INSURANCE QUESTIONNAIRE

Patient Name: _____ Date: _____

PRIMARY INSURANCE

Please list your primary insurance information **PLEASE PRINT**

Name as appears on your card: _____

Insurance Name: _____

Member ID # : _____

Group #: _____

Group Name: _____

Start Date: _____

End Date: _____

SECONDARY INSURANCE

Please list your primary insurance information **PLEASE PRINT**

Name as appears on your card: _____

Insurance Name: _____

Member ID # : _____

Group #: _____

Group Name: _____

Start Date: _____

End Date: _____

OTHER INSURANCE

Please list your primary insurance information **PLEASE PRINT**

Name as appears on your card: _____

Insurance Name: _____

Member ID # : _____

Group #: _____

Group Name: _____

Start Date: _____

End Date: _____

BRANSON DIALYSIS, L.L.C

CONSENT FOR DIALYSIS AND RELATED TREATMENTS

GENERAL:

I give my consent for Branson Dialysis and Physicians to prescribe, direct, and provide dialysis treatment and other health care that I need because of my kidney failure. This care will include, but is not limited to:

1. Dialysis treatments prescribed, directed and supported by my doctor and other in the Branson Dialysis healthcare team.
2. My participation, to the best of my ability, in planning and carrying out my treatment.
3. Sharing of my health records and health information only with people involved in my health care, so that my health care can be better coordinated.

DRUGS AND OTHER TREATMENTS:

I understand that the physician may prescribe drugs that I need as part of my treatment. These drugs may be taken by me at home or given to me while I am at the dialysis clinic, by my doctor or members of the health care team. If I choose to dialyze at home, I or my dialysis assistant may give some of these medications at home.

Also I understand that small amounts of blood will be drawn for blood tests as directed by my doctor.

LAB:

I understand that, based on my medical condition when I arrive at the dialysis facility, the physician may direct members of the health care team to take small abound of blood for testing.

SIGNATURE OF CONSENT:

I have read this consent form (or it has been read to me) and I understand it. The form has been fully explained to me by a member of the health care profession. I have had a chance to ask questions, and all my questions have been answered to my satisfaction. I understand that I may withdraw my consent at any time by informing the Charge Nurse of Branson Dialysis.

I voluntarily consent to the dialysis treatment I have selected and authorize Branson Dialysis to provide these services to me.

_____ _____

Patient's name (Print) **Date**

_____ _____

Patient's Signature

If patient is unable to sign:

_____ _____

Patient's Representative **Relationship**

_____

Witness

BRANSON DIALYSIS, L.L.C

AUTHORIZATION FOR RELEASE OF INFORMATION

AND

ASSIGNMENT OF BENEFITS

Patient Name_____

1. I authorize you to release any information acquired in my examination and treatment to the appropriate insurance company for any associated charges.
2. I request that Payment be made directly to Branson Dialysis on any bills for services furnished by providers or licensed personnel employed by them, including outpatient dialysis treatments and services.
3. In cases where Medicare or Medicaid is the primary insurance, I understand that I am only responsible for the deductible and coinsurance at the Medicare or Medicaid allowable charge amount, respectively. For any services that are non-covered under Medicare or Medicaid programs, I agree to pay the usual and customary charge for that procedure.
4. In cases where my insurance is an Employer Group Health Plan or Individual Policy other that Medicare or Medicaid, I understand and agree that I am responsible for any charge, including deductibles and coinsurance amounts that are deemed to be my responsibility.

_____ _____

Patient Signature Date

By: _____ _____

Relationship to patient

BRANSON DIALYSIS

INSURANCE / PPO / HMO / VA

AUTHORIZATION ACKNOWLEDGEMENT

If your commercial primary or commercial secondary insurance company required prior authorization for the treatment, pharmacy, or blood products that you may require while at Branson Dialysis, you home unit is required to have that authorization in place prior to your treatment. A copy of the authorization must be faxed to out billing department two weeks prior to your arrival date**. If this authorization is not in place prior to your treatment, you will be required to pay your entire bill in advance. VA always requires prior authorization.**

I, _____, fully understand this policy and acknowledge my responsibility to ensure that any authorization required by my insurance policy is obtained in advance of my treatment at Branson Dialysis by my home unit, and I will be required to pay for the treatment in advance if this authorization is not obtained.

