

## New Patient Admission Worksheet

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.

<b>Prior to Patient Arrival</b>		<b>Core Task</b>
<input type="checkbox"/>	Review all documentation included with referral & initial order form	X
<input type="checkbox"/>	Enter dialysis orders	X
<input type="checkbox"/>	Enter labs per standing orders	X
<input type="checkbox"/>	Verify lab tests entered in lab portal for 1st treatment	X
<input type="checkbox"/>	Review records for required Treatment Alerts (e.g., Hepatitis B+ status)	X
<input type="checkbox"/>	Enter allergies	X
<input type="checkbox"/>	Enter code status (verify if POLST Form is completed)	X
<input type="checkbox"/>	Enter primary dialysis justification to Problem List (N18.6 or N17.9)	X
<input type="checkbox"/>	Enter access on Dialysis Accesses screen	X
<input type="checkbox"/>	Enter access surgeon on access and contact screens (if available)	X

<b>Prior to Initiating Treatment</b>		<b>Core Task</b>
<input type="checkbox"/>	Review & have patient sign consents – Provide photocopies to patient after signed <ul style="list-style-type: none"> <li>• Informed Consent for Treatment (CKD-PE-37)</li> <li>• 2728 Form (print name on page 1, have patient sign page 5, do not date form)</li> <li>• Joint Notice of Privacy Practices</li> </ul>	X

\_\_\_\_\_  
 Patient Name

\_\_\_\_\_  
 NKC #

<input type="checkbox"/>	Review & have patient sign Patient Finance Packet – Provide photocopies to patient after signed <ul style="list-style-type: none"> <li>• Patient Account Agreement (CKD-PE-42, 42a)</li> <li>• Patient Registration Form (CKD-PE-51)</li> <li>• Social Security Administration Release of Information (Form SSA-3288)</li> <li>• DSHS Authorized Representative Consent (DSHS 14-532)</li> </ul>	X
<input type="checkbox"/>	Review with patient (Handouts) Welcome to Northwest Kidney Centers! (CKD-PE-52)	X PCT
<input type="checkbox"/>	Obtain copy of picture ID and insurance cards (if available)	X PCT
<input type="checkbox"/>	Conduct quick orientation tour of the dialysis facility, including: <ul style="list-style-type: none"> <li>• Location/use of the restroom (including location of call light)</li> <li>• Location of sink to clean vascular access</li> <li>• Use of the scale</li> </ul>	X PCT
<input type="checkbox"/>	Measure and enter patient's height	X PCT
<input type="checkbox"/>	If pt has a AVF/AVG, instruct and observe patient washing access.	X
<input type="checkbox"/>	Conduct Pre-dialysis Patient Assessment (must be done by RN) including but not limited to: <ul style="list-style-type: none"> <li>• Pre-dialysis assessment</li> <li>• Assessment of access</li> <li>• Review of any known allergies</li> <li>• Review of medications taken last 24 hours</li> </ul>	X
<input type="checkbox"/>	Ultra-sound AVF, if medically indicated	
<input type="checkbox"/>	If diabetic, assess for risk of hypoglycemic episode during dialysis treatment	X

<b>Once the Patient Initiates Dialysis</b>		<b>Core Task</b>
<input type="checkbox"/>	Review with the patient the following: <ul style="list-style-type: none"> <li>• Location and use of call button</li> <li>• Length of treatment</li> <li>• Repeat information about most common side effects of dialysis (nausea, cramping, pain, dizziness, headache)</li> <li>• Use of a cell phone, TV, chair</li> <li>• Ability to have visitors with use of proper PPE per NKC policy</li> </ul>	X PCT

