1. CONSENT
I authorize my physician and other physicians that may treat me, their associates and assistants and St. Louis Kidney Consultants, its staff, employees, agents and students to provide the medical care considered advisable by my physician. In consenting to treatment, I have not relied on any statements as to results. My physician will provide a clear description of the treatment ordered or recommended the material risks associated with the proposed treatment, excepted benefits of the treatment, a comparison of the benefits versus no treatment, and reasonable alternatives to the recommended treatment. My participation in treatment will indicate the above referenced benefits and risks have been fully explained. My signature consenting to treatment will also signify my clear understanding that I am always in control of what treatment is performed and that I may, at any time, refuse all or any part of the recommended treatment. I may also withdraw from treatment at any time.

2. STORAGE AND RELEASE OF INFORMATION
I consent to the electronic storage and transmission of patient information, including medical information. I hereby authorize St. Louis Kidney Consultants, its affiliates, and my treating physician to release by electronic means or otherwise any medical, prescription and/or billing information concerning my care, including copies of my medical records, to the following:
A. Any health professional, including but not limited to my referring physician, involved in my care for the purpose of facilitating the continuity of my medical care.
B. Any person or entity responsible for, or any person or entity acting as an agent for, the party responsible to pay for the medical services rendered to me at St. Louis Kidney Consultants by employees of St. Louis Kidney Consultants or any person providing services at St. Louis Kidney Consultants or any affiliate.
C. The party responsible to pay may include third party payors, self-insurers, workers’ compensation carriers and governmental agencies.
D. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining eligibility in government sponsored benefit programs.
E. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by St. Louis Kidney Consultants, affiliates, and/or their physicians, provided that those studies are deemed appropriate by St. Louis Kidney Consultants, affiliates, and/or their physicians.
F. Any continuing care, residential, or long-term care facility, or home health agency for the purpose of providing services for my care.

I acknowledge that the above authorization for release of information to the above-mentioned has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

3. HEALTH INSURANCE BENEFITS
I understand that any insurance I may have is a contract between me and my insurance company. St. Louis Kidney Consultants is not a party to this contract, in most cases. In cases where St. Louis Kidney Consultants is a party to my insurance contract, St. Louis Kidney Consultants will handle claims according to its agreement with the insurance company. St. Louis Kidney Consultants will not become involved in disputes between me and my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual & customary” charges, etc. other than to supply factual information as necessary. I understand I am responsible for verifying my level of benefits with my insurance company obtaining appropriate referrals or preauthorization’s from my insurance carrier or my primary care physician, and for coverage of supply & educational items, probes, or other durable medical equipment (DME) should such items be needed. I am also responsible for timely payment on my account.

4. MEDICARE/TRICARE/VA INSURANCE BENEFITS
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim filled by St. Louis Kidney Consultants. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year.

5. GUARANTEE FOR PAYMENT
I accordance with the above terms and in consideration of the services provided to the above named patient by St. Louis Kidney Consultants the undersigned agrees, whether he/she signs as patient or guarantor, to pay St. Louis Kidney Consultants for all services rendered. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payor, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred. Further, the undersigned acknowledges and agrees that Late Payment/Rebilling charges of the greater 1.5% of the balance or $15.00 are added to unpaid accounts on a monthly basis after 30 days from date of initial billing, and that Patient and Guarantor shall be responsible for all collection fees, attorney fees, court costs, and other fees incurred by St. Louis Kidney Consultants as a result of collection action for amounts due on this account.

6. ASSIGNMENT OF INSURANCE BENEFITS
In consideration of any and all medical services furnished by St. Louis Kidney Consultants, and its physicians, I authorize direct payment to St. Louis Kidney Consultants of all insurance benefits applicable to my care, which are now or which shall become due payable by me.

7. DISCLOSURE STATEMENT – DAVITA TOWN AND COUNTRY WEST
Pursuant to Missouri state law this disclosure is to advise you the physicians of St. Louis Kidney Consultants, specifically, Graeme Mindel, MD, and Jay Seltzer, MD have an investment interest in Davita Town and Country West and Davita Town and Country West at Home. We wish to inform you that should you be referred to the above named facility you are free to seek services elsewhere. Your ongoing care will not be conditioned on, or affected by accepting the referral to Davita Town and Country West or Davita Town and Country West at Home.

