Surprise Health Center, PLLC

Medical History

Patient Name: _____ **DOB:** _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Height:**_____ **Weight:**_____

Employment Status: ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Student

If Employed Occupation _____ Employer _____

Preferred Pharmacy

Name _____

Major Intersections _____

City _____ Phone Number _____

For Women Only

Number of Children: _____

Age Menstruation Began: _____

Date of last menstrual period: _____

Social Habits (Check all that Apply):	Type	Frequency
☐ **Tobacco**		
☐ **Alcohol**		
☐ **Caffeine**		

Current Medications	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Surprise Health Center, PLLC

Patient Name: _____ DOB: _____/_____/_____

Allergies	Reaction
1.	
2.	
3.	
4.	
5.	

Hospitalization and Surgical History		
Hospital/Doctor	**Date**	**Reason/Procedure**
1.		
2.		
3.		
4.		
5.		

Personal and Family History (Check all that Apply)			
Anemia	☐ None	☐ Self	☐ Family Member:
Asthma	☐ None	☐ Self	☐ Family Member:
Bleeding Tendency	☐ None	☐ Self	☐ Family Member:
Cancer	☐ None	☐ Self	☐ Family Member:
		Type:	
Diabetes	☐ None	☐ Self	☐ Family Member:
Heart Disease	☐ None	☐ Self	☐ Family Member:
High Blood Pressure	☐ None	☐ Self	☐ Family Member:
Mental or Nervous Disorder	☐ None	☐ Self	☐ Family Member:
Migraine Headaches	☐ None	☐ Self	☐ Family Member:
Thyroid Disease and Goiter	☐ None	☐ Self	☐ Family Member:
Tuberculosis	☐ None	☐ Self	☐ Family Member:
Other	☐ None	☐ Self	☐ Family Member:
Other	☐ None	☐ Self	☐ Family Member:

Surprise Health Center, PLLC

Patient Registration Form

Patient Name | **Date of Birth** | **Age**

Sex ☐ Female ☐ Male

Mobile Phone | **Home Phone**

Email Address (For access to Patient Portal)

Mailing Address (Street/PO Box) | **City** | **State** | **Zip**

Emergency Contact Name | **Relationship to patient** | **Contact Number**

How did you hear about our office? _____

Insurance Information

Primary Insurance Plan Name | Effective Date | Member ID Number

Insurance Address (PO Box on back of card) | Group Number

Subscribers Name (If different from patient) | Date of Birth | Relationship to Patient

Subscribers Address | Phone Number | Sex: ☐ Female ☐ Male

Secondary Insurance Plan Name | Effective Date | Member ID Number

Address (PO Box on back of card) | Group Number

Subscriber Name (If different from patient) | Date of Birth | Relationship to Patient

Subscriber Address | Phone Number | Sex: ☐ Female ☐ Male

The above information is true to the best of my knowledge. I authorize Surprise Health Center to release any information required to process my claims to my insurance company(s), and request payment of benefits to my Physician. I acknowledge I am financially responsible for payment whether or not it is covered by insurance.

➢

Patient/Guardian Signature | **Date**

Surprise Health Center, PLLC

Patient Financial Responsibility Form

Patient Name **Date of Birth**

Payment is due at the time of service including, but not limited to, any copayments, unmet deductibles and any fees not covered by insurance will be your responsibility to pay. Payment can be cash, check, money order, VISA, Discover, or MasterCard and can be paid in office or by phone. You will be charged a fee of $25 for any returned check.

☐ I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.

☐ Co-payments are due at time of service.

☐ If my plan requires a referral, I must obtain it prior to my visit.

☐ In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

☐ If I am uninsured, I agree to pay for the medical services rendered to me, at time of service.

☐ Appointments not canceled with a 24 hour notice, are subject to a $25.00 "No-Show Fee"

☐ If labs are ordered during my visit, it is my responsibility to verify coverage of the lab tests (i.e., lab test ordered and diagnosis code/reason for the lab) by calling my insurance company, prior to having them done.

