Enter allergies	X
☐	Enter code status (verify if POLST Form is completed)	X
☐	Enter primary dialysis justification to Problem List (N18.6)	X
☐	Enter access on access screen	X
☐	Enter access surgeon on access and contact screens (if available)	X

	Prior to Initiating Treatment	**Core Task**
☐	Review & have patient sign consents – Provide photocopies to patient after signed • Informed Consent for Treatment (CKD-PE-37) • 2728 Form (print name on page 1, have patient sign page 5, do not date form) • Joint Notice of Privacy Practices	X

Patient Name _____ NKC # _____

☐	Review & have patient sign Patient Finance Packet – Provide photocopies to patient after signed • Patient Account Agreement (CKD-PE-42, 42a) • Patient Registration Form (CKD-PE-51) • Social Security Administration Release of Information (Form SSA-3288) • DSHS Authorized Representative Consent (DSHS 14-532)	X
☐	Review with patient (Handouts) Welcome to Northwest Kidney Centers! (CKD-PE-52)	X PCT
☐	Obtain copy of picture ID and insurance cards (if available)	X PCT
☐	Conduct quick orientation tour of the dialysis facility, including: • Location/use of the restroom (including location of call light) • Location of sink to clean vascular access • Use of the scale	X PCT
☐	Measure and enter patient's height	X PCT
☐	If pt has an AVF/AVG, instruct and observe patient washing access.	X
☐	Conduct Pre-dialysis Patient Assessment (must be done by RN) including but not limited to: • Pre-dialysis assessment • Assessment of access • Review of any known allergies • Review of medications taken last 24 hours	X
☐	Ultra-sound AVF, if medically indicated	
☐	If diabetic, assess for risk of hypoglycemic episode during dialysis treatment	X

Once the Patient Initiates Dialysis		**Core Task**
☐	Review with the patient the following: • Location and use of call button • Length of treatment • Repeat information about most common side effects of dialysis (nausea, cramping, pain, dizziness, headache) • Use of a cell phone, TV, chair • Ability to have visitors with use of proper PPE per NKC policy	X PCT

Patient Name _____ NKC # _____

☐	Enter home medications into record	
Post Treatment		**Core Task**
☐	Review with patient (Handout) • First Treatment Discharge Instructions (CKD-PE-47) • Patient Portal Information	X
☐	Include appropriate instruction and supply list document: Access Care supplies packet – Fistula or Graft (CKD-PE-49) Access Care supplies packet – IJ Catheter (CKD-PE-48) Provide patient with access care supplies (based on type of access) ***Fistula/Graft*** (4) 4x4 gauze (1) 1-inch single use paper tape ***IJ Catheter*** (1) Chlorascrub pad (4) 2x2 gauze (1) 1-inch single use paper tape (2) Mask (2) Gloves	X PCT
☐	Enter Primary Prescription & Primary Modality on General Information	X
☐	Enter access status	
☐	Enter BP cuff size in exam screen and Nurses Worksheet	
☐	Enter admission progress note	X
☐	Complete Education dropdowns *Note*: If access care was reviewed during the first treatment by a staff member other than the Primary Nurse, the Primary Nurse needs to verify understanding during a subsequent treatment and document education.	
☐	Notify the following staff of patient admission, include the following: • Clinical Informatics Team (support@nwkidney.org) • Patient Finance Team (PatientFinanceList@nwkidney.org) • Clinical Supervisor/Manager • Primary Care Nurse(s) • Social Worker(s) • Dietitian(s)	X

Patient Name _____ NKC # _____

Patient History Form

Please provide the information below by performing a chart review of the patient's medical history available in EMR Document Management.

Send this form to Clinical Informatics at Burien Pavilion via interoffice mail with the signed 2728 Form.

Patient Name: _____
Last First Middle / Initial

Did patient start chronic dialysis prior to admission to Northwest Kidney Centers? ☐ Yes ☐ No If yes, date: _____

Location: _____

Prior to ESRD Therapy

Did patient receive EPO or equivalent? ☐ Yes ☐ No ☐ Unknown If yes, ☐ <6 months ☐ 6-12 months ☐ >12 months

Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If yes, ☐ <6 months ☐ 6-12 months ☐ >12 months

Was patient under care of a kidney dietitian? ☐ Yes ☐ No ☐ Unknown If yes, ☐ <6 months ☐ 6-12 months ☐ >12 months

Was patient diagnosed with AKI in the last year? ☐ Yes ☐ No ☐ Unknown If yes, was dialysis required? ☐ Yes ☐ No

Does patient indicate they received & understood the option of not starting dialysis at all? ☐ Yes ☐ No

Treatment Options

Does the patient understand kidney transplant options? ☐ Yes ☐ No

If patient is not informed (or does not understand), check all that apply:

☐ Patient found information overwhelming
☐ Cognitive impairment
☐ Patient has an absolute contraindication
☐ Patient declined information
☐ Patient has not been assessed at this time
☐ Other

Has the patient been connected to a transplant center with a referral? ☐ Yes ☐ No

If yes, date of referral: _____ Name of transplant center: _____

Does the patient understand home dialysis treatment options? ☐ Yes ☐ No

If not informed (or does not understand), check all that apply:

☐ Patient found information overwhelming
☐ Cognitive impairment
☐ Patient has an absolute contraindication
☐ Patient declined information
☐ Patient has not been assessed at this time
☐ Other

