NORTHWEST Kidney Centers

# New Patient Admission
# Acute AKI Patient Worksheet

(Packet B)

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 |
| ☐ | Enter allergies | X |
| ☐ | Enter code status (verify if POLST Form is completed) | X |
| ☐ | Enter primary dialysis justification to Problem List (N17.9) | 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<br>• Informed Consent for Treatment (CKD-PE-62)<br>• Joint Notice of Privacy Practices | X |
| ☐ | Review & have patient sign Patient Finance Packet – Provide photocopies to patient after signed<br>• Patient Account Agreement (CKD-PE-42)<br>• Patient Registration Form (CKD-PE-51)<br>• Social Security Administration Release of Information (Form SSA-3288)<br>• DSHS Consent Authorized Representative Consent (DSHS 14-532) | X |

Patient Name ______________________  NKC # ______________



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| | | |
|---|---|---|
| ☐ | Review with patient (Handouts)<br>Welcome to Northwest Kidney Centers! (CKD-PE-52) | X<br>PCT |
| ☐ | Obtain copy of picture ID and insurance cards (if available) | X<br>PCT |
| ☐ | Conduct quick orientation tour of the dialysis facility, including:<br>• Location/use of the restroom (including location of call light)<br>• Location of sink to clean vascular access<br>• Use of the scale | X<br>PCT |
| ☐ | Measure (PCT may take) and enter patient's height | X<br>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:<br>• Pre-dialysis assessment<br>• Assessment of access<br>• Review of any known allergies<br>• 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:<br>• Location and use of call button<br>• Length of treatment<br>• Repeat information about most common side effects of dialysis (nausea, cramping, pain, dizziness, headache)<br>• Use of a cell phone, TV, chair<br>• Ability to have visitors with use of proper PPE per NKC policy | X<br>PCT |
| ☐ | Enter home medications into record | |
| **Post Treatment** | | **Core Task** |
| ☐ | Review with patient (Handout)<br>• First Treatment Discharge Instructions (CKD-PE-47)<br>• Patient Portal Information | X |

Patient Name ____________________ NKC # ____________



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| | | |
|---|---|---|
| ☐ | Include appropriate instruction and supply list document:<br>Access Care supplies packet – Fistula or Graft (CKD-PE-49)<br>Access Care supplies packet – IJ Catheter (CKD-PE-48)<br><br>Provide patient with access care supplies (based on type of access)<br><br>***Fistula/Graft***<br>(4) 4x4 gauze<br>(1) 1-inch single use paper tape<br><br>***IJ Catheter***<br>(1) Chlorascrub pad<br>(4) 2x2 gauze<br>(1) 1-inch single use paper tape<br>(2) Mask<br>(2) Gloves | X<br>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<br><br>*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:<br>• Clinical Informatics Team (support@nwkidney.org)<br>• Patient Finance Team (PatientFinanceList@nwkidney.org)<br>• Clinical Supervisor/Manager<br>• Primary Care Nurse(s)<br>• Social Worker(s)<br>• Dietitian(s) | X |

Patient Name ______________________ NKC # ____________


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NORTHWEST Kidney Centers

# Northwest Kidney Centers Informed Consent for Treatment for Non-ESRD (AKI) Patients

I have the right to make decisions about my healthcare. My kidney doctor (nephrologist) has explained to me that I have a form of kidney failure called acute kidney injury (AKI).

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

## Information about my kidney failure (AKI)

- My kidney doctor has explained my kidney failure to me
- My kidney doctor told me what to expect from hemodialysis, the effects of treatment, and the risks of dialysis treatments
- NKC provides the hemodialysis 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

## Kidney function and dialysis

I know my kidneys are not currently able to clean the wastes and extra fluid from my blood. Since my kidneys are not working, I need dialysis as a lifesaving treatment. I am not able to live without dialysis.

During hemodialysis my blood moves through tubing connected to me and is passed through a filter (dialyzer) and returned back to my body. The dialyzer removes waste products and extra fluid from my body.

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.

## NKC services

- Hemodialysis provided at an NKC dialysis center
- Laboratory draws to determine how well my dialysis is working and whether my kidneys are recovering
- Medications or special diet needs will be ordered specifically for me by my kidney doctor

**Patient Name** ______________________ **NKC#** ____________


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## NKC services (continued)

- 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.