I have read and agree to the Financial responsibilities listed above

➢ **Patient/Guardian Signature** **Date**

Policy on Advance Directives

The State of Arizona regulations require that your medical chart contains the following information.

☐ I have a Living Will State: _____

☐ I have a Medical Power of Attorney Designee: _____

☐ I have appointed a surrogate Agent: _____

☐ I have **NONE** of the above

Please note: As a patient of Surprise Health Center, we wish to inform you that regardless of any of the above arrangements, physicians and staff of Surprise Health Center will in case of a life threatening emergency, resuscitate and maintain life as is possible until appropriate and safe transfer can be made to the nearest hospital.

➢ **Patient/Guardian Signature** **Date**

Surprise Health Center, PLLC

Authorization to Disclose Information

Patient Name **Date of Birth**

☐ At this time I **DO NOT** wish to authorize Surprise Health Center to discuss my records with anyone other than myself.

Name:____________________________ DOB: ____/____/____ Relationship: ________________

☐ I wish to release **ALL** aspects of my records to the above mentioned person.

☐ I wish to release **LIMITED** aspects of my records to the above mentioned person.

- ☐ Lab Results
- ☐ Imaging Results
- ☐ Prescriptions
- ☐ Referral Information
- ☐ Office Visit Notes
- ☐ Miscellaneous Document

Name:____________________________ DOB: ____/____/____ Relationship: ________________

☐ I wish to release **ALL** aspects of my records to the above mentioned person.

☐ I wish to release **LIMITED** aspects of my records to the above mentioned person.

- ☐ Lab Results
- ☐ Imaging Results
- ☐ Prescriptions
- ☐ Referral Information
- ☐ Office Visit Notes
- ☐ Miscellaneous Document

Name:____________________________ DOB: ____/____/____ Relationship: ________________

☐ I wish to release **ALL** aspects of my records to the above mentioned person.

☐ I wish to release **LIMITED** aspects of my records to the above mentioned person.

- ☐ Lab Results
- ☐ Imaging Results
- ☐ Prescriptions
- ☐ Referral Information
- ☐ Office Visit Notes
- ☐ Miscellaneous Document

We are required to provide you with a copy of Notice of Privacy Practices, which states how we may use and/or disclose your health information.

By Signing I Agree That

- I hereby acknowledge that I have been notified I can receive at my request a copy of Surprise Health Center's Notice of Privacy Practices.
- I Hereby Authorize Surprise Health Center to discuss my personal medical records with the above list of persons they may receive my Protected Health Information.
- I understand that I may revoke this release in writing at any time at my discretion.

➢ ______________________________________ ______________________

Patient/Guardian Signature **Date**

Surprise Health Center, PLLC

Cellular Device Consent

☐ **OPT-IN** (Complete Info Below) ☐ **OPT-OUT**

I, _____ consent to ☐ **Receiving Calls**
Patient Name

AND/OR ☐ **SMS/Text Messages** on my cellular device _____
Cell Phone Number

placed by the Clinic, its affiliates, business associates, and its service providers, from an automatic telephone dialing system and/or using an artificial or pre-recorded voice, including, but not limited to, for the purpose of appointment reminders and office closure announcements, and for the purpose of servicing my account, payment and billing, or collecting any amounts I may owe. I agree to notify the Clinic immediately if I change or obtain a new cell phone number, or no longer maintain the cell phone number provided in this provision at **www.surprisehealthcenter.com/appointments** or in writing, at the following address: **14973 W. Bell Rd., Suite 100, Surprise, AZ 85374**, and agree to provide my full name, address, date of birth, and Clinic number in my notification. I expressly acknowledge that I may be held liable for failure to do so, as outlined below in the **Indemnity Provision**.

Indemnity Provision

You agree to indemnify and hold the Clinic, its officers, agents and employees harmless from any liability, loss or damage, including but not limited to, attorney's fees they may suffer as a result of claims, demands, costs or judgments against them arising out of alleged violations of the Telephone Consumer Protection Act (TCPA) or similar laws, resulting from autodialed or artificial or pre-recorded voice calls placed to a reassigned cell phone number(s), originally belonging to you or which you provided to the clinic, but of which you failed to timely notify the Clinic that such number(s) was no longer assigned to your cellular device.

