Sun Valley House Call

14973 W. Bell Rd. Suite 100, Surprise, AZ 85374
Phone: 623-934-1245 Fax: 623-934-3598 Registration Email: registration@sv-hc.com

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

Date:_____ Requesting Services: **PCP** ☐ **Podiatry** ☐ **Wound Care** ☐

Resides In: **Group Home** ☐ **Independent Living** ☐ **Assisted living** ☐ **Memory Care** ☐ **Private Home (Podiatry Only)** ☐

Group Home/Facility Name:_____ Apartment/Room #: _____

Address:_____ City:_____ State:_____Zip:_____

Fac/GH Contact Info:_____ Fac/GH Phone#:_____ Fac/GH Fax#:_____

Fac/GH Cell#:_____ Fac/GH E-mail:_____

Last Name:_____ First Name:_____ MI:_____ DOB:_____

Social Security:____-____-____ Race:_____ Ethnicity: Non-Hispanic ☐ Hispanic ☐

Marital Status: **S** ☐ **M** ☐ **D** ☐ **W** ☐ Patient in Hospice? **YES** ☐ **NO** ☐ Company Name:_____

Male: ☐ Female: ☐

Primary Insurance:_____ ID#:_____ Group #:_____
Effective Date:_____ **Provide Copies of Card**

Secondary Insurance:_____ ID#:_____ Group #:_____
Effective Date:_____ **Provide Copies of Card**

☐ **I DO HAVE** an Active Medical Power of Attorney (MPOA) making all of my medical decisions on my behalf: SVHC is required to contact the MPOA prior to any and all treatments or evaluations (we do request a copy to keep in our office).

☐ **I DO NOT HAVE** an Active Medical Power of Attorney (MPOA), family member or requested caregiver that oversees all consent to rendering medical decisions or acting on my behalf. I am solely responsible for making all medical decisions myself.

Responsible Party/MPOA Name: _____ Relationship_____
Address: _____ City: _____ State:_____ Zip: _____Phone: _____
Email: _____
Emergency Contact Name: _____ Relationship_____
Address: _____ City: _____ State:_____ Zip: _____Phone: _____
Email: _____

Can you (**Patient**) Make your own Decisions: **YES** ☐ **NO** ☐
Do You Have a Current Living Will: **YES** ☐ **NO** ☐
Do You Have an Advanced Directive: **YES** ☐ **NO** ☐
We Do Request a Copy of All Forms to keep in our Medical Record

Patient / MPOA Signature: _____ Date: _____

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Patient Name: _____ DOB: _____ Date: _____

Medical History, Current Medical Conditions :

Past Medical History (Include Traumatic Events, Surgeries, Past Medical Conditions**):** _____

_____

_____

_____

Current Medical Conditions: _____

_____

_____

*Provide Copies of Current Medication List ***Required**

Name of Current Pharmacy: _____ Phone #: _____ Fax #: _____

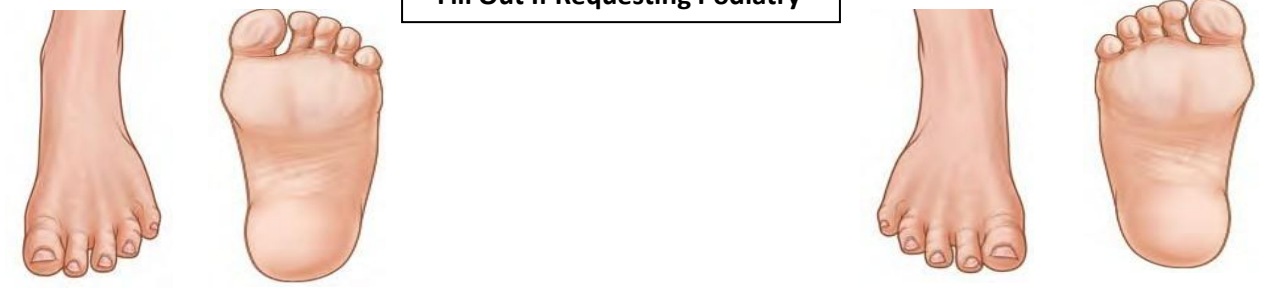
Address / Cross Streets: _____ City: _____ State: _____ Zip: _____

Patient's Current Chief Complaints (CC)/History of Present Illness (HOPI)

LEFT FOOT

Fill Out If Requesting Podiatry

RIGHT FOOT



Indicate the location of your problem or pain on the diagram above.

