SNOWY RANGE
KIDNEY CARE

Patient Registration Form

Welcome to Snowy Range Kidney Care. We look forward to working with you. To help us serve you better, we would like to help prepare in advance for your visit with us.

Please return completed forms:

- Mail back to 1760 Prairie Ave, Suite #100, Cheyenne, WY 82009
- Fax back to 307-263-4023

Providing the packet to our practice ahead of your visit will allow our team to gather additional records so our doctors can provide you the most comprehensive consult on your visit day. If you are unable to mail or fax forms in advance of your appointment, please bring the completed forms to your visit.

What to expect on the day of your appointment:

- Be ready to submit a urine sample for your provider's review in clinic
- Bring all your medications in bottles (including vitamins, herbs, etc.) with you
- Bring a list of your other providers so we can better communicate with your whole care team
- Should you need to cancel your appointment, please notify us as soon as possible.
- Questions? Call us 307-263-4022

You may request an appointment via a teleconference if you prefer. Please call our office if you are interested in this option.

Warmly,

Your Healthcare Team

SNOWY RANGE
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Demographic Information

Patient Name:_____ Date of Birth: _____/_____/____

Preferred Name:_____ Social Security #:_____

Address: _____ City: _____ State: _____ZIP:_____

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

Email: _____ May we leave messages?___Yes ___No

Prefer Communication By: _____Home phone _____Mobile Phone _____Email _____Text

Birth Gender: ____Male ____Female Identifies As:___Male ____Female ____ Neither

Race: ____African Amer ___Amer Indian ____Asian ___ Caucasian ____Other_____

Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino Preferred Language: _____

Emergency Contact: _____ Emergency Contact #:_____Relation:_____

Do you have a Living Will? ____Yes _____No Advanced Directive? ____Yes _____No

Primary Care Provider? _____ Who Referred You? _____

Please list any other providers you see_____

Do you consent to phone calls? ___Yes ___No Consent to text messages? ___Yes ____No

Authorization to download the patient's medication history automatically from pharmacy ___ Yes ___ No

Authorize discussion of health records to family/friends:

Name:_____ Relationship:_____ Phone: _____

Pharmacy and Lab Info

Preferred Pharmacy: _____

Pharmacy Address:_____ Pharmacy Phone: (____) _____-_____

Preferred Laboratory: _____

Laboratory Address:_____ Laboratory Phone: (____) _____-_____

Preferred Imaging: _____

Imaging Address:_____ Imaging Phone: (____) _____-_____

Billing Information

Primary Insurance:_____ ID #_____ Group#_____

Secondary Insurance:_____ID#_____Group#_____

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Patient Name:_____ Date of Birth: _____/_____/____

1) **Consent for rendering medical care**. I voluntarily give my consent to Snowy Range Kidney Care, its providers, staff, and affiliates (hereafter "the Clinic"), to render health care typical to outpatient services including history taking, diagnostic procedures including labs and radiology imaging, medications both oral and injectable, both in-person and via alternative means such as telehealth. I understand that the Clinic and its designees will provide care to the best of their ability, and that despite this, medical care is not an exact science and therefore no guarantees are made regarding treatment or services and their outcomes in the Clinic.
2) **Financial agreement.** I understand that this agreement is a contact which obligates me to pay all charges for my treatment, whether through insurance company (whether private, nonprofit or governmental such as Medicaid or Medicare) reimbursement for services, out-of-pocket payments, or a combination of both. I understand that the Clinic has predetermined charges consistent with area norms and the services it provides. I acknowledge that it frequently is not possible to predetermine which exact services are indicated and their specific cost at the Clinic is acting in good faith to offer the best medical care possible, and certain costs are either unpredictable or unknown. I am aware that I have a right to request a non-binding estimate of charges for the services to be rendered.
3) **Specimen handling.** I understand that specimens as a byproduct of my care may be produced and will be retained, managed and disposed of by the Clinic in accordance with the law.
4) **Financial assistance.** If I cannot pay my bill, I understand that I may be able to inquire about and qualify for financial assistance.
5) **Nonpayment.** I understand that after a good faith effort to notify in compliance with the law, the Clinic may employ third party services for the collection of delinquent debts due to my nonpayment for services rendered.
6) **Communication consent.** I understand that by providing my telephone number or email, I give my consent to the Clinic and its assigns to receive communications for the purposes of scheduling, follow-up, and or payment of bills.
7) **Preauthorization.** I understand it is my duty to obtain preauthorization for services where required by my insurance coverage plan.
8) **Assignment for payment.** I authorize and direct payment for health care services be paid on my behalf of the Clinic.
9) **_____ (initials) Acknowledgement of privacy practices.** I acknowledge that the Clinic has provided me a copy of its Notice of privacy practices which is also available on its website, snowyrangekidney.com, and that this does not affect the care I receive at the Clinic.

I acknowledge that I have read this document, I understand its contents, and I have access to a copy for my records. I am the patient or authorized person to sign this consent.

My signature is my consent to the above terms:

Signature: _____ Date: _____
Patient/parent/legal guardian (or person authorized to give consent)

Name of Patient: _____

If signed by person other than patient, provide:

Name:	Relationship to patient:	ID/Driver's license number:
Witness name:	Witness signature:	Date: