SURPRISE
12329 W Bola Dr, Suite 100, Surprise, AZ 85378
Phone 623-270-7441 · Fax 623-270-7442 · heelexsurprise.com

New Patient Registration

Fill this out on your computer or phone. Type in the boxes, save the file, and email it to **office@heelexsurprise.com** before your visit so we can set up your chart. You can also print it and bring it, or fax it to 623-270-7442. Your email address is needed to set up your patient portal.

PATIENT INFORMATION

Last name _____ **First name** _____ **M.I.** ____ **Today's date** _____

Date of birth _____ **Age** _____ **Sex** _____ **SSN** _____

Email _____

Street address _____

City _____ **State** _____ **ZIP** _____

Cell phone _____ **Home phone** _____

Employer _____ **Marital status** _____

May we leave a voicemail or text appointment reminders? ☐ Yes ☐ No

EMERGENCY CONTACT

Name _____ **Relationship** _____ **Phone** _____

May we share information with this contact? ☐ Medical ☐ Billing ☐ Both ☐ None

LEGAL GUARDIAN / HEALTHCARE POWER OF ATTORNEY

Do you have a legal guardian or healthcare power of attorney? ☐ Yes ☐ No

If yes, name _____ **Relationship** _____ **Phone** _____

RESPONSIBLE / INSURED PARTY *Complete only if different from the patient*

Name _____ **Date of birth** _____

Relationship to patient _____ **Phone** _____

PRIMARY CARE & PHARMACY

Primary care physician _____ **Date last seen** _____

Referring physician (if any) _____ **How did you hear about us?** _____

Pharmacy name _____ **Pharmacy phone** _____

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Health History

VITALS

Height _____ **Weight** _____ **Shoe size** _____

LIFESTYLE

Smoking ☐ Never smoked ☐ Former smoker ☐ Current smoker

How long _____ **Quit date** _____

Do you drink alcohol? ☐ Yes ☐ No **Drinks per week** _____

Recreational drug use? ☐ Yes ☐ No **Comments** _____

YOUR CONDITION

Briefly describe your symptoms (where, how long, what makes it better or worse):

_____

_____

Other practitioners you have seen and treatments you have tried for this problem:

_____

Do you get prescriptions from a pain clinic? ☐ Yes ☐ No **If yes, where** _____

Pacemaker, defibrillator, stents, metal implants, or organ transplant? ☐ Yes ☐ No

If yes, describe _____

Previous surgeries and dates	**Current medications (include over-the-counter & supplements)**
☐ None	☐ None

Serious medical problems in family members	**Medication allergies (and reaction)**
☐ None	☐ None

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Past Medical History

Do you now have, or have you ever had, any of the following? Check all that apply.

☐ Diabetes	☐ Pneumonia	☐ Colitis
☐ High blood pressure	☐ Tuberculosis	☐ Rheumatic fever
☐ High cholesterol	☐ Hypothyroidism	☐ Arthritis
☐ Heart problems	☐ Goiter	☐ Gout
☐ Heart murmur	☐ Kidney disease	☐ Lupus
☐ Angina	☐ Kidney stones	☐ Scleroderma
☐ Stroke	☐ Anemia	☐ Psoriasis
☐ DVT (blood clot)	☐ Hepatitis	☐ Epilepsy (seizures)
☐ Pulmonary embolism	☐ Jaundice	☐ Cataracts
☐ Asthma	☐ Stomach or peptic ulcer	☐ HIV / AIDS
☐ Emphysema / COPD	☐ Crohn's disease	☐ Leukemia

Cancer ☐ Yes ☐ No **Type and year** _____

Any autoimmune disorder? ☐ Yes ☐ No **Which** _____

Other _____

_____

☐ **None of the above**

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Heelex Surprise (Heelex 2 LLC) and JSPhyMgmt to release any information needed by my insurance carrier(s) to process claims for services provided to me. I assign insurance benefits for those services directly to Heelex Surprise and JSPhyMgmt. I understand that I am responsible for any amount not covered by insurance, or for the full amount if I do not have insurance.

MEDICAL RECORDS RELEASE

I authorize Heelex Surprise and JSPhyMgmt to request my medical records from, and send records of my visits to, my primary care physician and/or referring physician listed on page 1.

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Medication History & E-Prescribing Consent

Medication history is a list, from your pharmacy and/or your physicians, of medications you take or have taken. We use it to treat you safely and to avoid dangerous drug interactions.