## Treatment choices

- I have the choice to not start dialysis, or to stop dialysis treatments at any time
- NKC staff is available to discuss these choices at any time and will support my choices
- I understand that stopping or not starting dialysis treatments may result in my death

## 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

**Patient Name** ______________________ **NKC#** ____________


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## 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 due to hospital stay. If I 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#** ______________


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NORTHWEST Kidney Centers

# Northwest Kidney Centers Informed Consent for Treatment for Non-ESRD (AKI) 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 Non-ESRD (AKI) Patients** (CKD-PE-62, 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


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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

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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 #**

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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



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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: ______________



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CKD-PE-51 09/19/2024

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



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# 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



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# 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: ____________



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# 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) |

Washington State Department of Social & Health Services — Transforming lives

# Authorized Representative

Washington State Health Care Authority

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<br>**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**

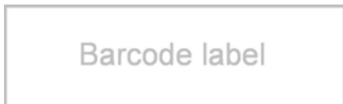
| AUTHORIZED BY (CLIENT SIGNATURE) | DATE SIGNED | PRINT NAME | PHONE NUMBER (AREA CODE) |
|---|---|---|---|
| | | | |

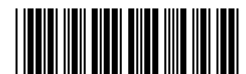
NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a DSHS 14-012, Consent form. This includes disclosure of mental health information, 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.**





NORTHWEST Kidney Centers

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 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: ______________________________________________

# First Treatment Discharge Instructions

## Important information

Nephrologist's number ___________________

Unit phone number _______________________

## Your next dialysis is:

_______________________________________

(Date) (Day) (Time)

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

## Your ongoing schedule is:

_______________________________________

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

## 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

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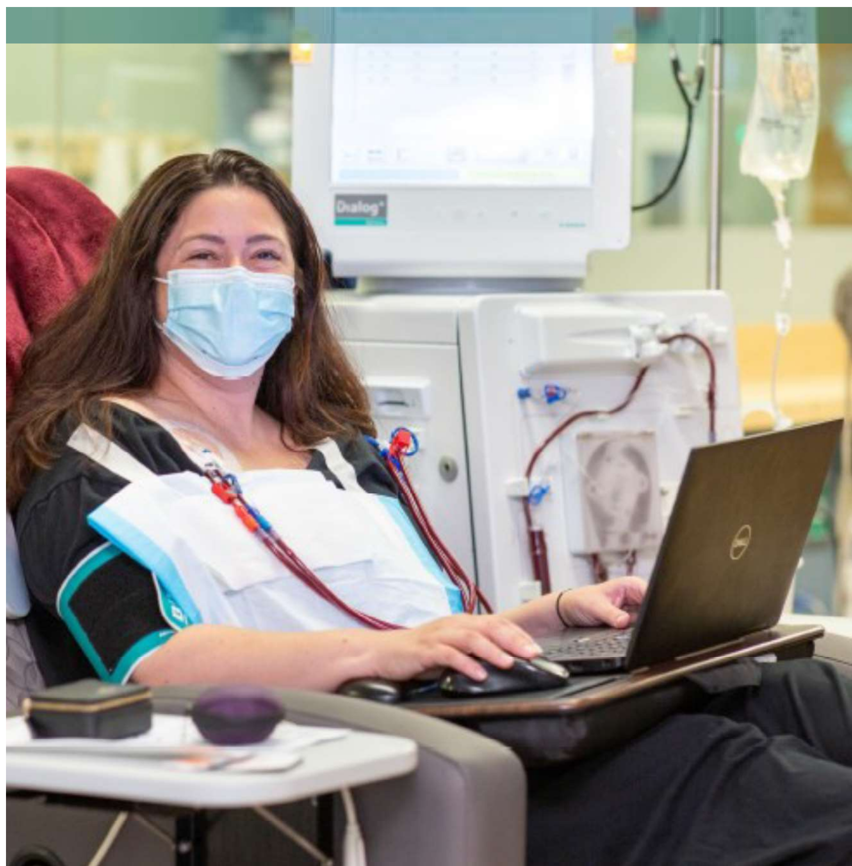
CKD-PE-47



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

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Kidney Centers