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046
Expires: 11/30/2026

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT

Medicare entitlement and/or patient registration

A. Complete for all ESRD patients.

Select one: ◯ **Initial** ◯ **Re-entitlement** ◯ **Supplemental**

1. Last name | First name | Middle initial

2. Medicare Number (if available) | 3. Social Security Number | 4. Date of birth (mm/dd/yyyy)

5. Patient mailing address (include city, state and ZIP Code)

6. Phone number (including area code) | 7. Alternate phone number (including area code)

8. Sex assigned at birth, on your original birth certificate
◯ Male ◯ Female

9. How do you currently describe yourself
◯ Male ◯ Female ◯ Transgender male ◯ Transgender female ◯ None of these

10. Ethnicity*
◯ Not Hispanic or Latino ◯ Hispanic or Latino

11. Country/area of origin or ancestry

12. Race* ☐ Multiracial (check all that apply)

☐ American Indian/Alaska Native

☐ Asian
- ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Other Asian

☐ Black or African American

☐ Middle Eastern or North Africa

☐ Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan

☐ White

☐ Other if unable to identify with any of these six race categories

Print name of enrolled/principal tribe: _____

13. Is patient applying for ESRD Medicare coverage? ..... ◯ Yes ◯ No

14. Current medical coverage (check all that apply)
☐ Employer group health insurance ☐ Medicare ☐ Medicaid ☐ Veterans Administration ☐ Medicare Advantage ☐ Other
☐ None

15. Height: inches _____ **OR** centimeters _____

16. Dry weight: pounds _____ **OR** kilograms _____

17. Primary cause of renal failure (use code at end of form)

*Go to instructions

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security Number is authorized by Executive Order 9397.

Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health.

18. Occupation status (6 months prior and current status)

Prior	Current		Prior	Current	
○	○	Unemployed	○	○	Retired (disability)
○	○	Employed full time	○	○	Medical leave of absence
○	○	Employed part time	○	○	Student
○	○	Homemaker	○	○	Volunteer
○	○	Retired due to age/preference			

19. Co-morbid conditions (check all that apply currently and/or during last 10 years)

- ☐ a. Congestive heart failure
- ☐ b. Atherosclerotic heart disease ASHD
- ☐ c. Other cardiac disease
- ☐ d. Cerebrovascular disease, CVA, TIA*
- ☐ e. Peripheral vascular disease*
- ☐ f. History of hypertension
- ☐ g. Amputation
- ☐ h. Diabetes
  - ☐ Currently on insulin
  - ☐ Currently use other injectable
  - ☐ On oral medications
  - ☐ Without medications
- ☐ i. Diabetic retinopathy
- ☐ j. Chronic obstructive pulmonary disease
- ☐ k. Tobacco use (current smoker)
- ☐ l. Malignant neoplasm, cancer
- ☐ m. Toxic nephropathy
- ☐ n. Alcohol dependence
- ☐ o. Drug dependence*
- ☐ p. Inability to ambulate*
- ☐ q. Inability to transfer*
- ☐ r. Needs assistance with daily activities*
- ☐ s. Alternate housing arrangement:
  - ☐ Assisted living
  - ☐ Nursing home
  - ☐ Other institution
- ☐ t. Non-renal congenital abnormality
- ☐ u. None (no comorbidities)
- ☐ v. Protein calorie malnutrition
- ☐ w. Morbid obesity
- ☐ x. Endocrine metabolic disorders
- ☐ y. Intestinal obstruction/perforation
- ☐ z. Chronic pancreatitis
- ☐ aa. Inflammatory bowel disease
- ☐ bb. Bone/joint/muscle infections/ necrosis
- ☐ cc. Dementia
- ☐ dd. Major depressive disorder
- ☐ ee. Myasthenia gravis
- ☐ ff. Guillain-Barre syndrome
- ☐ gg. Inflammatory neuropathy
- ☐ hh. Parkinson's disease
- ☐ ii. Huntington's disease
- ☐ jj. Seizure disorders and convulsions
- ☐ kk. Interstitial lung disease
- ☐ ll. Partial-thickness dermis wounds
- ☐ mm. Complications of specified implanted device or graft
- ☐ nn. Artificial openings for feeding or elimination

Consider for Pediatric Patients:

- ☐ oo. Chronic lung disease (including dependency on CPAP and ventilators)
- ☐ pp. Vision impairment
- ☐ qq. Feeding tube dependence
- ☐ rr. Failure to thrive/feeding disorders
- ☐ ss. Congenital anomalies requiring subspecialty intervention (cardiac, orthopedic, colorectal)
- ☐ tt. Congenital bladder/urinary tract anomalies
- ☐ uu. Non-kidney solid organ
- ☐ vv. Stem cell transplant
- ☐ ww. Neurocognitive impairment
- ☐ xx. Global developmental delay
- ☐ yy. Cerebral palsy
- ☐ zz. Seizure disorder

20. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ○ Yes ○ No ○ Unknown
If yes, answer: ○ <6 months ○ 6-12 months ○ >12 months

b. Was patient under routine care of a nephrologist? ○ Yes ○ No ○ Unknown
If yes, answer: ○ <6 months ○ 6-12 months ○ >12 months

c. Was patient under routine care of kidney dietitian? ○ Yes ○ No ○ Unknown
If yes, answer: ○ <6 months ○ 6-12 months ○ >12 months

d. What access was used on first outpatient dialysis:
○ AVF ○ Graft ○ PD catheter ○ Central venous catheter ○ Other

If not AVF, then: Is maturing AVF present? ○ Yes ○ No
Is graft present? ○ Yes ○ No
Was one lumen of the central venous catheter used and one needle placed in a AVF or graft? ○ Yes ○ No
Is PD catheter present? ○ Yes ○ No

e. Was patient diagnosed with an acute kidney injury in the last 12 months? ○ Yes ○ No ○ Unknown
If yes, was dialysis required? ○ Yes ○ No

f. Does the patient indicate they received and understood options for a home dialysis modality? ○ Yes ○ No

g. Does the patient indicate they received and understood options for a kidney transplant? ○ Yes ○ No
For living donor transplant ○ Yes ○ No

h. Does the patient indicate they received and understood the option of not starting dialysis at all, also called active medical management without dialysis? ○ Yes ○ No

*Go to instructions

21. Laboratory values within 45 days prior to the most recent ESRD episode. If not available within 30 days of admission to the dialysis facility for ESRD treatment, admission laboratory values may be used. (HbA1c and LDL within 1 Year of most recent ESRD episode).

