



ROBERT DAVIDSON, MD  
MARY DITTRICH, MD, FASN  
CHRISTOPHER KELLER, MD  
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AMIT SHARMA, MD, FACP, FASN  
ARNOLD SILVA, MD, PhD

**MERIDIAN**

3525 E. LOUISE DRIVE, STE. 100

MERIDIAN, ID 83642

**MERIDIAN**

3525 E. LOUISE DRIVE, STE. 195

MERIDIAN, ID 83642

**CALDWELL**

4620 ENTERPRISE WAY, STE. 101

CALDWELL, ID 83605

**NAMPA**

280 W. GEORGIA AVENUE

NAMPA, ID 83686

Dear Patient,

We are very excited to welcome you to our Kidney and Hypertension practice and want you to know that we appreciate the opportunity to provide your medical care. Our Doctors and Staff are focused on providing high quality, personal care and look forward to building a relationship with you.

Enclosed you will find both a new patient registration form and health history form. Having this completed as accurately as possible prior to your first appointment is important. We appreciate you taking the time to do so. It is also helpful to bring a current list of the medications you are taking for the Doctor to review. You can expect that your initial consultation will take approximately one hour. The Doctor will possibly ask for a urine sample and blood to be drawn. Please show up for your appointment 20 minutes early so the Medical Assistant can go over medications with you.

As a courtesy, our office staff will gladly submit your claims to your insurance company. Please bring in the most current insurance card along with any applicable claim forms. We will verify coverage during your visit so please be prepared to pay your copay or coinsurance at that time. If you do not have medical insurance, please notify a member of our office staff and we will be happy to discuss payment options with you.

Also included in this packet are maps to both locations. Please verify with the office if you are not sure which location your appointment is scheduled. If you have any further questions please do not hesitate to call us at (208) 846-8335.

Thank you again for allowing us to serve you. We look forward to meeting you.

Sincerely,

Boise Kidney & Hypertension Institute

# Boise Kidney & Hypertension Institute

3525 E. Louise Dr. Suite #100

Meridian, ID 83642

Office: (208)846-8335 Fax: (208)846-8336

Arnold Silva, MD ~ Mary O. Dittrich, MD FASN ~ Christopher Keller, MD  
Jerry Meng, MD ~ Robert L Davidson, MD

### Demographics:

Referring Doctor: \_\_\_\_\_

Date: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender:  M  F Marital Status:  Married  Single  Divorced  Other

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_ Language: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Alternative: \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

Person to Notify in case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please list all persons who may obtain or receive medical information on your behalf:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Providers:

Please list providers who are also responsible for your care and check the boxes for those, who you would like follow-up notes and/or labs faxed to:

Dr.: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Dr.: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Dr.: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Dr.: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Dr.: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

Dr.: \_\_\_\_\_ Facility: \_\_\_\_\_ Phone: \_\_\_\_\_

### Pharmacies:

Please list pharmacies that you wish to use for prescriptions. If Medicare patient, please specify which company covers medication prescriptions:

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information**

**Person Responsible for Bill:**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

SS#: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Insurance Coverage:**

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Our office will bill your insurance. I understand I am responsible for the deductible, share of cost, co-payment, and any cost not a benefit of my plan or denied by my plan as medically unnecessary. I authorize and request my insurance company to make payments directly to Boise Kidney & Hypertension Institute, LLC. I also authorize Boise Kidney & Hypertension Institute, LLC or any billing agency acting in their behalf, to release any information necessary to process any claim on my behalf.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Medicare (if applicable)** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Boise Kidney and Hypertension Institute, LLC for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to CMS and its agents any information to determine these benefits payable for related services.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



Phone (208) 846-8335 Fax (208) 846-8336

**New Patient Information**

**Please fill out this information prior to your visit with the doctor. Thank you!**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Please indicate if you have experienced any of the following:

**Pulmonary:**

- Shortness of Breath at Rest
- Frequent Cough
- Coughing up Blood
- Wake up at night, short of breath
- Wheezing

**Cardiac:**

- High Blood Pressure
- Heart Attack
- Leg Swelling
- Shortness of breath w/ exercise
- Chest Pain
- Heart racing or thumping
- Need to sleep on more than 2 pillows
- High Cholesterol