By Signing I Agree That

- I understand that SMS/text messages and cell phone messages carry certain risks. For example, messages may be sent in unencrypted form. They could be received by others if others have access to my device or if my messages are sent to another device. I understand the risks, and I expressly consent to receiving these messages and ask the Clinic to communicate with me in this form.
- I have read this disclosure in its entirety and agree that the Clinic, its affiliates, business associates and/or its service providers may contact me as described above.

➢ _____ _____ _____
Patient/Guardian Signature **Date of Birth** **Clinic #**

➢ _____ _____
Printed Name (Legal Representative or Guardian) **Relationship to Patient**

Surprise Health Center, PLLC

Patient Name: _____ DOB: _____/_____/_____

Office Policies Agreement

Phone Calls

Appointments

Late Policy

Cancelled Appointments

Medication Refills

Insurance Coverage of Tests/ Services/etc.…

Non-Clinical Office Services

Payment

Communication with Your Doctor

Getting Results of Labs/Tests

Patient Conduct

Dismissal from the practice

Confidentiality

Emergencies

By Signing I Agree That

- I have been offered/given a copy of the office policies for my records.
- I have read and agree to all of the office policies listed above

➢ _____ _____

Patient/Guardian Signature **Date**

Surprise Health Center, PLLC

KEEP PAGES 8-11 FOR YOUR RECORDS

Surprise Health Center
14973 W. Bell Rd. Surprise, AZ 85374
Phone: 623-815-2900 Fax: 623-583-1319

Office Policies

Office Hours: Monday - Friday 8:00 AM – 5:00 PM Closed on Holidays

Phone Hours: Monday-Thursday 8:05 AM – 4:30 PM; Friday 8:05 AM – 4:00 PM

Voice Mail available for Lunch (12:15-1:00 daily), after hours, weekends, and holidays

Phone Calls

Please be specific when you are calling in as to what your call is regarding i.e. appointments, prescriptions, referrals etc. This may prevent you from being sent to someone's voicemail. Calls are usually returned by the end of the day, but no later than 1-2 business days. If it is an urgent issue ask the receptionist to take a message. If you reach the voice mail, please leave a detailed message with your name and date of birth, phone number and the reason for your call. All calls will be returned within 24-48 hours.

Controlled substances CANNOT be refilled by phone and will require appointment.

Appointments

Appointments can be scheduled with a receptionist during normal business hours or online. Routine appointments can usually be scheduled within 24-72 hours with your PCP. Only two family members may be scheduled on a single day. Some appointments can be accommodated the same day for urgent issues. Urgent same day appointments may have an additional charge that may not be covered by your insurance. Please plan accordingly as appointments are typically scheduled as follows:

New Patient Visits: 30 minutes

Established Patient Follow Up: 15 minutes

Established Patient Urgent Issue: 15 minutes

Time constraints limit the number of issues that can be addressed in any single visit. If you think you may need a longer appointment, please let the receptionist know during scheduling. Multiple issues could require additional visits. Follow-up appointments are scheduled based on the physicians' recommendation. Use the time you have with the provider efficiently.

Although we do accept many insurance plans, it is the patient's responsibility to verify that we are a covered provider with their insurance or network. Otherwise, we may only be covered out of network, putting the patient in a higher deductible situation.

Late Policy

If you are more than 15 minutes late to your appointment, you will be required to reschedule your appointment and a "No Show" fee will be applied.

Medication Refills

Upon physician approval, refill requests will be processed in 3 business days. Please factor that into the timing of your refill requests.

Controlled substances CANNOT be refilled by phone and will require an appointment.