◯ Prior lab values ◯ Admission lab values

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Serum albumin g/dl	___.___		e. Hemoglobin g/dl	___.___	
b. Serum albumin lower limit	___.___		f. HbA1c	___.___	
c. Lab method used (BCG/BCP)	___.___		g. LDL	___.___	
d. Serum creatinine mg/dl	___.___		h. Cystatin C	___.___	

22. Does the patient have living will or medical/physician order for life sustaining treatment? ..... ◯ Yes ◯ No

23. Are you currently concerned about where you will live over the next 90 days? ..... ◯ Yes ◯ No

24. Do you have caregiver support to assist with your daily care? ..... ◯ Yes ◯ No
With home dialysis/kidney transplant? ..... ◯ Yes ◯ No
Does the caregiver live with you? ..... ◯ Yes ◯ No

25. Do you have access to reliable transportation? ..... ◯ Yes ◯ No

26. Do you understand health literature in English? ..... ◯ Yes ◯ No
Do you need a different way other than written documents to learn about your health? ..... ◯ Yes ◯ No
Do you need a translator to understand health information? ..... ◯ Yes ◯ No

27. Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating? ..... ◯ Yes ◯ No

28. Within the past 12 months, has the food you bought not lasted and you didn't have money to get more? ... ◯ Yes ◯ No

29. Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months? ..... ◯ Yes ◯ No

B. Complete for all ESRD patients in dialysis treatment

30. Name of dialysis facility

31. CMS Certification Number (CCN) (for item 30)

32. Primary dialysis setting
◯ Home ◯ In-center ◯ SNF/LTC*

33. Primary type of dialysis
◯ Hemodialysis (sessions per week____/minutes per session____) ◯ CAPD ◯ CCPD ◯ Other

34. Date regular chronic dialysis began (mm/dd/yyyy)

35. Date patient started chronic dialysis at current facility (mm/dd/yyyy)*

36. Does the patient understand kidney transplant options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 20(g)

37. If patient NOT informed of transplant options (or does not understand transplant options) please check all that apply:
☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

38. Has the patient been connected to a transplant center with a referral?* ..... ◯ Yes ◯ No
Date of referral (mm/dd/yyyy): _____
Name of transplant center: _____

39. Does the patient understand home dialysis options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 20(f)

40. If patient NOT informed of home dialysis options (or does not understand home dialysis options) please check all that apply:
☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

*Go to instructions

C. Complete for all kidney transplant patients

41. Date of transplant (mm/dd/yyyy)

42. Name of transplant hospital	43. CMS Certification Number (CCN) (for item 42)

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

44. Enter date (mm/dd/yyyy)

45. Name of preparation hospital	46. CMS Certification Number (CCN) (for item 45)

47. Current status of transplant (if functioning, skip items 49 and 50)

◯ Functioning ◯ Non-functioning

48. Type of transplant:

◯ Deceased donor ◯ Living related ◯ Living unrelated ◯ Multi-organ ◯ Paired exchange

49. If non-functioning, date of return to regular dialysis (mm/dd/yyyy)

50.Current dialysis setting

◯ Home ◯ In-center ◯ SNF/LTC* ◯ Transitional care unit*

D. Complete for all ESRD self-dialysis training patients (Medicare applicants only)

51. Name of training provider

52. CMS Certification Number (CCN) of training provider (for item 51)	53. Date training began (mm/dd/yyyy)

54. Type of training

☐ Hemodialysis: (select one) a. ◯ Home b. ◯ In-center ☐ CAPD ☐ CCPD ☐ Other

55. This patient is expected to complete (or has completed) training and will self-dialyze on a regular basis. .....◯ Yes ◯ No

56. Date when patient completed, or is expected to complete, training (mm/dd/yyyy)

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

57. Printed name and signature of physician personally familiar with the patient's training

a. Printed name

b. Signature	c. Date (mm/dd/yyyy)

58. NPI of physician (for item 57)

*Go to instructions

E. Physician Identification

59. Attending physician (print)

60. Physician's phone number (include area code)	61. NPI of physician

Physician attestation

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

62. Attending physician's signature of attestation (same as item 59)	63. Date (mm/dd/yyyy)
64. Physician recertification signature	65. Date (mm/dd/yyyy)

66. Remarks

F. Obtain signature from patient

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

67. Signature of patient (signature by mark must be witnessed.)	68. Date (mm/dd/yyyy)

If patient unable to sign/mark: (select one)

☐ Lost to follow-up ☐ Moved out of the United States and territories ☐ Expired date (mm/dd/yyyy)

G. Privacy statement

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

Northwest Kidney Centers Informed Consent for Treatment for Chronic Kidney Failure (ESRD) Patients

I have the right to make decisions about my healthcare. My kidney doctor (nephrologist) has explained to me that I have end-stage renal disease (ESRD) and that my kidneys no longer work well enough to support my health.