**Musculoskeletal:**

- Muscle Weakness
- Joint Pain
- Joint Swelling

**Constitutional:**

- Fever
- Night Sweats
- Chills
- Weight Loss
- Weight Gain

**Hematologic/Oncologic:**

- Anemia
- Cancer
- Bleeding Tendency
- Blood clot in legs or lungs

**Gastrointestinal:**

- Trouble Swallowing
- Heartburn
- Abdominal Pain
- Nausea
- Vomiting
- Diarrhea
- Ulcers

**Renal:**

- Blood in Urine
- Protein in Urine
- Urinary Tract Infections
- Kidney Stones
- Frequent Urination at Night
- Painful Urination
- Difficulty Emptying Bladder

**Other:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Neurological:**

- Frequent Headaches
- Numbness or Tingling
- Seizures
- Imbalance or Unsteadiness
- Dizziness

**Eyes, Ears, Nose, Throat:**

- Blurred Vision
- Decreased Hearing
- Snoring
- Sinus Infections
- Eye Exam: Date of Last: \_\_\_\_\_

**Endocrine:**

- Diabetes Mellitus
  - Type I
  - Type II
- Controlled
- Uncontrolled

**Psychiatric:**

- Anxiety
- Depression
- Poor Sleep

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Please list current medical problems: \_\_\_\_\_  
\_\_\_\_\_

Please list past medical problems: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed with:

- Kidney Disease                      Date: \_\_\_\_\_                       Diabetes                      Date: \_\_\_\_\_
- Heart Disease                      Date: \_\_\_\_\_                       High Blood Pressure                      Date: \_\_\_\_\_

Please list past hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

Please list any past surgeries: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke now? \_\_\_\_\_ Did you ever smoke? \_\_\_\_\_ If yes, packs per day: \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, drinks per day \_\_\_\_\_ History of drug use? \_\_\_\_\_ If yes, which drug: \_\_\_\_\_

Please list any food or drug allergies & reactions: \_\_\_\_\_  
\_\_\_\_\_

Do any of these medical conditions run in your family?

- Cancer:                      Grandparent \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_ Type: \_\_\_\_\_
- Heart Disease:                      Grandparent \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_
- Stroke:                      Grandparent \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_
- Kidney Disease:                      Grandparent \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_
- Dialysis:                      Grandparent \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_
- Diabetes:                      Grandparent \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Brother \_\_\_\_\_ Sister \_\_\_\_\_
- Other Conditions? \_\_\_\_\_



**Current Medication List**

<u>Name of Medication</u>	<u>Dosage</u>	<u>How often do you take it?</u>	<u>Date Started</u>	<u>Prescribing Doctor</u>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				

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

Date of Birth \_\_\_\_\_

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

Date \_\_\_\_\_

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Jerry Meng, MD ~ Robert L Davidson, MD

## AUTHORIZATION FOR PATIENT INFORMATION

I, \_\_\_\_\_ authorize:

\_\_\_\_\_, with \_\_\_\_\_  
(Doctor of Hospital) (Facility)

\_\_\_\_\_  
(Address) (Phone & Fax)

To release any health information concerning the treatment, diagnosis and hospitalizations to:

\_\_\_\_\_, with \_\_\_\_\_  
(Doctor of Hospital) (Facility)

\_\_\_\_\_  
(Address) (Phone & Fax)

\_\_\_\_\_  
Name Signature

\_\_\_\_\_  
D.O.B. Relationship to Patient Witness

\_\_\_\_\_  
Address Date of Signature

\_\_\_\_\_  
City, State, Zip Expiration

**Boise Kidney and Hypertension Institute, LLC  
Arnold L Silva, MD, PhD \* Amit Sharma, MD \* Mary O Dittrich, MD  
Christopher Keller MD\*Jerry Meng MD\*Robert Davidson MD**

Receipt of Notice of Privacy Practices  
Written Acknowledgement Form

I, \_\_\_\_\_, have been informed of the Privacy Practice Notice of the above named clinic. I am aware a written copy is available to me upon request.  
(Please check appropriate box below)

- I have requested a copy of the Notice of Privacy Practices.
- I have declined a copy of the Notice of Privacy Practices.