_____ _____

Patient's signature Date

BRANSON DIALYSIS CENTER

PHYSICIANS STATEMENT OF PATIENT STABILITY / COMORBID CONDITIONS

Patient: _____

Please check one of the following:

- ☐ I feel this patient is stable and should have no problems with traveling to another dialysis unit for transient treatments.
- ☐ I have advised this patient that they should not travel at this time for the following medical reasons:

  _____

  _____

1. Has the patient had any of the following acute co morbid conditions in the past 90 days? (If yes, give IDC 9 code associated with condition)?

   GI bleed ☐ Y ☐ N – IDC 9 code _____

   Pneumonia ☐ Y ☐ N – IDC 9 code _____

   Paracarditis ☐ Y ☐ N – IDC 9 code _____

2. Does the patient have any of the following chronic co morbid conditions? . (If yes, give IDC 9 code associated with condition)?

   Hereditary hemolytic and sickle cell anemia ☐ Y ☐ N – IDC 9 code _____

   Monoclonal gammopathy (in absence of multiple myeloma) ☐ Y ☐ N – IDC 9 code _____

   Myelodysplastic syndrome ☐ Y ☐ N – IDC 9 code _____

Comments_____
_____
_____
_____

_____ _____

Physicians signature Date

January 11, 2011

BRANSON DIALYSIS

101 SKAGGS ROAD, SUITE 301

BRANSON, MO 65616

PHONE: 417-335-5797, FAX: 417-334-3846

TO THE TRAVEL COORDINATOR:

Thank you for inquiring about travel arrangements for your patient. We are happy to have visiting patients and during the "season", frequently accommodate as many as twenty visitors a week. Because of this volume, we count on you to ensure that we have all of the information we need to provide good treatment to your patient. Although some of this information may seem excessive or unnecessary, we request what is required by our state licensing agency or more importantly, what we may need in the event of an emergency involving your patient. The physician's statement of stability provides us with a "heads up" for those patients who may be at a higher risk for developing problems while out of town. We know that sometimes patients will insist on taking a vacation in spite of their physician's recommendations against travel. If we know that, we can keep a closer eye on them while they are here.

We do our best to arrange your patient's treatment schedule so that they can take full advantage of their time here. However, we also maintain a regular patient roster and cannot ask them to disrupt their schedules for nine months of the year to accommodate visitors. Most of the shows have more than one show scheduled each day. Patients can arrange their show schedule more easily than they think, and we encourage them to check show schedules on-line and by calling the theatres. Most every visitor wants an early morning spot, as do most of our patients. However, if a patient is in the hospital or is not here for some reason, we will call someone to fill that spot. For that reason, it is very important that we have a means of contacting the visiting patient. Please provide us with a working cell phone number and ask the patient to keep it on.

Because we have so many visitors, it is impossible for us to call on each visiting patient to determine if prior authorization is require and to then obtain prior authorization. We, therefore, ask that the home unit bear that responsibility. If prior authorization is required for an insurance or VA patient and not provided to us by the home unit, the patient will unfortunately be required to pay for his or her treatment. If prior authorization is not required you may state that on the fax cover sheet. **PLEASE** ensure that you send this information to us two weeks prior to the scheduled visit.

We must have the requested information at least one week prior to the patient's visit. We do not require the most recent flow sheets. For example, if your patient is scheduled for the second week of the month, we can the flow sheets from the last week of the previous month. We must have the charts to our physician for review and signatures by Wednesday of the week prior to the scheduled visit. We do not require labs from the month of the visit- three months prior to the visit are sufficient. For example send January, February, March for an April visit.