By signing this form, I authorize Northwest Kidney Centers (NKC) to treat my kidney failure with dialysis treatments at the direction of my kidney doctor and/or any other doctor appointed by him or her.

Information about my kidney failure (ESRD)

- My kidney doctor has explained my kidney failure to me
- I understand dialysis is one type of treatment for kidney failure; I may also choose to not start dialysis treatment, chose to stop dialysis later (will result in death), or to receive a kidney transplant
- My kidney doctor told me what to expect from dialysis, the effects of treatment, and the risks of dialysis treatments
- NKC provides the dialysis treatments my kidney doctor has ordered for me
- NKC staff are available to answer any questions I might have about my kidney failure and/or treatments and will support the choices I make regarding my treatment

Dialysis treatment options

NKC provides two types of dialysis treatments: hemodialysis and peritoneal dialysis (PD).

Hemodialysis

- Requires having access to my blood through a catheter or a vein
- Treatment can be done in a center or at home
- Blood moves through tubing from my body through a filter (dialyzer) connected to a dialysis machine
- Extra waste, salt, and water are removed in the filter, and then my blood is returned to my body

Patient Name _____ **NKC#** _____

Peritoneal Dialysis (PD)

- Requires having a tube placed in my abdomen
- Treatment is done at home
- A cleansing solution goes into my abdomen (belly) and draws out waste, salt and water from blood vessels
- The solution, along with waste and water, is drained out and replaced
- PD is done by doing several procedures by hand each day (CAPD), or with the help of a machine overnight while I sleep (APD)

Kidney function and dialysis

I know my kidneys are no longer able to clean the wastes and extra fluid from my blood. Since my kidneys do not work, I need dialysis as a lifesaving treatment. I am not able to live without dialysis. I have the right to choose which type of dialysis I receive after reviewing my options with my kidney doctor.

I understand I may be able to have hemodialysis or peritoneal dialysis in my home. If I am a candidate for home dialysis, NKC will train me to do my dialysis in my home. I understand I need a permanent access for NKC staff to train me for home dialysis.

I understand that I may change the type of treatment with the agreement of my kidney doctor and that I may need to change the treatment type for medical or other reasons in the future.

I understand that I will need to participate in care planning with my kidney doctor and NKC staff.

I understand that information about the payment for my dialysis treatments will be explained to me by my financial case manager.

I understand that during dialysis, a medication called heparin is used, which is derived from pork. I am aware I can refuse to have heparin given during my treatment and that my doctor will be contacted. I understand that NKC encourages me to discuss this matter or seek advice from my religious leaders if I have concerns.

Risks of dialysis

I understand that dialysis is a lifesaving treatment, but it also has risks which can be serious and even cause coma or death.

The risks can include:

- Low blood pressure (symptoms may include feeling weak or faint, headache, nausea, vomiting, chest pain or falls)
- Cramping from fluid removal (usually in legs, feet, hands)
- Chest pain
- Irregular or fast heart rate
- Fever and/or chills (may be a sign of infection)
- Infection of blood or dialysis access site
- Clotting of the blood at the access site, the dialyzer, or the blood tubing
- Bruising or bleeding due to blood thinning medications used in hemodialysis
- Allergic reactions which can cause itching or more serious symptoms
- Reactions and side effects from medications that are given during dialysis
- Hemodialysis equipment problems
- During the first peritoneal treatment, dialysate may cause some belly discomfort

NKC services

- Hemodialysis provided at an NKC dialysis center or training for home
- Laboratory draws to determine how well my dialysis is working for me
- Medications that are ordered by my kidney doctor to be given in-center or by me at home, will be administered during my dialysis treatment
- Care and services will be provided by NKC staff: nurses, technicians, social workers, dietitians, pharmacists, financial case managers, and other support staff as needed
- Doctors doing advanced studies in the care of kidney patients from the University of Washington may also take part in my care
- New employees or other students may provide care under the supervision of NKC staff

Unexpected medical needs

I know that during my treatment, unexpected situations may occur that require additional care. In these unusual circumstances, I authorize my doctor or his/her designee to order care for me to be performed by NKC staff.

Patient Name _____ **NKC#** _____

Financial responsibility (see also Patient Account Agreement)

I agree to pay for all services provided by NKC according to the then current rates and terms of the facility

I agree to apply for and use all available funding sources that are needed to pay for NKC charges and I understand that NKC will provide a Financial Case Manager to assist me with applications for funding sources, as necessary.

I agree to provide NKC with any financial and personal information needed to obtain and maintain coverage from funding sources. I agree to pay any applicable charges not paid by funding sources.

I agree to notify NKC about any changes in funding sources, including but not limited to, loss of or change in insurance coverage, eligibility for new coverage or enrollment in Medicaid or other programs.

Privacy of medical records (see also Notice of Privacy Practices)

I have received and understand the Northwest Kidney Centers Notice of Privacy Practices.

I understand that information in my medical record is protected and private and can only be shared under certain conditions that affect my medical care.

Duration of consent

I understand this consent will stay in effect for all treatments at any NKC facility, even if the care is interrupted (for example, by a hospital stay or travel). If I receive a kidney transplant or regain kidney function, this consent will stay in effect for three months following my last treatment at NKC. I can cancel this consent in writing at any time and NKC can cancel it in writing at any time.

Patient Name _____ **NKC#** _____

NORTHWEST Kidney Centers

Northwest Kidney Centers Informed Consent for Treatment for Chronic Kidney Failure (ESRD) Patients Acknowledgement

By signing this form I certify I have read, or someone else has read to me, the **Northwest Kidney Centers Informed Consent for Treatment for Chronic Kidney Failure (ESRD) Patients** (CKD-PE-37, 1/01/2023). I have received a copy, have had any questions answered, and I understand the information.