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Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Disclosures

Our office will bill your insurance. I understand I am responsible for the deductible, share of cost, co-payment, and any cost not a benefit of my plan as medically unnecessary. I authorize and request my insurance company to make payments directly to Boise Kidney & Hypertension Institute, LLC. I also authorize Boise Kidney & Hypertension Institute, LLC or any billing agency acting in their behalf, to release any information to process any claim on my behalf.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Medicare (If applicable) I request that payment of authorized Medicare benefits be made either to me or on my behalf to Boise Kidney and Hypertension Institute, LLC for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these to determine these benefits payable for related services.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW CAREFULLY – YOU WILL BE ASKED TO SIGN AN ACKNOWLEDGMENT YOU HAVE READ AND UNDERSTOOD THIS POLICY.**

Our commitment to Your Privacy:

Protection of a patient's private health information is a matter of great importance to us. Our practice is dedicated to maintaining the privacy of your medical information. In conducting our business, we will create records regarding you and the treatment and the services we provide for you. We are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice. This notice outlines the federal regulations for maintaining the privacy of your medical records.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

There are certain instances that we may use and disclose health information without an authorization. These are stated as follows:

- . We may use and disclose health information for your treatment and to provide you with treatment related services. For example we may disclose health information to doctors, nurses, technicians, or other personnel (including people outside our office), who are involved in your medical care.
- . We will use and disclose your health information to provide, coordinate, or manage your health care and any related services, e.g. coordination of care with your referring physician.
- . Your health information will be used, as needed, to obtain payment for your health care services. Including, but not limited to activities your health insurance may undertake before it approves or pays for health care services we recommend for you.
- . As required to support the business activities of this clinic. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care professionals, licensing, and credentialing.
- . This clinic may contact you to make appointment reminders.
- . We may also contact you regarding treatment alternatives or other health-related benefits and services that may be available.

### SPECIAL SITUATIONS WE ARE REQUIRED TO RELEASE HEALTH INFORMATION:

- . **As required by Law:** We will disclose health information when required to do so by international, federal, state or local law.
- . **Public Health Risks:** A public health authority that is authorized by law to collect or receive information for the purpose of preventing or controlling disease, injury, or disability; including, but not limited to the report of birth or death.
- . **To Avert a Serious Threat to Health or Safety:** A public health authority or other appropriate government authorized by law to receive reports of child abuse or neglect. A government authority, including a social service or protective services agency, authorized by law to receive such reports, on neglect or domestic violence.
- . **Government Activities:** The Food and Drug Administration to report adverse events, product defects or problems, enable product recalls, repairs, or replacement.
- . **Workers Compensation:** An employer, about an individual who works under the employer, if:
  1. The clinic provides service to the individual at the request of the employer to evaluate work-related illness or injury.
  2. The clinic finds a work related illness or injury.
- . **Health Oversight Activities:** To a health oversight agency for activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions or other activities necessary for oversight of the health care system; government benefits programs for which health information is relevant to eligibility, government regulatory programs for which health information is necessary for determining compliance with program standards.
  - NOTE: Health oversight activities investigations only pertain to the receipt of health care, a claim for public benefits related to health.
- . **Lawsuits & Disputes:** In response to an order of court, subpoena, court-ordered warrant, discovery request or other lawful process.
- . **Business Associates:** To perform functions on our behalf or provide us with services if the information is necessary for such functions or services, for example, transcription services and/or billing services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information. The Business Associates abide by the same rules, regulations and laws.
- . **Coroners, Medical Examiners, and Funeral Directors:** To identify a deceased person or as necessary for their duties.
- . **National Security and Intelligence Activities:** To authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. For protection to the President, other authorized persons, or foreign heads of state, or to conduct, special investigations.
- . **Inmate or Individuals in Custody:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release information to the correctional institution or law enforcement official. This release would be necessary:
  1. For the institution to provide you with health care.
  2. To protect your health and safety or the health and safety of others.
  3. For the safety and security of the correctional institution.
- . **Law Enforcement:** For law enforcement purposes, as required by law that require the reporting of certain types of wounds or other physical injuries, in information sought is relevant and material to a legitimate law enforcement inquiry.
  1. Limited information may be released for the purpose of identifying or locating a suspect, fugitive, material witness or missing persons.
  2. To law enforcement official for information needed to determine whether a violation of law by a person, other than the victim, has occurred and such information is not intended to be used against the victim.
  3. To law enforcement official if the professional believes in good faith the evidence constitutes criminal conduct that occurred

on the premises of the clinic.