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Patient Name

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NKC #

<input type="checkbox"/>	Enter home medications into Medications screen	
<b>Post Treatment</b>		<b>Core Task</b>
<input type="checkbox"/>	Review with patient (Handout) <ul style="list-style-type: none"> <li>• First Treatment Discharge Instructions (CKD-PE-47)</li> <li>• Patient Portal Information</li> </ul>	X
<input type="checkbox"/>	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)  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b><u>Fistula/Graft</u></b></p> <p>(4) 4x4 gauze</p> <p>(1) 1-inch single use paper tape</p> </div> <div style="width: 45%;"> <p><b><u>IJ Catheter</u></b></p> <p>(1) Chlorascrub pad</p> <p>(4) 2x2 gauze</p> <p>(1) 1-inch single use paper tape</p> <p>(2) Mask</p> <p>(2) Gloves</p> </div> </div>	X PCT
<input type="checkbox"/>	Enter Primary Prescription & Primary Modality on General Information	X
<input type="checkbox"/>	Enter access status	
<input type="checkbox"/>	Verify first treatment is posted in Real Time Charting	X
<input type="checkbox"/>	Enter admission progress note	X
<input type="checkbox"/>	Initiate Patient Education checklist & document required items & handouts, including: NKC Consents, Rights & Responsibilities within first six treatments, access care education, ESA medication guide (as necessary)	X
<input type="checkbox"/>	Notify the following staff of patient admission, include the following: <ul style="list-style-type: none"> <li>• Clinical Informatics Team (support@nwkidney.org)</li> <li>• Patient Finance Team (PatientFinanceList@nwkidney.org)</li> <li>• Clinical Supervisor/Manager</li> <li>• Primary Care Nurse(s)</li> <li>• Social Worker(s)</li> <li>• Dietitian(s)</li> </ul>	X

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 Patient Name

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 NKC #

## 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 (SSN) 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. What is your sex?

☐ Male ☐ Female

9. Is patient applying for ESRD Medicare coverage? ..... ☐ Yes ☐ No

10. Current medical coverage (check all that apply)

- ☐ Employer group health insurance  
☐ Medicare  
☐ Medicaid  
☐ Veterans Administration  
☐ Medicare Advantage  
☐ Other  
☐ None

11. Height: inches \_\_\_\_\_ OR centimeters \_\_\_\_\_ 12. Dry weight: pounds \_\_\_\_\_ OR kilograms \_\_\_\_\_

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

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

Prior Current

- ☐ ☐ Unemployed  
☐ ☐ Employed full time  
☐ ☐ Employed part time  
☐ ☐ Homemaker  
☐ ☐ Retired due to age/preference

Prior Current

- ☐ ☐ Retired (disability)  
☐ ☐ Medical leave of absence  
☐ ☐ Student  
☐ ☐ Volunteer

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.

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

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

16. 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

17. 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). (select one)

☐ 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	____.____	

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

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

20. 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

21. Do you have access to reliable transportation? .....☐ Yes   ☐ No

22. Do you understand the information received to make an informed healthcare decision? .....☐ Yes   ☐ No

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

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

25. 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

26. Name of dialysis facility

27. CMS Certification Number (CCN) (for item 26)

28. Primary dialysis setting (select one)

☐ Home   ☐ In-center   ☐ SNF/LTC\*

29. Primary type of dialysis (select one)

☐ Hemodialysis (sessions per week \_\_\_\_/minutes per session \_\_\_\_ )   ☐ CAPD   ☐ CCPD   ☐ Other

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

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

32. Does the patient understand kidney transplant options at the time of admission?\* .....☐ Yes   ☐ No

☐ N/A (if patient answered yes to question 16(g))

33. 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

34. Has the patient been connected to a transplant center with a referral?\* .....☐ Yes   ☐ No

Date of referral (mm/dd/yyyy): \_\_\_\_\_

Name of transplant center: \_\_\_\_\_

35. Does the patient understand home dialysis options at the time of admission?\* .....☐ Yes   ☐ No

☐ N/A (if patient answered yes to question 16(f))

36. 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

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**C. Complete for all kidney transplant patients**

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

38. Name of transplant hospital

39. CMS Certification Number (CCN) (for item 38)

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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.