Cancelled Appointments

APPOINTMENTS MUST BE CANCELED 24 HOURS IN ADVANCE OR ELSE THE PATIENT WILL BE RESPONSIBLE FOR A $25 NO SHOW/ CANCELATION FEE

If you fail to cancel your appointment at least 24 hours prior to your appointment, it will be tracked on your account and you will be charged a $25.00 "No-Show Fee". If you have 3 Cancelled/No Show appointments in a row you will be discharged from the practice unless the cancellation was due to a medical emergency. If you are unable to speak with the staff directly, leave a detailed message on the Front Office/Scheduling Voice Mail Box.

Insurance Coverage of Tests/ Services/etc.…

It may be necessary for your provider to order labs, tests, medications, consults, or other services NOT COVERED by your insurance plan. Different insurance plans vary widely in what they will and will not cover. Your provider orders what they determine is appropriate for your care independent of insurance coverage concerns. It is recommended you contact your insurance if you have questions about coverage.

Non-Clinical Office Services

Filling out disability paperwork, FMLA forms, Insurance related paperwork, and other similar services are not typically paid for by insurance. A paperwork Fee of $50 may be charged.

Payment

Payment is due at the time of service including, but not limited to; any co-payments and unmet deductibles. Any portion of fees not covered by insurance will be your responsibility to pay. Payment can be by cash, check, money order, Debit/Credit Card (except for American Express or Care Credit). You will be charge a $25 fee for any returned check.

Communication with Your Doctor

Direct contact during a scheduled appointment is the most effective forum for communication with your provider. Faxes, letters, and phone messages left for your provider are addressed as time allows and according to provider availability. There can be significant delays in communication through these formats. Additionally, most medical issues cannot be appropriately managed without a scheduled appointment as that is the only way you the patient has the undivided attention of your provider.

Messages can also be sent using your **Patient Portal**, contact the front office staff for an invitation to set up your portal at **623-815-2900**.

Getting Results of Labs/Tests

Results of labs/tests are the patients' responsibility. It is recommended that the patient schedule an appointment to discuss results directly with your provider. Information will not be communicated to relatives or others unless specifically requested by the patient by filling out the Authorization to Disclose Form. This includes spouses and parents of legal aged children. The phone number you provide as your contact number indicates you are willing to receive confidential messages regarding your healthcare at that number unless you specify in writing to the contrary. You should schedule a follow-up with the office to discuss your results 7-10 days of getting routine labs and tests done (some labs/tests may take longer)

Patient Conduct

Patients who are verbally or physically abusive, inappropriate or life threatening to staff in any way for any reason will be dismissed from the practice. This policy is strictly enforced.

Dismissal from the practice

Any patient can be dismissed from the practice for any reason at the sole discretion of Surprise Health Center. You will be notified in the event of dismissal and will have 30 days to find a new provider. Potential issues that might initiate dismissal of a patient include, but are not limited to; consistent cancellations, excessive calling, inappropriate behavior, noncompliance with medical advice, failure to pay fees, dishonesty on medical issues, differences in philosophy about your healthcare, and personality conflicts.

Confidentiality

Surprise Health Center strives to maintain the confidentiality of your medical records in accordance with HIPPA standards. Our complete privacy policy is available upon request.

Emergencies

If you have an immediate life threatening emergency call 911 or go to the Emergency room or Urgent Care for assistance.

Surprise Health Center, PLLC

Patients' Bill of Rights

The following is a statement of your rights, under the Patients' Bill of Rights

In reference to your health care.

1. The right to accurate and easily-understood information about the patient's health care and the providers of such care. If the patient speaks another language, has a physical or mental disability or just doesn't understand something, help should be given so that the patient can make informed health care decisions.

2. The right to know treatment options and take part in decisions about care. Parents, guardians, family members, or others can speak for the patient, if the patient cannot make his/her own decision.

3. The right to considerate, respectful care from your doctors and other health care providers that does not discriminate against the patient.

4. The right to talk privately with health care providers and to have health care information protected.

5. The right to read and copy your own medical record, and the right to ask that your doctor change the record if it is not correct, relevant or completed.

6. The right to examine and receive a detailed explanation of any medical bill, and the right to information regarding financial assistance the practice may offer.