4. The clinic may disclose information of a patient who has died, to a law enforcement official if the clinic believes that such death was the result of criminal conduct.

## **YOUR RIGHTS:**

### **YOU HAVE THE FOLLOWING RIGHTS WHEN IT COMES TO YOUR PERSONAL HEALTH INFORMATION AND HOW THIS INFORMATION IS MAINTAINED.**

**. Right to request restrictions:** You have the right to request a restriction or limitation on your personal health information we use to carry out treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose to someone involved in your care, like a family member or friend, E.g.: We will not disclose information about you to your spouse unless a written request is received. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide emergency treatment or unless required to release information as required by law. If you would like to terminate a restriction, it must be in writing and given to the receptionist.

**. Right to inspect and obtain a copy:** You have the right to inspect and copy health information that may be used to make decisions about your care or payment for your care. This includes medical billing records. To inspect and copy this health information, you must make your request by completing the appropriate form obtained from the receptionist. The exceptions to inspecting and copying are:

1. Psychotherapy notes.
2. Medical information created by another physician.
3. Information created in reasonable anticipation of use in a civil, criminal, or administrative action or proceeding.
4. The personal health information created by the provider acting under the directions of a correctional institution.
5. If the healthcare provider has determined that access is reasonable likely to endanger the patient's life or physical safety of another person.

**. Right to request confidential communication:** You have the right to request alternative means of communication with you about medical matters. For example, you may request that we only contact you at work or not leave messages on your answering machine, to request alternative communication complete the "alternative communication" form you can request from the receptionist. Your request must include specifically how or where you wish to be contacted. The request will be reviewed and we will accommodate reasonable requests.

**. Right to Amend:** If you feel that the health information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment if you the information requested was created by our office. You may request this by completing an amendment form provided by the receptionist. The clinic has certain rights to deny this request if the information was not created by our office.

**. Right to an accounting of disclosure:** You have the right to request a list of certain disclosures we made of our health information. To request an accounting please notify the receptionist for an accounting log. The exception to an account is:

1. To receive payment, treatment or operations.
2. For National security or intelligence purposes.
3. To correctional intuitions or enforcement officials.
4. That occurs before April 2003.

**IDAHO HEALTH DATA EXCHANGE:** Boise Kidney and Hypertension Institute are participants in the Idaho Health Data Exchange (IHDE). You have the choice not to participate in the IHDE, which will exclude your health care information to be shared with other medical providers involved in your care. To opt out, you must complete and sign the IHDE "Request Disclosure of Health Information" form and mail or fax to IHDE. You will then receive a confirmation letter upon completion of your request. This request only restricts your information from being released through the exchange only. IHDE opt out form is available at the front desk, if you do not complete this form, we may share your protected health information with other participating healthcare providers involved in your care through IHDE. This is secure statewide internet-based health information exchange, with the goal of improving the quality and coordination of health care in Idaho.

**MEDICATION HISTORY DOWNLOAD:** By signing this form you authorize Boise Kidney and Hypertension Institute to download your medication history from Sure Scripts, pharmacies and/or your insurance companies.

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice and make new notice apply to the information we already have as well as information received in the future. A copy of the current notice will be posted with the new effective date.

**COMPLAINTS:** If you feel your privacy rights have been violated according to this notice, please contact the office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

This notice is effective April 2003 until further notice.

## Patient Financial Policy

### Self Pay Policy (patients without insurance)

If you do not have insurance, we are very sensitive to your individual financial constraints.

If you gave no insurance at your first visit to our office, we require payment of \$150.00 at your initial visit, prior to being seen by the doctor. This payment may not cover the entire cost of the visit. Each follow up visit, requires \$50.00, prior to being seen by the Doctor. Again, this payment may not cover the entire cost of your visit.

If you cannot abide by this policy, we will refer you to our Patient Financial Representative, Michelle O'Riley. She will help create a payment plan to fit your financial needs.

It is critical for you to stay in contact with our billing department. If you choose not to stay in touch with our billing department, your account may not clear on a timely basis; and we want you to understand the steps we will take to collect any outstanding balances.