40. Enter date (mm/dd/yyyy)

41. Name of preparation hospital

42. CMS Certification Number (CCN) (for item 41)

43. Current status of transplant (if functioning, skip items 45 and 46)

☐ Functioning ☐ Non-functioning

44. Type of transplant (select one)

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

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

46. Current dialysis setting (select one)

☐ Home ☐ In-center ☐ SNF/LTC\* ☐ Transitional care unit\*

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

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47. Name of training provider

48. CMS Certification Number (CCN) of training provider (for item 47)

49. Date training began (mm/dd/yyyy)

50. Type of training

☐ Hemodialysis (select one): a. ☐ Home b. ☐ In-center☐ CAPD☐ CCPD☐ Other51. This patient is expected to complete (or has completed) training and will self-dialyze on a regular basis. .... ☐ Yes ☐ No

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

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**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.**

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

a. Printed name

b. Signature

c. Date (mm/dd/yyyy)

54. NPI of physician (for item 53)

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\*Go to instructions

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**E. Physician Identification**

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55. Attending physician (print)

56. Physician's phone number (include area code)

57. 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.

58. Attending physician's signature of attestation (same as item 55)

59. Date (mm/dd/yyyy)

60. Physician recertification signature

61. Date (mm/dd/yyyy)

62. Remarks

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**F. Obtain signature from patient**

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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.

63. Signature of patient (signature by mark must be witnessed.)

64. 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)

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**G. Privacy statement**

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0046 (Expires 11/30/2026). This is a mandatory to obtain a benefit ESRD Medicare information collection. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the ESRD Network in your region.



## Northwest Kidney Centers Informed Consent for Treatment

I have the right to make decisions about my healthcare. My nephrologist (kidney doctor) has explained to me that I have a form of kidney failure called acute kidney injury (AKI) or 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 (AKI or 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, choose to stop dialysis later (which may 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 not currently able or are no longer able to clean the waste and extra fluid from my blood. Since my kidneys are not working, I need dialysis as a lifesaving treatment. I understand 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 may 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, but are not limited to:

- 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, and/or 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 dialysis
- 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, including 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 authorized 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, regain kidney function, or transfer care to another dialysis provider, this consent will be terminated and a new Consent for Treatment will be required upon my return to NKC. I can cancel this consent in writing at any time and NKC can cancel it in writing at any time.

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## Northwest Kidney Centers Informed Consent for Treatment 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** (CKD-PE-37, 11/13/2025). I have been offered a copy, have had any questions answered, and I understand the information.

### Signed:

\_\_\_\_\_  
Patient Name (Print)

X

\_\_\_\_\_  
Patient Signature

☐ Patient    ☐ Legal Guardian/Representative    ☐ Power of Attorney

\_\_\_\_\_  
Date

\_\_\_\_\_  
NKC Staff Witness Name (Print)

X

\_\_\_\_\_  
NKC Staff Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Translator or Reader Witness Name (Print)

X

\_\_\_\_\_  
Signature

☐ Reader    ☐ Translator

\_\_\_\_\_  
Date

**When this form requires two witnesses per NKC Patient Consents Policy, a second NKC staff must sign:**

\_\_\_\_\_  
NKC Staff Witness Name (Print)

X

\_\_\_\_\_  
NKC Staff Witness Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_

NKC# \_\_\_\_\_

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

## 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 #**

## 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 ☐ Separated ☐ Domestic Partner

Spouse name: \_\_\_\_\_ Maiden name: \_\_\_\_\_

Spouse date of birth: \_\_\_\_\_ Spouse Social Security: \_\_\_\_\_

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



## 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: \_\_\_\_\_

## 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

## 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

## 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: \_\_\_\_\_

**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](http://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](http://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](http://www.socialsecurity.gov). Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TTY 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.***

**Consent for Release of Information**

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:**

**\*ADDRESS OF PERSON OR ORGANIZATION:**

Northwest Kidney Centers/Patient Finance Dept.

