

Arizona Kidney Disease and Hypertension Centers, LLC

Welcome to AKDHC! Our goal is to provide the best care possible in a professional and friendly environment.

Please review the following summary of our billing and payment policy:

Payment:

Payment is expected at the time of service unless other arrangements have been made. You are responsible for all fees associated with your care.

Insurance Information:

If we are billing your insurance, please provide the receptionist with your insurance information, including any updates or changes as they occur. A copy of your insurance cards are required at every visit to ensure proper billing processes.

Co-Pays:

For physician visits, your co-pay will be collected at the time of service. You will be billed for any co-pay associated with the services listed below if a copay applies.

Anemia Management

Office anemia visits with medication injections

AKDHC Ultrasound

Fistula, Vessel Mapping

AKDHC Access Center

Dialysis access procedures

Clinical Research

CKD and ESRD

Transplant Management

Referral to Transplant Center thru Immunosuppression maintenance and prevention of complications

Educational Services

Prevention, FAQ's, Modality, Home Therapies

Insurance Coverage:

Insurance coverage does not guarantee full payment for services provided. You will be billed for any fees determined by your insurance plan to be your responsibility. If you would like information regarding your payment responsibility for any of the above services, including physician office visits, please contact our billing office at 602-997-1098. Our knowledgeable staff will be happy to answer your questions.

If we can assist you in any way, please do not hesitate to ask, and we thank you for choosing AKDHC for your medical care.

Arizona Kidney Disease and Hypertension Centers, LLC

To Our Valued Patients:

Thank you for selecting our physician as your nephrology provider. An important part of your care plan is information regarding financial responsibility as it relates to your nephrology care. We would like to share with you our collection procedures regarding co-pay and co-insurance collection.

Contracted providers with your insurance company are contractually obligated to collect a portion of the payment from you. These portions could be any of three different types of payment:

Co-Pays

Network physicians with your payor are obligated to collect the co-pay at the time of service. Co-pays are associated with physician visits and are payable at the time of service.

Co-Insurance

In addition to co-pays, some payors have a co-insurance amount that is due as part of the service delivered. The amount of co-insurance due is based upon the individual policy for each patient.

Yearly Deductible

Some patients have a set yearly deductible in addition to co-pays, or co-insurance. This is an amount set by your insurance carrier. Charges that are applied to your deductible will be billed to you. We will not be able to determine the deductible amount due prior to your service. If you have questions regarding your deductible you will need to direct those to your insurance carrier.

Patient Portal

Our portal gives patients secure and convenient access to their health information. Patients can use the Patient Portal to view, download, and transmit their health information, and send secure messages to their provider.

We are committed to providing high quality care to our patients and strive to provide the best communication possible regarding our billing procedures.

Thank you for your cooperation in this matter. If you have any questions concerning this procedure, please do not hesitate to call our billing department at 602-997-1098.