- 1) You will receive three statements subsequent to your visit to our clinic.
- 2) If the account is not paid in full, and you have not made payment arrangements, we refer your account to a collection agency.
- 3) We will send you notification by mail of a past due payment at your last known address. If you choose to ignore this letter, your account is at risk of being referred to a collection agency

Our Patient Financial Representative, Margaret Outhet, will be able to assist you with any payment arrangements.

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It is our experience that the majority of our patients understands and cooperates with our financial Policy; and we are disclosing our policy to you, so that we may avoid any misunderstandings in the future.

I have read and understand Boise Kidney's financial policy and understand that BKHI is willing to work with me to keep my patient balance in good standing.

---

Patient Signature (or legal Guardian)

---

Date

If you have any questions or concerns, please contact our Billing Department:

Margaret Outhet  
Insurance Specialist  
(208)472-0514  
[mouthet@boisekidney.com](mailto:mouthet@boisekidney.com)

### Patient Financial Policy

As the cost of healthcare continues to rise, it is our desire to provide medical services at an affordable price. This policy is written to assist our clinic in serving our patients.

**For patients with insurance coverage**, it is the patient's responsibility:

- 1) To check with their insurance company to confirm that Boise Kidney & Hypertension is in contact. We also use Quest Diagnostics & Satellite Laboratories for all labs drawn in our office. It is the patient's responsibility to contact their insurance to confirm these labs are in contract. These laboratories will be billing you after insurance processes.
- 2) To provide BKHI with the correct insurance information by presenting the insurance card to the front office staff prior to the appointment.
- 3) To provide payment at time of service, which will be applied to the oldest balance. This includes any co-pays, deductibles, co-insurance, and/or outstanding balances. If no payment is made at your time service, we will expect you to contact billing departments to set up a payment arrangement.

**BKHI** will bill your insurance on a timely basis. It is critical for you to stay in contact with our billing department. If you choose not to stay in touch with our billing department, your account may not clear on a timely basis; and we want you to understand the steps we will take to collect any outstanding balances.

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Patient Signature (or legal Guardian)

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Date

If you have any questions or concerns, please contact our Billing Department:

Margaret Outhet  
Insurance Specialist  
(208)472-0514  
[mouthet@boisekidney.com](mailto:mouthet@boisekidney.com)



**Authorization for Use or Disclosure of Health Information**

Boise Kidney and Hypertension Institute is currently conducting several clinical research studies in our offices. The purpose of conducting research trials varies from investigating new therapies to treat chronic kidney disease, high blood pressure and diabetes, to finding new ways to create and improve treatments for chronic kidney disease care as a whole.

Boise Kidney and Hypertension Institute is informing you that our research team will be reviewing your medical records over the course of your treatment here. The employees will be able to review your data to see if you may qualify for a research trial. If you should qualify, you will be asked to participate in a research trial or study procedures until you are presented with specific information regarding the appropriate trial. You will then be asked to read the consent form and discuss with your kidney doctor the effects of the individual study, and make an informed decision on whether or not you would like to participate.

You may or may not qualify for a clinical research study depending on your medical history and lab tests currently found in your records. We appreciate your support to progress the field of Kidney Science.

Please sign below to acknowledge that you have read the above information.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF INSURANCE BENEFITS

1. RELEASE OF INFORMATION FOR \_\_\_\_\_ (name of patient)

I hereby authorize \_\_\_\_\_ Boise Kidney & Hypertension Institute \_\_\_\_\_

and my attending physicians to release medical and other personal information necessary to complete medical claim forms on my behalf and to release any medical information and/or test results to other health care providers who need to administer care to me.

2. INSURANCE BENEFITS:

I hereby authorize and instruct my insurance carrier to make payment directly to ASCEND CLINICAL for my laboratory expenses. Benefits otherwise payable to me are not to exceed the laboratory's regular charges for their services rendered.

3. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION and PAYMENT REQUEST:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare/CMS or other insurance carriers, any information needed for this or a related claim for laboratory services rendered. I request that payment of authorized Medicare, or other insurance benefits, be made on my behalf to ASCEND CLINICAL.