Signed:

Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

If this form is signed by someone else, there must be two witnesses:

Witness Name (Print)

x _____ _____
Date

NORTHWEST Kidney Centers

Dear New Patient,

Northwest Kidney Centers has a Patient Finance Department located in SeaTac at our Burien Pavillion. You have been assigned a Financial Case Manager to work with you to make sure you have the funding you need to cover dialysis services.

We know you may have a lot of questions regarding your dialysis funding. In order for your Financial Case Manager to be able to best answer your questions, we need you to complete and sign the following forms in your packet:

- Read the Patient Account Agreement, sign and date where indicated. There is also a copy of this form for you to *keep a copy for your records*.
- Fully complete the Patient Registration Form
- Sign Part I of the Appointment of Representative form for Social Security where it states "Signature (Claimant)"
- Sign the Department of Social and Health Services (DSHS) Authorization form in the box marked "Authorized By (Client Signature)"
- Provide a copy of your driver's license and insurance card(s). Free copies can be made at the dialysis center.
- If you were **not** born in the United States, provide a copy of your green card, passport or Visa. Free copies can be made at the dialysis center.

Once your Financial Case Manager receives the above information, they will call you to review your funding options and answer any questions you may have. Meanwhile, if you wish to speak with someone about dialysis coverage, call (206) 292-2771, press 0 and ask to speak to your Financial Case Manager.

Thank you very much,

Patient Finance Department
Northwest Kidney Centers

NORTHWEST Kidney Centers

Patient Account Agreement

By signing this form

I agree to pay for all services provided, arranged or furnished by Northwest Kidney Centers (NKC) according to the current rates and terms of the facility.

Financial Responsibility and Sources of Payment

- I agree to apply for and use all available funding sources that are needed to pay for NKC charges; NKC will provide a Financial Case Manager to assist with applications.
- I agree to provide NKC with any financial and personal information needed to obtain and maintain coverage from funding sources.
- I agree to pay any applicable charges not paid by funding sources.
- I agree to notifying NKC about any changes in funding sources, including:
  - Loss of or change in insurance coverage
  - Eligibility for new coverage
  - Enrollment in Medicare or Medicaid

Assignment of Benefits

- I agree to assign to NKC all insurance benefits payable toward NKC charges.
- I agree to forward NKC any insurance payments received that are intended to pay for NKC charges.

Authorization to Release Information

- I authorize NKC to release any needed information to funding sources in order to apply for funding or to determine eligibility and/or benefits payable.

I have read, or someone has read to me, the **Patient Account Agreement** (CKD-PE-42, 1/01/2023). I have received a copy and I understand the information.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

Patient Name **NKC #**

NORTHWEST Kidney Centers

Patient Registration Form

Patient Information

Legal name: _____

Last First Middle / Initial

Date of birth: _____ Sex assigned at birth: ☐ Male ☐ Female

Place of birth (City, State, Country): _____

How do you currently describe yourself?

☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ None of these

Maiden name: _____ Social Security Number: _____

Home address: _____

City: _____ State: _____ Zip code: _____ Primary phone: _____

Email address: _____ Secondary phone: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated

Spouse name: _____ Maiden name: _____

Spouse date of birth: _____ Spouse Social Security: _____

Do you understand health literature in English? ☐ Yes ☐ No

Do you need a different way other than written documents to learn about your health? ☐ Yes ☐ No

Is an interpreter needed? ☐ Yes ☐ No If yes, language: _____

Is transportation needed? ☐ Yes ☐ No

Are you hearing impaired? ☐ Yes ☐ No Are you visually impaired? ☐ Yes ☐ No

Do you have power of attorney? ☐ Yes ☐ No ☐ Not sure *If yes, please provide a copy.*

Do you have a living will or Physician Order for Life Sustaining Treatment (POLST)?

☐ Yes ☐ No ☐ Not sure

Do you have a caregiver who assists with your daily care? ☐ Yes ☐ No

Do you have a caregiver who can help you with home dialysis or after a kidney transplant? ☐ Yes ☐ No

If you have a caregiver, do they live with you? ☐ Yes ☐ No

NORTHWEST Kidney Centers

Patient Registration Form

Emergency Contacts

1. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

2. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

3. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

Employment

Current Employment:

☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Homemaker
☐ Medical leave ☐ Retired due to age/preference ☐ Retired (disability) ☐ Volunteer

Employment 6 months ago:

☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Homemaker
☐ Medical leave ☐ Retired due to age/preference ☐ Retired (disability) ☐ Volunteer

Employer name: _____ Phone number: _____

Employer address: _____

Number of employees: ☐ Over 20 ☐ Over 100

If you are retired, please provide the reason and date of retirement:

_____

Are you on medical leave? ☐ Yes ☐ No

If yes, start date of medical leave: _____ end date of medical leave: _____

Are you on COBRA or elected COBRA coverage? ☐ Yes ☐ No

If yes, start date of coverage: _____ end date of coverage: _____

NORTHWEST Kidney Centers

Patient Registration Form

Have you served in the military? ☐ Yes ☐ No

If yes, dates of service: from year _____ to year _____

Citizenship, Race & Ethnicity

Are you a U.S. citizen? ☐ Yes ☐ No

If you were not born in the United States, please provide a copy of your passport or Visa.