E-prescribing allows your provider to send prescriptions electronically to the pharmacy of your choice. This reduces medication errors and improves patient safety. The Medicare Modernization Act (MMA) of 2003 set standards that every e-prescribing program must include:

- **Formulary and benefit transactions** – tell the prescriber which drugs your plan covers.
- **Medication history transactions** – show the prescriber the medications you already take, to reduce adverse drug events.
- **Fill status notifications** – let the prescriber know whether a prescription was picked up, not picked up, or partially filled.

Please tell us about every medication you take, including prescriptions, over-the-counter drugs, supplements and herbal products. Medications paid for without insurance may not appear in your history.

HIPAA Authorization for Disclosure of Protected Health Information

For treatment, payment, and healthcare operations

I understand that as part of my healthcare, this Practice creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care. This information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who contribute to my care;
- a source of information for applying my diagnosis and treatment information to my bill;
- a means by which a third-party payer can verify that billed services were actually provided; and
- a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I have been offered a copy of the Practice's Notice of Privacy Practices, which describes in more detail how my information may be used and disclosed. I understand that it may be necessary to share my Protected Health Information with other covered entities involved in my care, and that I have the right to review the Notice before signing. I authorize the disclosure of my Protected Health Information for the purposes described above.

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HIPAA Consent for Use and Disclosure of Protected Health Information

I understand that:

- I have the right to review the Practice's Notice of Privacy Practices before signing this consent.
- The Practice may change its Notice and practices, and will mail me a copy of any revised Notice at the address I provided, if I request it.
- I have the right to object to the use of my health information for directory purposes.
- I may ask the Practice to restrict how my Protected Health Information is used or disclosed for treatment, payment, or healthcare operations. The Practice is not required by law to agree to the restrictions I request.
- I may revoke this consent in writing at any time, except to the extent the Practice has already acted in reliance on it.

I consent to Heelex Surprise (Heelex 2 LLC) and JSPhyMgmt and their affiliated providers using and disclosing my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO).

With this consent, the Practice may:

- call or email me at home or another location I provide, and leave a voice, email, or in-person message about items that support TPO, such as appointment reminders, insurance matters, and my clinical care, including test results; and
- mail items that support TPO, such as appointment reminder cards, statements, and clinical information, to my home or another location I provide, as long as they are marked “Personal and Confidential.”

If I do not sign this consent, or if I later revoke it, the Practice may decline to provide treatment to me.

Consent to Use Artificial Intelligence (AI) in Medical Documentation

Your provider may use an AI documentation tool to help write accurate, complete, and efficient visit notes. The tool helps draft and organize the note from what your provider dictates. Your provider reviews and approves every note before it is signed and becomes part of your permanent record.

AI is only a tool for documentation. It does not replace your provider. Your diagnosis and treatment plan are decided by you and your provider. Your information remains protected under HIPAA.

Lab Work, Biopsies & Cultures

Bloodwork. Your provider will give you an order to take to the lab of your choice.

Biopsies and cultures. Your provider will send these to the lab for you. The lab bills you separately. For lab billing questions, please call:

Laboratory	Billing phone
Integrated Pathology	623-889-0100
Sonora Quest Diagnostics	602-685-5000

Questions? Call Heelex Surprise at 623-270-7441.

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care, or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or deductible. You may have other costs, or have to pay the entire bill, if you see a provider or visit a facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. It can happen when you can't control who is involved in your care, such as when you have an emergency, or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles you would pay if the provider or facility were in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must: cover emergency services without requiring approval in advance (prior authorization); cover emergency services by out-of-network providers; base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility, and show that amount in your explanation of benefits; and count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact: **Heelex Surprise, 12329 W Bola Dr, Suite 100, Surprise, AZ 85378, 623-270-7441.**

For more information about your rights under federal law, visit the CMS No Surprises website: https://www.cms.gov/nosurprises/consumers

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Acknowledgment and Consent

Please read, then sign below.