Signature of Patient or Responsible Party

Date

Printed or Typed Name

Relationship to Patient: [ ] Patient [ ] Father [ ] Mother [ ] Spouse [ ] Other \_\_\_\_\_ Specify

Signature of Witness



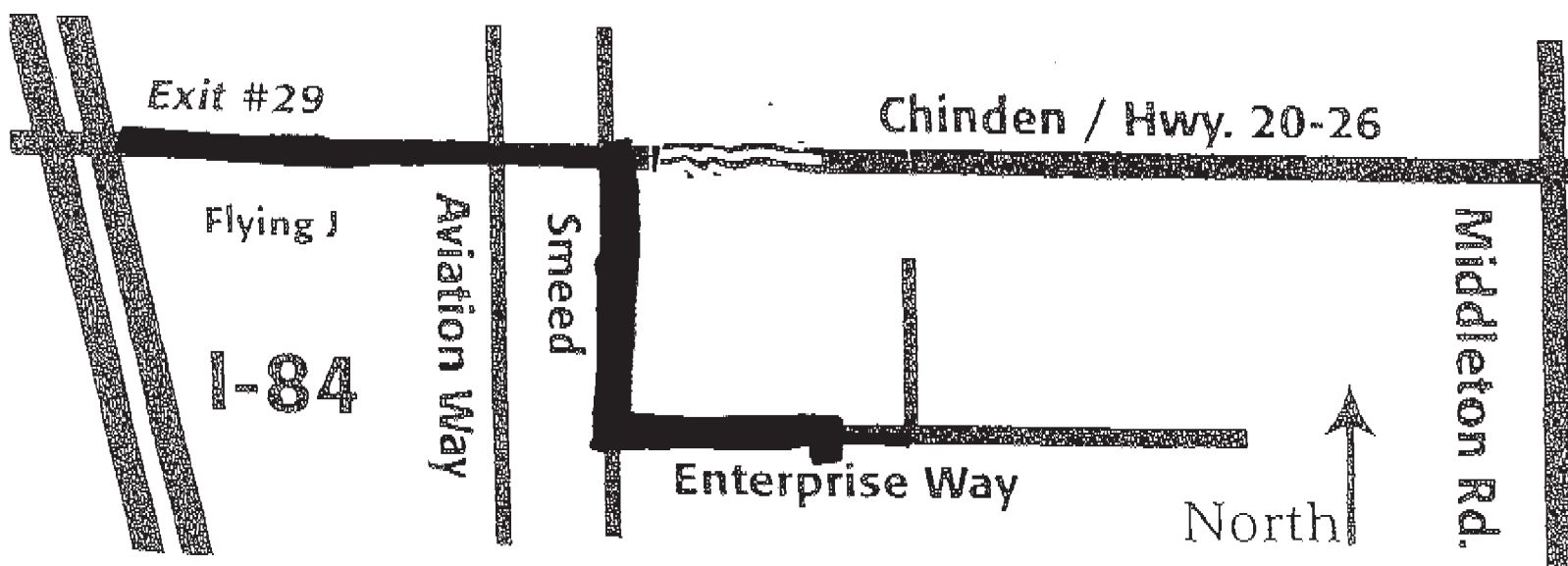
# BOISE KIDNEY & HYPERTENSION INSTITUTE

**4620 Enterprise Way  
Caldwell, ID 83605  
(208)846-8335**

Coming from Boise Take the I-84 west, Exit 29 (Franklin) Make a Right Heading towards HWY 20/26. Make a RIGHT in to the Sky Ranch Business Park; Building is located behind the Idaho Athletic Club.

Coming from Ontario, OR on the I-84 East exit 29 (Franklin) make a LEFT towards HWY 20/26. Make a RIGHT in to the Sky Ranch Business Park; Building is located behind the Idaho Athletic Club.

Dr. Christopher Keller, MD  
Dr Robert L. Davidson, MD



### BOISE KIDNEY AND HYPERTENSION INSTITUTE

3525 E. Louise Dr.

Meridian, ID 83642

208-846-8335

(Meadow Lake Plaza Office Building)

Dr. Silva Suite 195

Dr. Dittrich Suite 100

Dr. Meng Suite 100

Dr. Davidson Suite 195

Turn onto St Lukes St., go past the emergency room entrance, Make a Left at the Meadow lake plaza building it will be the last building on the left. We are located on the 1<sup>st</sup> floor.