Are you an undocumented resident? ☐ Yes ☐ No

Are you a resident of Washington State? ☐ Yes ☐ No

Please self-identify your race and ethnicity. For American Indian/Alaskan Native responders, please indicate tribal affiliation(s).

Ethnicity: Country of Origin: _____

☐ Non-Hispanic or Non-Latino
☐ Hispanic or Latino

Race (check all that apply):

☐ American Indian/Alaska Native Name of Enrolled/Principal Tribe: _____

☐ Asian
- ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese
- ☐ Guamanian or Chamorro ☐ Other Asian

☐ Black or African American

☐ Middle Eastern or North Africa

☐ Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan

☐ White

☐ Multiracial (check all that apply)

☐ Other if unable to identify with any of these races

NORTHWEST Kidney Centers

Patient Registration Form

Medical History

Are you on the list for a kidney transplant or currently working with a transplant program?

☐ Yes ☐ No ☐ Unknown

If yes, hospital name: _____

Have you ever had a kidney transplant? ☐ Yes ☐ No

If yes, hospital name: _____ City/State: _____

Do you understand your options when it comes to kidney transplant? ☐ Yes ☐ No

Do you understand your options for a living donor transplant? ☐ Yes ☐ No

Have you been on dialysis before? ☐ Yes ☐ No

If yes, dates of dialysis treatment: from month/year _____ to month/year _____

City/State: _____

Do you understand what the options are for performing dialysis at home? ☐ Yes ☐ No

Insurance Information

Please complete the information and provide a copy of your insurance card(s).

Medicare number: _____ Effective date A/B: _____

Do you need help with insurance premiums, including COBRA? ☐ Yes ☐ No

Do you need help with prescription costs? ☐ Yes ☐ No

Insurance name: _____

Group number: _____ Policy number: _____

Subscriber name: _____ Effective date: _____

Have you applied for Medicaid from the Department of Social and Health Services (DSHS)?

☐ Yes ☐ No ☐ Not sure

Do you have prescription coverage? ☐ Yes ☐ No

NORTHWEST Kidney Centers

Patient Registration Form

Do you expect a change in your or your spouse's employment any time soon? ☐ Yes ☐ No

If yes, what change and how soon? _____

Number of years you have worked and paid Social Security taxes? _____

Number of years your spouse worked and paid Social Security taxes? _____

Are you currently receiving Social Security income? ☐ Yes ☐ No

Please complete if you are receiving insurance benefits through someone other than yourself.

Name: _____ Relationship: _____

Current Employment:

☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Homemaker
☐ Medical leave ☐ Retired due to age/preference ☐ Retired (disability) ☐ Volunteer

Employer name: _____ Phone number: _____

Employer address: _____

Number of employees: ☐ Over 20 ☐ Over 100

If you are retired, please provide the reason and date of retirement:

_____

FOR FACILITY USE ONLY

Staff Name: _____ Date: _____

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** Northwest Kidney Centers/Patient Finance Dept.

***ADDRESS OF PERSON OR ORGANIZATION:** 12901 20th Ave S, SeaTac, WA 98168-5159

***I want this information released because:** It is required by the state Medicaid Program

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☑ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Medicare award letter or denial letter, Social Security Award letters.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Authorized Representative

An Authorized Representative is someone you designate to represent you when you apply for or receive benefits with the Department of Social and Health Services (DSHS) or Health Care Authority (HCA). This individual or organization is authorized to act on your behalf for eligibility purposes. Having an authorized representative is optional; DSHS or HCA cannot withhold benefits if you do not sign this form.

Client Information

NAME	ACES CLIENT ID NUMBER

Authorized Representative Information

NAME	ORGANIZATION AND DEPARTMENT (IF APPLICABLE)	PHONE NUMBER (AREA CODE)
	Northwest Kidney Centers	(206) 292-2771

MAILING ADDRESS	CITY	STATE	ZIP CODE
12901 20th Ave S	SeaTac	WA	98168-5159

Program and Duration Information

Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply.

☐ Cash Benefits ☐ Basic Food Benefits ☒ Health Care Coverage ☐ Long-term Care Coverage

How long do you want your authorized representative to act on your behalf?

☐ 90 days ☒ End of certification period (usually one year)

You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.

Correspondence Information

Please check the level of information or benefits you want your authorized representative to receive.

	FOR DEPARTMENT USE ONLY Rep Type
For Cash, Basic Food, Health Care Coverage or Long-Term Care (check only one of the four boxes below)	
☐ Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.	NC
☐ Receive DSHS/HCA letters and discuss my eligibility for benefits.	NO
☒ Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.	AD
☐ Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits	NA
For Health Care Coverage Only (check either box below if applicable)	
☐ Hospital representative – receive letters and discuss my eligibility for benefits.	HO
☐ Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery	SB

Client Authorization

AUTHORIZED BY (CLIENT SIGNATURE) DATE SIGNED	PRINT NAME	PHONE NUMBER (AREA CODE)

NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a DSHS 14-012, Consent form. This includes disclosure of mental health information, HIV/AIDS and STD test results, or treatment and chemical dependency services.

FOR DEPARTMENT USE ONLY
INSTRUCTIONS

Rep Type – ACES does not limit the Rep Type selections to the codes listed above. If a program requires a Rep Type not listed above or if one of the above codes is selected but is not appropriate for the situation (such as for a group home, protective payee, etc.) enter the appropriate program specific Rep Type on the AREP screen.

Barcode label

14532

JOINT NOTICE OF PRIVACY PRACTICES

This Joint Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice applies to all health information created or received by the medical staff, health care workers, employees, contract staff, students, trainees, and volunteers at Northwest Kidney Centers ("NKC").

