NORTHWEST Kidney Centers

Dear New Patient,

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

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

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

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

Thank you very much,

Patient Finance Department
Northwest Kidney Centers

NORTHWEST Kidney Centers

Patient Account Agreement

By signing this form

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

Financial Responsibility and Sources of Payment

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

Assignment of Benefits

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

Authorization to Release Information

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

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

Signed:

_____
Patient Name (Print)

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

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

Patient Name **NKC #**

NORTHWEST Kidney Centers

Patient Registration Form

Patient Information

Legal name: _____

Last First Middle / Initial

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

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

How do you currently describe yourself?

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

Maiden name: _____ Social Security Number: _____

Home address: _____

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

Email address: _____ Secondary phone: _____

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

Spouse name: _____ Maiden name: _____

Spouse date of birth: _____ Spouse Social Security: _____

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

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

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

Is transportation needed? ☐ Yes ☐ No

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

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

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

☐ Yes ☐ No ☐ Not sure

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

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

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

NORTHWEST Kidney Centers

Patient Registration Form

Emergency Contacts

1. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

2. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

3. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

Employment

Current Employment:

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

Employment 6 months ago:

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

Employer name: _____ Phone number: _____

Employer address: _____

Number of employees: ☐ Over 20 ☐ Over 100

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

_____

Are you on medical leave? ☐ Yes ☐ No

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

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

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

Patient Registration Form

Have you served in the military? ☐ Yes ☐ No

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

Citizenship, Race & Ethnicity

Are you a U.S. citizen? ☐ Yes ☐ No

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

Are you an undocumented resident? ☐ Yes ☐ No

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

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

Ethnicity: Country of Origin: _____

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

Race (check all that apply):

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

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

☐ Black or African American

☐ Middle Eastern or North Africa

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

☐ White

☐ Multiracial (check all that apply)

☐ Other if unable to identify with any of these races

NORTHWEST Kidney Centers

Patient Registration Form

Medical History

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

☐ Yes ☐ No ☐ Unknown

If yes, hospital name: _____

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

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

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

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

Have you been on dialysis before? ☐ Yes ☐ No

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

City/State: _____

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

Insurance Information

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

Medicare number: _____ Effective date A/B: _____

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

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

Insurance name: _____

Group number: _____ Policy number: _____

Subscriber name: _____ Effective date: _____

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

☐ Yes ☐ No ☐ Not sure

Do you have prescription coverage? ☐ Yes ☐ No

NORTHWEST Kidney Centers

Patient Registration Form

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

If yes, what change and how soon? _____

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

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

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

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

Name: _____ Relationship: _____

Current Employment:

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

Employer name: _____ Phone number: _____

Employer address: _____

Number of employees: ☐ Over 20 ☐ Over 100

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

_____

FOR FACILITY USE ONLY

Staff Name: _____ Date: _____

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

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

NOTE: Do not use this form to:

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

How to Complete this Form

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

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

PRIVACY ACT STATEMENT

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

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

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

TO: Social Security Administration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Authorized Representative

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

Client Information

NAME	ACES CLIENT ID NUMBER

Authorized Representative Information

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

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

Program and Duration Information

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

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

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

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

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

Correspondence Information

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

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

Client Authorization

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

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

FOR DEPARTMENT USE ONLY
INSTRUCTIONS

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

Barcode label

14532