8. NOTICE OF PRIVACY PRACTICE
I acknowledge that I have received and been given the opportunity to review St. Louis Kidney Consultants Notice of Privacy Practice and am aware of my rights and the uses of my protected health information as indicated in this notice.

___________________  ____________________  __________________
Signature of Patient or Person Authorized to Consent/ Relationship to Patient  Date
Signature of Guarantor (if other than custodial Parent or legal guardian)  Date
Witness  Date
MEDICAL RECORDS REQUEST & RELEASE

Date:_____________________________

Patient Name: _____________________________________ D.O.B. _____________________________

To:  ___________________________________________________
Name of Provider or Medical Provider

___________________________________________________
___________________________________________________

I, _________________________________________, hereby authorize and request the following information related
to my treatment and examination:

Initial Office Note                                                                          Other: _______________________________
Three (3) Most Recent Office Notes
Three (3) Most Recent Imaging Studies
Three (3) Most Recent Labs

_______________________________
be sent to:

St Louis Kidney Consultants
12855 N. Forty Drive, Suite 205
St. Louis, Mo  63141
Fax: (314) 548-6555

Patient’s Signature: _______________________________________

Patient’s Address: _______________________________________

_________________________________________

Patient’s Phone Number: _________________________________
St. Louis Kidney Consultants
HIPAA Acknowledgement
(Health Insurance Portability & Accountability Act)

I acknowledge that I have received and been given the opportunity to review St. Louis Kidney Consultants Notice of Privacy Practices and am aware of my rights and the uses of my protected health information as indicated in this notice. This HIPAA agreement will remain valid until otherwise terminated.

________________________________________________  _______________________________
Signature        Date of Birth

________________________________________________  _______________________________
Printed Name        Today’s Date

**Below is a list of persons I authorize to receive my medical information and/or may discuss my care with St. Louis Kidney Consultants.**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MEDICAL HISTORY

NAME:______________________________________________ DATE:_________________________

DATE OF BIRTH:____________________________________ MARITAL STATUS:____________________

OCCUPATION:____________________________________________________________________________

PREVIOUS OCCUPATION:__________________________________________________________________

DATE OF LAST PHYSICAL EXAMINATION:____________________________________________________

PLEASE LIST ALL SYMPTOMS:

1. _______________________________________________________________________________________
2. _______________________________________________________________________________________
3. _______________________________________________________________________________________
4. _______________________________________________________________________________________
5. _______________________________________________________________________________________
6. _______________________________________________________________________________________

PERSONAL HISTORY  (please circle all answers that apply)

Have you ever had:

- Anemia                     yes   no    Gallbladder Disease   yes   no    High Blood Pressure    yes   no
- Jaundice                   yes   no    Rheumatic Fever       yes   no    Colitis or Bowel Disease  yes   no
- Arthritis                  yes   no    Kidney Disease         yes   no    Thyroid Disease        yes   no
- Tuberculosis               yes   no    Bladder Disease        yes   no    Bleeding Disorder      yes   no
- Measles                    yes   no    Chicken Pox            yes   no    Small Pox              yes   no
- Mumps                      yes   no    Pleurisy                yes   no    Cancer                 yes   no
- Stroke                     yes   no    Diabetes                yes   no    Epilepsy                yes   no
- Hay Fever                  yes   no    Asthma                  yes   no    Pneumonia               yes   no

Any Bone or Joint Disease   yes   no

Do you smoke?_________________  Do you drink alcohol?__________________

Do you have any allergies?    yes   no

Please list your allergies:  _____________________________________________________________________
__________________________________________________________________________________________

Surgery

Have you had any operations? Please list below.