For purposes of complying with the Health Information Portability and Accountability Act ("HIPAA"), NKC and its medical staff, which includes members of the Division of Nephrology from the University of Washington, designate themselves an Organized Health Care Arrangement ("OHCA"). They may share health information with each other for treatment, payment, and health care operations of the OHCA and as described in this Notice.

Personal Health Information About You

The following list identifies the different ways we may use and disclose your health information. In most cases, we will use and disclose only the minimum health information necessary for the purpose.

Treatment, Payment, and Health Care Operations

To Treat You: We may use and share health information about you to give you care and to manage your treatment or other services. For example, we may tell a doctor needing to perform surgery on you that you are on dialysis.

To Be Paid for Our Services: We may use and share health information about you to bill and collect payment for services received. We will get your authorization to disclose this information. For example, we may submit a bill to your health plan for care we provided you.

For Our Operations: We may use and disclose information about you to run our business. For example, we may use health information about you to review the quality of care we are providing.

Uses and Disclosures When You Do Not Object

We may use and disclose health information about you for the purposes below, but only after you have had the chance to object, unless otherwise permitted by law.

- To family and friends who are involved in your care or to notify familyand friends of your condition or location.
- To provide directory information (for example, to confirm you are in our facility).
- For emergency and notification purposes, such as to a disaster relief agency to coordinate disaster relief efforts.

Uses and Disclosures of Health Information Not Requiring Your Permission

We may use and disclose health care information for the following reasons without your permission.

- For public health and safety.
- For health and safety oversight activities.
- To other entities that we contract to assist us. We require these entities to protect the privacy and confidentiality of your health information.

- Incidental disclosures that happen during permitted uses and disclosures, such as someone in the waiting room hearing your name called.
- For education. We may send educational materials and newsletters to you to keep you informed about your care.
- For fundraising. We may contact you as part of a fundraising effort, but **you have the right to tell us you do not wish to receive fundraising communications**.
- To avert a serious threat to health or safety.
- For a court order, subpoena, search warrant, or other legal or law enforcement purpose.
- As de-identified information or part of a limited data set, after removing information that could be used to identify you, as allowed by law.
- To organ procurement organizations or persons who obtain, store, or transplant organs.
- For specialized government functions, such as for national security purposes.
- To correctional institutions, if you are in prison or in police custody.
- To report suspected child abuse or neglect or other abuse or neglect.
- To military or veterans' authorities if you are or were affiliated with the military.
- To coroners, medical examiners, or funeral directors to perform their duties.
- To comply with workers' compensation laws for workers' compensation claims.
- To personal representatives for minors and incapacitated adults.
- As otherwise required by law.

Additional Protections

We provide additional protections to your health information and may need your permission, as required by law, to share information related to AIDS/HIV, sexually transmitted and another communicable disease, drug and alcohol abuse, and mental health services.

Authorization

Other uses and disclosures will be made only with your authorization. For example, we need your permission to use and disclose health information for marketing; if we are receiving something of value for the health information; or psychotherapy notes. In most cases, you have the right to revoke or cancel your authorization, in writing, at any time.

Your Rights

You have personal rights concerning your health information. You may act on these rights by contacting your Northwest Kidney Centers Social Worker or the Northwest Kidney Centers privacy officer at:

Compliance & Privacy Officer
Northwest Kidney Center
12901 20th Avenue South
SeaTac, WA 98168
Phone: 206-720-8806
PrivacyOfficer@nwkidney.org

- You can file a complaint with at:

  U.S. Department of Health and Human Services
  Office for Civil Rights
  200 Independence Avenue, S.W.,
  Washington, D.C. 20201
  Phone: 877-696-6775
  https://www.hhs.gov/hipaa/filing-a-complaint/index.html

We will not retaliate against you for filing a complaint.

Additional Rights

Ask us to limit the information that we use and share: You have the right to ask us in writing to limit uses or disclosures of information about you for treatment, payment, and business purposes. We may deny your request in certain situations.

Request confidential communications: You have the right to receive confidential communications in other ways or at other locations. This includes a different mailing address or an email address.

Inspect and copy: In most cases, you have the right to look at health information about you or request a paper or electronic copy. You also may ask us to send an electronic copy of your health information to another person if your request is in writing, signed by you, and clearly says who the person is where to send the health information. We may charge a reasonable, cost-based fee.

Request changes: You have the right to request that we correct information in your record or add information you believe is missing. Wemay deny your request in certain situations.

Know about disclosures: You have the right to ask for and receive a list (called an accounting) of times where we have disclosed information about you, except for disclosures for treatment, payment, related business purposes, or other disclosures specified by law.

Receive a copy of this Notice: You have the right to receive a paper copy of this Notice, even if you received an electronic copy of this Notice.

Our Duties

We are required by law to keep health information about you private. We must give you this Notice of our legal duties and privacy practices, and we must follow the practices that are stated in the Notice. We will notify you if there is a breach of unsecured health information about you.

Changes to This Notice

We reserve the right to change this Notice. The revised Notice will be effective for information we already have about you as well as any information we receive in the future. Unless required by law, the revised Notice will be effective on the new effective date of the Notice. For a copy of the current Notice, please ask at one of our registration areas. The current Notice also is posted on our website (www.nwkidney.org) and in our facilities. The notice will state an effective date.

NORTHWEST Kidney Centers

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I am a patient or a personal representative of a patient of Northwest Kidney Centers. By signing this form, I acknowledge that I have been offered a copy of the Northwest Kidney Centers Joint Notice of Privacy Practices.