Please do not hesitate to contact is if you have any questions or concerns. We want this to be a time for the patient to relax and have some fun. You can help us do that by preparing your patients and sending the necessary information. **We do not schedule a chair for a patient until all of the requested information is received!** Thank you for your help in making vacation a fun experience for your patient and we look forward to assisting you and your patient during their visit.

IMPORTANT INFORMATION

BRANSON DIALYSIS

101 SKAGGS ROAD, SUITE 301

BRANSON, MO 65616

PHONE: 417-335-5797, FAX: 417-334-3846

TO THE VISITING PATIENT:

Thank you for your interest in visiting Branson and our dialysis unit. We are very happy to have visiting patients and look forward to seeing you. Included here is some information that may be useful as you prepare to visit.

We **CANNOT** give out specific treatment times until the day before your visit. The reason for this is that there are frequent changes in the schedule due to patient hospitalizations, new patients who must be schedule at the last minute, or other visiting patients who may have cancelled their visit for a variety of reasons. We therefore are not able to predict exactly which time slot may be available. We understand that most visitors may want to schedule shows ahead of time or may want an early treatment time. However, we have a regular patient load and cannot displace them from a time slot for a visitor. We hope that you can put yourself in their place and understand that, with sometimes as many as twenty visitors a week during the busy season, it would be very disruptive to their lives to be moved around to accommodate visitors. **Call 417-335-5797 and speak with the Charge Nurse or the Transient Coordinator. Two other numbers that may be helpful are Branson Dialysis at 417-335-8288 and Cox Medical Center Branson (hospital) at 417-335-7000.**

In the unlikely event that we need to change your scheduled time, it is important that you provide us with a cell phone number or a phone number where you will be staying. **Occasionally an early morning patient is hospitalized or unable to come at their time. We can then call and offer you that time slot, if we can contact you.**

You will need to bring whatever blankets or pillows you need during your treatment. We are unable to keep a supply available due to infection control issues. You will have a television available to you that will require headphones to hear with. We do allow eating in the unit and suggest you bring something if you are used to eating at the time of your scheduled treatment. We can provide you with ice during your treatment; however, we cannot keep food in the refrigerator or heat food in the microwave for you.

We are located next to Cox Medical Center Branson and a map has been provided to your travel coordinator. Please let us know if you require additional information and we look forward to seeing you. Please keep in mind that Branson traffic in “the season” can be extremely slow. It may benefit you to pre-drive your route to determine how long it will take you to get to the dialysis unit.

BRANSON DIALYSIS

VISITING PATIENT POLICY

1. Visiting hemodialysis patients are accepted for short-term dialysis care on a space available basis. Due to the frequent changes in patient's schedules in the unit, we cannot give visitors a specific treatment time until the day before their scheduled visit. Please call 417-335-5797 the day before your treatment for a specific time. (If that day is a Monday, please call on Saturday) The treatment time may be an evening shift.
2. The visiting patient's clinic must forward all required paperwork to Branson Dialysis. A checklist is included in the packet to assist with medical record collection and submission.
3. Copies of the patient's insurance cards must be received at least two weeks prior to the projected arrival date. The cards must be legible and enlarged. The home unit must obtain prior authorization for insurance.
4. Patients that have both primary and secondary insurance coverage will be responsible for any deductable, coinsurance or denied charges for all treatments and medications by their insurance plan.
5. Patients with Medicare only will be responsible for the 20% coinsurance of all treatments and medications provided. This amount must be paid prior to each dialysis treatment.
6. Patients with primary insurance will be responsible for the portion their insurance company states is their responsibility due to fee schedules, allowable, deductibles and co-payments.
7. Patients that are uninsured must prepay for their treatments and any medications prior to their first scheduled treatment.
8. Visiting patients must provide a local telephone number or working cell phone number where they may be contacted. At times, we may have the opportunity to offer an earlier treatment time, if a regular patient is in the hospital, for instance. Visiting patients must also provide a name and telephone number of a local person we can contact in the event of an emergency during the visitors treatment.
9. Routine laboratory work and EKGs will not be performed on visiting patients unless it is deemed medically necessary by the Medical Director or attending Nephrologists.
10. Patients may have sack lunches or snacks during treatment. 1 cup of ice will be provided.
11. We suggest that visitors bring pillows and blankets from home, if these are generally needed during treatment. Televisions are available at each station, but patients will need to bring headphones or ear buds with them to access the sound.