I have read and understand each section of this packet, and by signing I agree to:

- Insurance Authorization and Assignment
- Medical Records Release
- Medication History / E-Prescribing Consent
- HIPAA Authorization for Disclosure of Protected Health Information
- HIPAA Consent for Use and Disclosure of Protected Health Information
- Consent to Use Artificial Intelligence (AI) in Medical Documentation
- Your Rights and Protections Against Surprise Medical Bills
- Lab Work, Biopsies & Cultures
- Financial Policy: Payment, Collections and $25 No-Show Fee
- Medical Records Release Authorization (family members), Surescripts Medication History Consent and HIPAA E-Mail Consent, where signed

By signing, I authorize and consent to Heelex Surprise and JSPhyMgmt and their affiliated providers to:

- Evaluate, diagnose, and treat my condition
- Submit claims to my insurance company
- Send prescriptions to my pharmacy
- Send specimens to a laboratory for testing
- Request records from my primary care physician
- Send my medical records to providers I am referred to
- Share my information with affiliated Heelex practices involved in my care
- Use AI documentation tools in my medical record

FINANCIAL POLICY

Payment. Copays, coinsurance, deductibles, and services my insurance does not cover are due at the time of service or when billed. If my account is not paid, it may be sent to a collection agency.

Missed appointments. If I miss a scheduled appointment without calling ahead to cancel or reschedule, a $25 no-show fee will be charged to my account. Insurance does not pay this fee.

I confirm that all information completed by me or my representative is true and correct to the best of my knowledge.

Patient legal name (print) _____

Patient signature _____ **Date** _____

If signed by a guardian or authorized representative:

Representative name (print) _____ **Relationship** _____

Representative signature _____ **Date** _____

OFFICE USE ONLY Chart # _____ Entered by _____ Date _____ ☐ Insurance card scanned ☐ Photo ID scanned

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Medical Records Release Authorization

Release of medical records to family member(s)

I, the undersigned, authorize the healthcare provider listed below to release my protected health information (PHI), including medical records, test results, and treatment history, to the following family member(s):

Patient name _____ **Date of birth** _____

Healthcare provider _____

Name	Relationship	Phone number

INFORMATION TO BE RELEASED *Check all that apply*

- ☐ Complete medical records
- ☐ Appointments / scheduling
- ☐ Test results
- ☐ Billing information
- ☐ Other (please specify): _____

PATIENT RIGHTS

- I may revoke this authorization at any time by submitting a written request to the provider listed above.
- Revocation will not apply to information already released based on this authorization.
- My healthcare provider cannot require me to sign this form as a condition of receiving treatment.
- Once information is released, it may no longer be protected by HIPAA privacy regulations.

Patient signature _____ **Date** _____

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Consent to Access Medication History from Surescripts

Patient name _____ **Date of birth** _____

PURPOSE

Heelex Surprise uses Surescripts, a secure electronic network, to access prescription medication history. This lets our providers get an accurate and complete medication list so your treatment is safe and effective.

CONSENT

I authorize Heelex Surprise and its healthcare providers to access and import my medication history and prescription information through the Surescripts electronic prescribing network. This information may include prescriptions filled at retail pharmacies and mail-order pharmacies, and prescriptions written by other healthcare providers.

I understand that:

- This information will be used only to provide me with medical care and treatment.
- My medication history may include information going back several years.
- I may revoke this consent at any time by submitting a written request to Heelex Surprise.
- Revoking this consent will not affect any actions taken before the revocation date.

AUTHORIZATION

By signing below, I acknowledge that I have read and understand this consent form. I authorize Heelex Surprise to obtain my medication history through the Surescripts network.

Patient signature _____ **Date** _____

If signed by an authorized representative:

Representative name (print) _____ **Relationship to patient** _____

Representative signature _____ **Date** _____

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HIPAA E-Mail Consent

Important: please read before signing

Patient name _____ **Date of birth** _____

Email address _____

ABOUT EMAIL AND YOUR PRIVACY

HIPAA (the Health Insurance Portability and Accountability Act) was passed by the U.S. government in 1996 to establish privacy and security protections for health information.

Most popular email services (such as Gmail, Yahoo, Hotmail and Microsoft Outlook) do not use encrypted email. When we send you an email, the information is not encrypted. This means a third party may be able to access and read it while it travels over the Internet. Once the email reaches you, someone may also be able to access your email account and read it.

Because email is a popular and convenient way to communicate, the federal government provided guidance on email in its latest updates to HIPAA (Federal Register, January 25, 2013, page 5634; https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf).

The guidance states that if a patient has been made aware of the risks of unencrypted email, and the patient consents to receive health information by email, the healthcare provider may send that patient personal medical information by unencrypted email.

YOUR CHOICE

☐ **I will allow unencrypted email**

I understand the risks of unencrypted email and give permission to David M. Bates and Heelex Surprise to send me personal health information by unencrypted email.

Patient name (print) _____

Patient signature _____ **Date** _____