Name: _____

(Please Print)

Signature: _____

Date: _____

OR

I am the parent or legal guardian of:

_____

(patient name)

I hereby acknowledge that I have been offered a copy of the Northwest Kidney Centers Joint Notice of Privacy Practices with respect to the above-named patient.

Name: _____

(please print)

Relationship to Patient (please check one):

☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

NORTHWEST Kidney Centers

Dear New Patient

Welcome to Northwest Kidney Centers! We were the first outpatient dialysis provider in the world. Northwest Kidney Centers is private, non-profit, and committed to being a model in our field in improving the health and survival of people with kidney disease.

Starting dialysis is hard. Our job is to make it easier for you, by educating you and giving you information about how to live well on dialysis.

At Northwest Kidney Centers, we believe in education. Over the next several months, your care team will be spending a lot of time with you to help you understand:

- What you can do to improve your health and survival
- Your kidney disease
- How dialysis works and how it affects your body
- Other treatments—home dialysis and transplant
- What to do in an emergency

If you have questions, ask! Don't be afraid to say if you don't understand something—there is a lot to learn.

Dialysis is a lifesaving treatment. Let's work together to make sure you understand how to make **your life** as long and as healthy as possible.

Let's get started!

Your Northwest Kidney Centers' Care Team

First Treatment Discharge Instructions

Important information

Nephrologist's number _____

Unit phone number _____

Your next dialysis is:

_____

(Date) (Day) (Time)

Your ongoing schedule is:

_____

(Days of the week) (Arrival time) (Dialysis time)

- Remember to arrive 30 minutes early
- Call the dialysis unit if you cannot make it to your next dialysis treatment

Activities

- It is normal to feel tired after your first dialysis treatment
- Resume normal activity as you feel ready
- Continue with your medications
- Resume the diet you were eating prior to your first dialysis treatment

Access issues

- If you have bleeding from the access site
  - Press down on the area with gauze or clean cloth until bleeding stops
- If you have bruising at your access site
  - Put ice on the area right away and several times in the next 24 hours for 20 minutes each time
- If your catheter dressing gets wet, dirty or comes off

Contact your Nephrologist if —

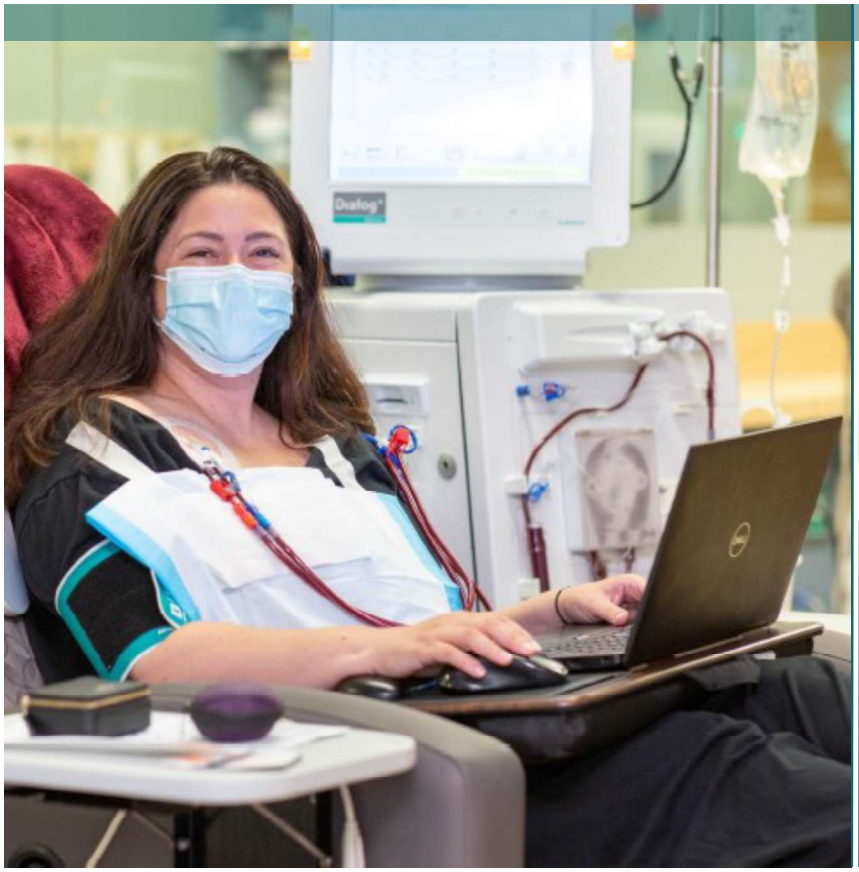
- You have a fever or chills, the skin around your access is painful, hot, red, swollen or has pus
- You do not feel a buzzing sensation or hear the swish of blood in your fistula or graft
  - Don't eat or drink until you get directions from your doctor
- If your catheter is loose or coming out
  - Don't try to put it back in or move it
  - Tape the catheter down if you can
- You have questions or concerns about your condition

Seek care immediately or call 911 if—

- You have sudden chest pain, rapid heartbeat, or trouble breathing
- You cannot get bleeding to stop from access sites after applying pressure

NORTHWEST Kidney Centers

CKD-PE-47



A round-the-clock, secure way to track your dialysis care

Sign up for our online patient portal

Real-time care information at your fingertips

MyNWKidney

Gives you access to you medical records

- Lab results
- Treatment data
- Medications and immunizations
- Hospitalizations and problem lists

Ask your care team to help get you started today!

- Your care team will add your account
- You will be given a registration code good for 72 hours
- Use the code to verify your account

NORTHWEST Kidney Centers