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NSAID HISTORY						
Are you currently, or have you taken any of the following medications in the past?						
<input type="checkbox"/> Advil / Co-Advil	<input type="checkbox"/> Disalcid		<input type="checkbox"/> Mefenamic/ Ponstel			
<input type="checkbox"/> Aleve/Anaprox/Naprosyn/Naproxen	<input type="checkbox"/> Emprin/Genprin		<input type="checkbox"/> Meloxicam/ Mobic			
<input type="checkbox"/> Ansaid	<input type="checkbox"/> Etodolac/Lodine		<input type="checkbox"/> Midol-IB/Pampri-IB			
<input type="checkbox"/> Arthrotec/Cataflam/Diclofenac/Voltaren	<input type="checkbox"/> Feldene/ Piroxicam		<input type="checkbox"/> Ponstel			
<input type="checkbox"/> Asprin/Easpirin/Ecotrin/ Zorprin	<input type="checkbox"/> Fenoprofen/ Nalfon		<input type="checkbox"/> Relafen			
<input type="checkbox"/> Baclofen/Kemstro/ Lioresal	<input type="checkbox"/> Flurbiprofen		<input type="checkbox"/> Robaxin			
<input type="checkbox"/> Bextra	<input type="checkbox"/> Halprin/Iburin		<input type="checkbox"/> Salsitab			
<input type="checkbox"/> Butazolodin	<input type="checkbox"/> Ibuprofen/Motrin/ Rufen/Trendar/Medipren		<input type="checkbox"/> Sulidac/Clinoril			
<input type="checkbox"/> Celebrex/ Celecoxib	<input type="checkbox"/> Indocin/Indomethicin/Rheumacin		<input type="checkbox"/> Tolectin			
<input type="checkbox"/> DayPro	<input type="checkbox"/> Magnaprin		<input type="checkbox"/> Toradol			
<input type="checkbox"/> Diflunisal/ Dolobid	<input type="checkbox"/> Meclomen		<input type="checkbox"/> Trilisate			
Tylenol and Extra Strength Tylenol are the medication of choice for pain management for people with Kidney problems.						
FAMILY HISTORY						
Adopted Family History Unknown <input type="checkbox"/>						
	Living	Deceased	Age at Death	Cause of Death		
Father	<input type="checkbox"/>	<input type="checkbox"/>				
Mother	<input type="checkbox"/>	<input type="checkbox"/>				
Please indicate if a family member has/had any of the following:						
	Father	Mother	Brother	Sister	Children	Other (identify)
Diabetes, Type I:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Type II:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis (identify cause):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (identify type):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL HISTORY						
Smoking Status:						
<input type="checkbox"/> Current every day smoker: packs smoked per day _____ Year started: _____						
<input type="checkbox"/> Current some day smoker: packs per week _____ Year started: _____						
<input type="checkbox"/> Former smoker: Year started: _____ Years smoked: _____ Packs smoked per day _____						
<input type="checkbox"/> Never smoked						
<input type="checkbox"/> Heavy tobacco user : Year started: _____ <input type="checkbox"/> Light tobacco user: Year started: _____						
Alcohol Use:						
<input type="checkbox"/> No history of alcohol use						
<input type="checkbox"/> Currently consume alcohol (provide quantity and frequency): _____						
<input type="checkbox"/> Former Drinker: Sober since: _____ Previous quantity and frequency: _____						
<input type="checkbox"/> Recovering alcoholic: Sober since: _____ Previous quantity and frequency: _____						
<input type="checkbox"/> Rehabilitation: Year treatment received for alcohol abuse: _____						
Illicit Drug Use:						

Arizona Kidney Disease and Hypertension Centers, LLC

<input type="checkbox"/> No history of illicit drug use <input type="checkbox"/> Current use: Type of drug _____, frequency: _____ Dates/Years of use _____ <input type="checkbox"/> Previous use: Type of drug _____, frequency: _____ Dates/Years of use _____ <input type="checkbox"/> Rehabilitation: Year treatment received for drug abuse: _____	
Claustrophobic: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Education: <input type="checkbox"/> less than 8 th grade <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 2 year college <input type="checkbox"/> 4 year college <input type="checkbox"/> post graduate	
Employment status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	
Employer: _____	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner	
Advance Directive: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Medical Power of Attorney in effect : <input type="checkbox"/> YES <input type="checkbox"/> NO Name of Responsible Party: _____	
SURGICAL HISTORY	
Name	Date Of Surgery
<input type="checkbox"/> Adrenal Surgery	
<input type="checkbox"/> Amputation Type:	
<input type="checkbox"/> Any metal in body, where?	
<input type="checkbox"/> Aortic Valve Repair	
<input type="checkbox"/> Appendectomy	
<input type="checkbox"/> AV Fistula	
<input type="checkbox"/> AV Graft	
<input type="checkbox"/> Bladder Surgery, Type:	
<input type="checkbox"/> Cancer Surgery, Type:	
<input type="checkbox"/> Carotid Artery Angioplasty	
<input type="checkbox"/> Carotid Endarterectomy	
<input type="checkbox"/> Cholecystectomy	
<input type="checkbox"/> Colon Surgery	
<input type="checkbox"/> Coronary Artery Angioplasty/Stent	
<input type="checkbox"/> Cystoscopy	
<input type="checkbox"/> Defibrillator AICD Implant	
<input type="checkbox"/> Eye Surgery	
<input type="checkbox"/> Gastric Bypass	
<input type="checkbox"/> Heart Bypass Surgery-CABG	
<input type="checkbox"/> Heart Transplant	
<input type="checkbox"/> Heart/ Cardiac Catheterization	
<input type="checkbox"/> Hemodialysis Catheter	
<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Kidney Ablation	
<input type="checkbox"/> Kidney Artery Angioplasty	
<input type="checkbox"/> Kidney Biopsy	
<input type="checkbox"/> Lithotripsy	
<input type="checkbox"/> Liver Transplant	
<input type="checkbox"/> Mitral Valve Repair	
<input type="checkbox"/> Mitral Valve Replacement	
<input type="checkbox"/> Nephrectomy	
<input type="checkbox"/> Orthopedic Surgery	
<input type="checkbox"/> Pacemaker	