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) Northwest Kidney Centers	PHONE NUMBER (AREA CODE) (206) 292-2771	
MAILING ADDRESS 12901 20th Ave S	CITY SeaTac	STATE WA	ZIP CODE 98168-5159
Program and Duration Information			
<p>Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply.</p> <p><input type="checkbox"/> Cash Benefits   <input type="checkbox"/> Basic Food Benefits   <input checked="" type="checkbox"/> Health Care Coverage   <input type="checkbox"/> Long-term Care Coverage</p> <p>How long do you want your authorized representative to act on your behalf?</p> <p><input type="checkbox"/> 90 days   <input checked="" type="checkbox"/> End of certification period (usually one year)</p> <p>You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.</p>			
Correspondence Information			
<p>Please check the level of information or benefits you want your authorized representative to receive.</p> <p><b><u>For Cash, Basic Food, Health Care Coverage or Long-Term Care</u></b> <b><u>(check only one of the four boxes below)</u></b></p> <p><input type="checkbox"/> Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters and discuss my eligibility for benefits. ....</p> <p><input checked="" type="checkbox"/> Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits .....</p> <p><b><u>For Health Care Coverage Only (check either box below if applicable)</u></b></p> <p><input type="checkbox"/> Hospital representative – receive letters and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery .....</p>			<p><b>FOR DEPARTMENT USE ONLY</b></p> <p><b>Rep Type</b></p> <p><b>NC</b></p> <p><b>NO</b></p> <p><b>AD</b></p> <p><b>NA</b></p> <p><b>HO</b></p> <p><b>SB</b></p>
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.

DSHS 14-532 (REV. 11/2014)

Barcode label



14532

## JOINT NOTICE OF PRIVACY PRACTICES

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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 family and 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](mailto: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. We may 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](http://www.nwkidney.org)) and in our facilities. The notice will state an effective date.

**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: \_\_\_\_\_

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

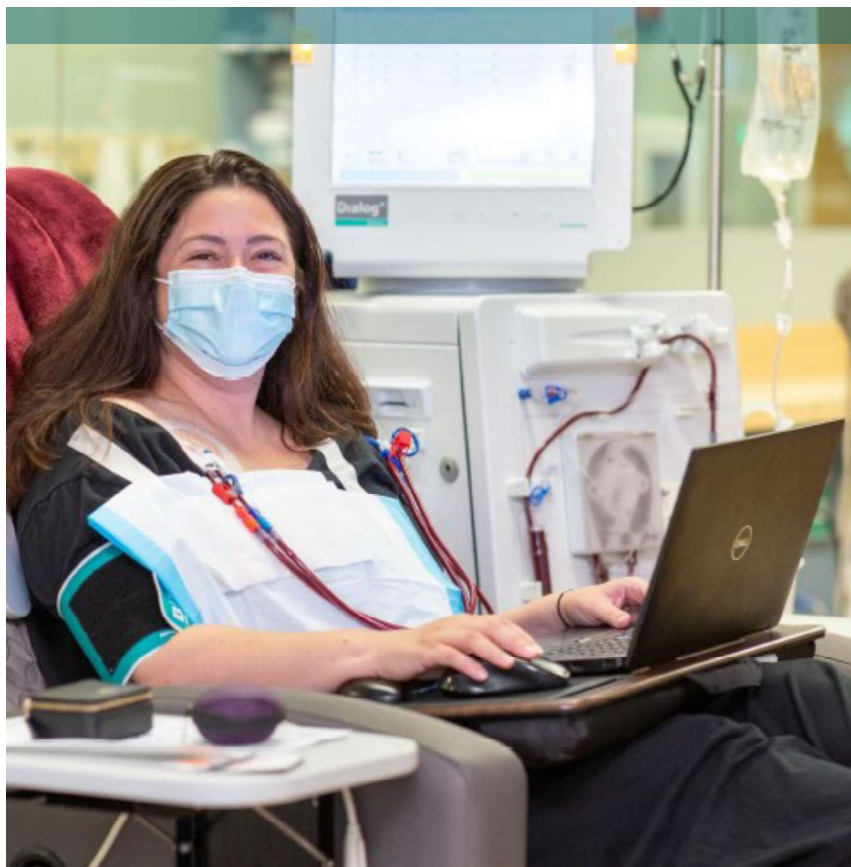
- If you have bleeding from the access site
  - Press down on the area with gauze or clean cloth until bleeding stops
- If you have bruising at your access site
  - Put ice on the area right away and several times in the next 24 hours for 20 minutes each time
- If your catheter dressing gets wet, dirty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



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 your 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