I, _____, fully understand this policy and my responsibilities as a visitor to Branson Dialysis.

_____ _____

Patient Signature Date

Patient Information

Patient Name:	DOB: / /	Sex:	Marital Status:
Parent or Legal Guardian (if minor):			
Address:	City:	State:	ZIP:
Phone: Cell	Home		
SSN:	HIC#:	Date 1st Dialysis: / /	
ESRD Diagnosis:	Primary	Secondary	
Treatment Dates Requested: ____/____/___ to ___/____/____		Total # of Treatments	

Referring Dialysis Unit Information

Referring Unit Name	Phone	Fax
Contact Nurse:	Social Worker:	
Primary Nephrologist	Phone:	Fax:
Emergency Contact	Relationship:	
Home Phone	Cell Phone	Work Phone

Local Residence Information (Transient City)

Local Address or Hotel:		
Local Emergency Contact:	Relationship	Phone
Dates Patient is planning on being in Branson ___/___/____ to ___/___/_____		Kt/V=_____ on ___/___/___

Home Facility Current Treatment Orders

In-Center Hemo
Self Care or Home Hemodialysis
Staff Assisted

Last Kt/V = _____ on ____/____/____

Dialyzer	Treatment Time:_____	Access:_____ _ Site:_____
Blood Flow Rate	Height: cm	Target weight kg
Heparinization: Total dose	Needle Gauge:_____ Button Hole Y N	Bath:
ESA	units Q_____	
Iron	mg Q_____	
Antibiotics		
Other		

Branson Dialysis Orders

Bath:____K	BFR:_____ _	Time:_____	TW:_____
Heparin:_____ unit bolus	Dialyzer : F160 _____	Needle GA:____	

Branson Medication orders

ESA: _____ u q _____ HGB:

Ferrlecit: / Prior month HGB:

Other Meds:

If not on 2K, what were last 2 potassium labs?
___/___/___ = _____ ; ___/___/___ = _____

Last 3 Post Weights: _____; _____; _____

Allergies	Branson Dialysis MD signature Date / /
CODE STATUS FULL DNR	Diabetic Yes No Insulin Dependent Yes No

Patient Specific Information
(Synopsis of unique characteristics of patient's treatments)

Patient's trends and usual response to treatment:	
Interdialytic wt. gains #kg	Usual B/P support methods
Unusual reactions or needs:	
Special needs or circumstances relative to transient visit:	

Intradialytic Monitoring

If applicable. Otherwise note "NA"

Special Labs:		Blood Glucose:	
Intradialytic treatments:	Dressing	O2	Other

Mobility: Ambulatory Non-ambulatory Ambulatory with assist Transfer independently
Amputee Single Double

Fluid restriction:

Enclosures: Check indicates information sent from home facility

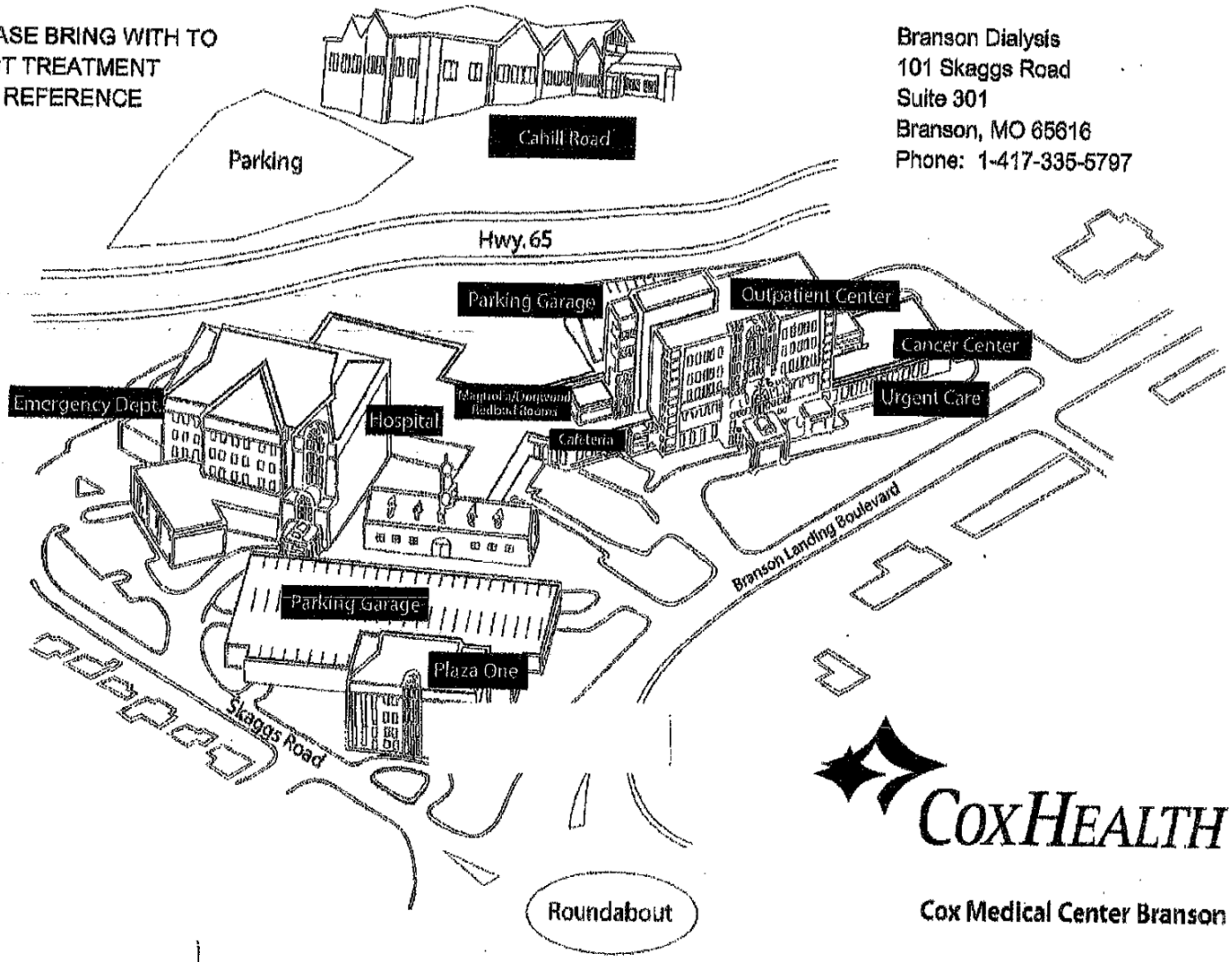
Standing orders	Advance Directive, if applicable
Completed ESRD transient hemodialysis form	Current H & P (within past 12 months)
Medication record (home and in-center)	3 flow sheets from week prior to visit date
Interdisciplinary Plan of Care (within 12 months)	Multidisciplinary Assessment (within 12 months)
MD progress notes (Last monthly note)	Visiting Patient Policy – signed by patient
PPD/Chest x-ray (within past 12 months)	Laboratory profile x 2 months prior to visit date
HbsAB Status Positive Negative date ____/____/____ (within 12 months)	HbsAg status must be negative and completed within 30 days of visit
Insurance cards – front & back (Must be Readable) Primary Secondary	CMS 2728
Demographics	

Prior Authorization completed, (must be obtained by home unit at least 2 weeks prior to visit date)

Special Instructions

PLEASE BRING WITH TO
FIRST TREATMENT
FOR REFERENCE

Branson Dialysis
101 Skaggs Road
Suite 301
Branson, MO 65616
Phone: 1-417-335-5797



CoxHealth

Cox Medical Center Branson

Date:_____
Time:_____
Co-payment $:_____
Pre-authorization needed: Y N