Arizona Kidney Disease and Hypertension Centers, LLC

	Date Of Surgery		
<input type="checkbox"/> Pancreas Transplant			
<input type="checkbox"/> Parathyroid Surgery			
<input type="checkbox"/> Peritoneal Catheter			
<input type="checkbox"/> Prostate Surgery			
<input type="checkbox"/> Renal Transplant, <input type="checkbox"/> Living-related or unrelated, <input type="checkbox"/> cadaveric, <input type="checkbox"/> left or right side, facility where transplant was performed:			
<input type="checkbox"/> Thyroid Surgery			
<input type="checkbox"/> Ureteral Stent			
<input type="checkbox"/> Vascular Surgery			
Other:			
MEDICAL HISTORY			
RENAL (KIDNEY)-HYPERTENSION-DIABETES			
Do you have a history of kidney disease? No <input type="checkbox"/> Yes <input type="checkbox"/> (check all that apply from below list)			
Name	Date Diagnosed	Name	Date Diagnosed
<input type="checkbox"/> Acute Renal Failure		<input type="checkbox"/> Interstitial Nephritis	
<input type="checkbox"/> Anemia - Chronic		<input type="checkbox"/> Kidney Cyst (s)	
<input type="checkbox"/> Anemia – Iron Deficient		<input type="checkbox"/> Lupus Nephritis	
<input type="checkbox"/> Chronic Kidney Disease		<input type="checkbox"/> Membranous Nephropathy	
<input type="checkbox"/> End Stage Kidney Disease		<input type="checkbox"/> Nephrolithiasis	
<input type="checkbox"/> Glomerulonephritis - Chronic		<input type="checkbox"/> Nephrotic Syndrome	
<input type="checkbox"/> Glomerulonephritis - FSGN		<input type="checkbox"/> Polycystic Kidney Disease	
<input type="checkbox"/> Glomerulonephritis - RPGN		<input type="checkbox"/> Proteinuria	
<input type="checkbox"/> Hypertension/High Blood Pressure		<input type="checkbox"/> Renal Tumor	
<input type="checkbox"/> IgA Nephropathy			
ENDOCRINE			
<input type="checkbox"/> Adrenal Gland Tumor		<input type="checkbox"/> Hyperaldosteronism	
<input type="checkbox"/> Diabetes Mellitus type 1		<input type="checkbox"/> Hyperparathyroidism	
<input type="checkbox"/> Diabetes Mellitus Type 2		<input type="checkbox"/> Hyperthyroidism	
<input type="checkbox"/> Diabetic Nephropathy		<input type="checkbox"/> Hypoaldosteronism	
<input type="checkbox"/> Diabetic Peripheral Neuropathy		<input type="checkbox"/> Hypothyroidism	
<input type="checkbox"/> Diabetic Retinopathy			
ELECTROLYTE IMBALANCE			
<input type="checkbox"/> Hypercalcemia		<input type="checkbox"/> Hypokalemia	
<input type="checkbox"/> Hyperkalemia		<input type="checkbox"/> Hypomagnesemia	
<input type="checkbox"/> Hypermagnesemia		<input type="checkbox"/> Hyponatremia	
<input type="checkbox"/> Hypernatremia		<input type="checkbox"/> Hypophosphatemia	
<input type="checkbox"/> Hyperphosphatemia		<input type="checkbox"/> Metabolic disorder	
<input type="checkbox"/> Hypocalcemia			
HEART			
<input type="checkbox"/> Anticoagulant use		<input type="checkbox"/> Congestive Heart Failure	
<input type="checkbox"/> Arrhythmias		<input type="checkbox"/> Coronary Artery Disease	
<input type="checkbox"/> Bradycardia		<input type="checkbox"/> Heart Murmur	
MEDICAL HISTORY (Continued on next page)			