Type:_____________________________________________________ Year:____________________
Type:_____________________________________________________ Year:____________________
Type:_____________________________________________________ Year:____________________
Type:_____________________________________________________ Year:____________________
MEDICATION LOG

Patient Name: ___________________________________________  DOB: ____________________________

Home Phone: _______________________________  Alternate Phone: ________________________________

Pharmacy: _______________________________  Pharmacy Phone: ________________________________

List All Allergies: ________________________________________________________________

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
St. Louis Kidney Consultants

PATIENT INFORMATION (Please Print)

Patient: ___________________________________________________________________________ Birth Date:_____________________ Age:_________________

last name                                   first                                      middle

Home Address:_________________________________________________________________________________________________________________________
street address                                                                  city/state/zip

Primary Phone:_____________________________ Check One: □ Home □ Cell □ Work □ Other:

Secondary Phone:_____________________________ Check One: □ Home □ Cell □ Work □ Other:

Email Address:________________________________________________          Preferred Correspondence Address: □ Email Address □ Mailing Address

Soc. Sec. No:_______________________________ Check One: □ Single □ Married □ Divorced □ Widowed

Employed by:_________________________________________________________________ Occupation_______________________________________________

Employer’s Address__________________________________________________________________________________________ (           )____________________
street address                                                                 city/state/zip                                                              work phone

How did you hear about us: ______________________________________________________________________________________________________________

Family Physician: ________________________________________________________   Referring Physician____________________________________________

Person/ Persons Responsible for Payment: (If different from patient)
Name: ____________________________________________________  Relationship: ___________________________ Soc. Sec. No. ________________________

Address: ______________________________________________________________________________________________________________________________
street address                                                                       city/state/zip

Primary Phone:   (           )_____________________________     Secondary Phone:  (            )_____________________________________

SPOUSE OR GUARDIAN INFORMATION

Check one: □ Spouse □ Guardian: ___________________________________________ Soc. Sec. No._________________________

Address: (street/city/zip) __________________________________________________________________________Home/Cell #(           )_____________________

Employed By:______________________________________________________________________________________ Work #(           )______________________

Address:  (street/city/zip)________________________________________________________________________________________________________________

If above name is a parent, please complete the following for the other parent:  Soc. Sec No. ______________________

Name:__________________________________________________________________________________________ Home #(           )_______________________

Employed By: ___________________________________________________________________________________ Work # (           )______________________

Address: (street/city/zip)_______________________________________________________________________________________________________________

INSURANCE INFORMATION

1st Insurance:________________________________________________________ 2nd Insurance:______________________________________________________

Person Insured:_____________________________________ □ M □ F   Person Insured:_____________________________________ □ M □ F

Relationship to Patient: □ Self □ Spouse □ Dependent                 Relationship to Patient: □ Self □ Spouse □ Dependent

Policy No.________________________________   Group No._________________   Policy No._________________   Group No._________________   

Soc. Sec. No. ____________________________  Birth Date__________________ Soc. Sec. No. ____________________________  Birth Date__________________

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled, to be made on my behalf to St. Louis Kidney Consultants for any services furnished me. I authorize release of medical information needed to determine these benefits payable to related services.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that any information obtained from St. Louis Kidney Consultants staff is not to be deemed as a guarantee of benefits. I also understand it is MY responsibility to determine my actual insurance benefit levels.

Signature of Patient (or Legal Guardian)
Patient Information Form
Supplement

Patient Name: ______________________________________________________________________

Last     First               Date of Birth

St. Louis Kidney Consultants

With the adoption of Electronic Medical Records (EHR) we have been asked to obtain the
following information:

This Information is Voluntary

Preferred Spoken Language: ___ English
___ Spanish
___ Other: Specify: ________________________________

Ethnicity: (Check One)

___ Hispanic or Latino
___ Non Hispanic or Latino

Race: (Check Applicable)

___ Black or African American
___ Asian
___ Native Hawaiian or Other Pacific Islander
___ American Indian or Alaska Native
___ White
___ Other: ________________________________
Cancellation Policy/ No Show Policy
For Doctor Appointments

Cancellation/ No Show Policy for Doctor Appointment
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. In order to be respectful of the medical needs of other patients, please be courteous and call St Louis Kidney Consultants promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance.

● Appointments not cancelled at least 24 hours prior to the scheduled appointment time will be assessed a $40.00 fee.

● All No Shows will be assessed a $40.00 fee.

How to Cancel Your Appointment
To cancel appointments, please call 314-720-0900, press #1. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

I have read and understand the Cancellation/ No Show Policy.

________________________________________
Print Name

_____________________________  _____________________
Signature Patient/ Guardian Date

Effective 01/01/2015
<table>
<thead>
<tr>
<th>Condition</th>
<th>No History</th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
<th>Son</th>
<th>Daughter</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Stones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>