Arizona Kidney Disease and Hypertension Centers, LLC

HEART			
<input type="checkbox"/> Cardiomyopathy		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Carotid Artery Stenosis		<input type="checkbox"/> Tachycardia	
<input type="checkbox"/> Congenital Heart Disease		<input type="checkbox"/> Valve Disorder	
VASCULAR			
<input type="checkbox"/> CVA/ TIA/ Stroke		<input type="checkbox"/> Peripheral Neuropathy	
<input type="checkbox"/> DVT/ Clotting Disorder		<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Peripheral Artery Disease		<input type="checkbox"/> Venous Insufficiency/ Stasis/ Varicose Veins	
PULMONARY/LUNGS			
<input type="checkbox"/> Asthma		<input type="checkbox"/> Sarcoidosis	
<input type="checkbox"/> COPD/ Emphysema		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Obstructive Sleep Apnea		<input type="checkbox"/> Valley Fever	
<input type="checkbox"/> Pulmonary Hypertension			
GASTROINTESTINAL			
<input type="checkbox"/> Cirrhosis		<input type="checkbox"/> GERD	
<input type="checkbox"/> Colitis		<input type="checkbox"/> GI Bleed	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Diverticulitis		<input type="checkbox"/> Irritable Bowel Syndrome	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Peptic Ulcers	
GENITOURINARY/UROLOGIC			
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Hematuria	
<input type="checkbox"/> Bladder Incontinent		<input type="checkbox"/> Hydronephrosis	
<input type="checkbox"/> Cystitis		<input type="checkbox"/> Recurrent UTI's	
RHEUMATOLOGY			
<input type="checkbox"/> Erythematous		<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Sjorgen's Syndrome	
<input type="checkbox"/> Gout		<input type="checkbox"/> Systemic Lupus	
<input type="checkbox"/> HIV		<input type="checkbox"/> Wegner's Granulomatosis	
<input type="checkbox"/> Rheumatoid Arthritis			
SKELETAL			
<input type="checkbox"/> Degenerative Joint Disease		<input type="checkbox"/> Osteopenia	
<input type="checkbox"/> Kyphosis		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Osteoarthritis		<input type="checkbox"/> Scoliosis	
CANCER			
<input type="checkbox"/> Bladder		<input type="checkbox"/> Ovarian/Uterus/Cervix	
<input type="checkbox"/> Breast		<input type="checkbox"/> Pancreatic	
<input type="checkbox"/> Colon		<input type="checkbox"/> Prostate	
<input type="checkbox"/> Lung		<input type="checkbox"/> Renal	
OTHER			
<input type="checkbox"/> Anxiety/Depression		<input type="checkbox"/> NSAID use	
<input type="checkbox"/> Deafness		<input type="checkbox"/> Obesity	
<input type="checkbox"/> Hyperlipidemia		<input type="checkbox"/> Vitamin D Deficiency	
Other:			

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AKDHC has adopted standards for certain questions that have been asked in the forms contained in this packet. To help our patients better understand some of these standards the below information may be helpful.

The difference between Race and Ethnicity	
Race	Race is an indication of the heritage with which you were born, regardless of location or learned behavior. Race cannot be altered.
Ethnicity	Ethnicity is about the learned cultural behaviors celebrated throughout regions around the world. Ethnicity can be altered or mimicked through choice and beliefs.
Source: http://www.differencebetween.net/science/nature/difference-between-ethnicity-and-race	

Race Reference Guide	
American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
Black or African American	A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” can be used in addition to “Black or African American.”
Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin,” can be used in addition to “Hispanic or Latino.”
Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Smoking Status Reference Guide	
Current Every Day Smoker	An individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes every day.
Current Some Day Smoker	An individual who has smoked at least 100 cigarettes during his/her lifetime and still regularly smokes periodically, yet consistently.
Former Smoker	An individual who has smoked at least 100 cigarettes during his/her lifetime but does not currently smoke.
Never Smoker	An individual who has not smoke 100 or more cigarettes during his/her lifetime.
Smoker, Current Status Unknown	An individual who has smoked at least 100 cigarettes during his/her lifetime, but whether they currently still smoke is unknown
Unknown if Ever Smoked	Unknown if an individual has ever smoked
Heavy Tobacco Smoker	An individual who smokes more than 10 cigarettes per day, or an equivalent (but less concretely defined) quantity of cigar or pipe smoke. This option can also be selected to identify chewing tobacco use.
Light Tobacco Smoker	An individual who smokes less than 10 cigarettes per day, or an equivalent (but less concretely defined) quantity of cigar or pipe smoke. This option can also be selected to identify chewing tobacco use.
Source: Center for Disease Control (CDC) http://www.cdc.gov/nchs/nhis/tobacco/tobacco_recodes.htm	