Does the pain radiate anywhere else on the foot/leg?

Indicate the severity of pain/discomfort

None ☐ **Light** ☐ **Moderate** ☐ **Strong** ☐ **Severe** ☐

Pain discomfort is

How long ago did pain/discomfort start? _____

Years ☐ **Months** ☐ **Weeks** ☐ **Days** ☐ **Hours** ☐

Pain occurs while

Walking ☐ **Standing** ☐ **Running** ☐ **Wearing Shoes** ☐

Does pain/discomfort cause difficulty with daily activity? YES ☐ NO ☐

Is this problem work related? YES ☐ NO ☐ Date of Injury: _____ Date of report to employer: _____

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Patient Name: _____ DOB: _____ Date: _____

A. **Medical Power of Attorney (MPOA) Declaration:** A representative of Sun Valley House Call is required to verify whether a patient has an active MPOA making medical decisions on their behalf. Whether a patient has one or not, SVHC is required to receive written consent from Patient / MPOA before evaluation or treatment can be rendered.

B. **Financial Responsibility:** I hereby authorize Sun Valley House Call to bill my insurance company for any and all services rendered and for the insurance to pay SVHC all proceeds or benefits directly. All co-pays, deductibles and out of pocket expenses will be billed to me or designated billing party, and are solely the responsibility of myself or designated billing party to pay SVHC in a timely matter. Any check submitted and returned for NSF will incur a $25.00 NSF fee

C. **Privacy Agreement:** HIPPA Notice of Privacy Practices; Patients' Rights and Responsibilities: By signing this document I acknowledge I have been educated of the Privacy Agreement - HIPPA Notice of Privacy Practices for Sun Valley House Call, and have been provided a copy. I may also obtain a copy upon request by calling the office of SVHC at 623-934-1245.

D. **Term of the Agreement and Consent:** This Agreement and Consent remains effective from the date signed, and includes all future services pertaining to the patient, until Patient / MPOA cancels consent for treatment in writing. I understand and agree that SVHC reserves the right to make changes to this agreement and that I, the Patient or MPOA will be notified in writing prior to any changes taking effect.

RELEASE ALL LIABILITY and CARE-GIVING OBLIGATIONS FROM MY CURRENT PRIMARY CARE PROVIDER / PODIATRIST:

I, "The Patient or MPOA for the Patient" , whose signature hereby release my current Primary Care Provider or Podiatrist from services. My new Sun Valley House Call PCP/POD will continue my care from this effective date forward: **I hereby consent to evaluation and treatment as directed by my SVHC Medical Provider or the designee.**

Previous PCP/POD : _____ **Phone:** _____ **Fax:** _____
Urology : _____ **Phone:** _____ **Fax:** _____
Cardiology : _____ **Phone:** _____ **Fax:** _____
Neurology :_____ _____ **Phone:** _____ **Fax:** _____
Last Hospitalization : _____ **Phone:** _____ **Fax:** _____
Last Rehab Facility : _____ **Phone:** _____ **Fax:** _____

RELEASE OF MEDICAL RECORDS REQUEST

I, "The Patient or MPOA for the Patient" , whose signature appears on this form, hereby authorize disclosure of the following information to Sun Valley House Call for the purpose of continuation of care with Sun Valley House Call and its' Providers. I understand I have the right to revoke this authorization at anytime and that the consent to release all medical records is voluntary. I understand that any disclosure of information carries with it the potential of unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. SVHC requests only pertinent medical records which consist of: problem lists, past and present medical history, surgical history, allergies, labs, radiology, vaccinations, physical exams, communicable, or infectious diseases, current and past medications, social history and any additional medical records that my SVHC medial provider deems necessary. I will permit all secure electronic means of transmitting my medical records. A copy of this authorization may be used in place of the original.

My signature below certifies that I have read and agree with all the notices, disclosures and consents posted on the front as well as the reverse side of form including "Privacy Agreement", "Term of this Agreement and Consent", "Release all Liability and Care-Giving Obligations" and "Release of Medical Records Request".

***Patient / MPOA Signature: X** _____ **Date: X** _____

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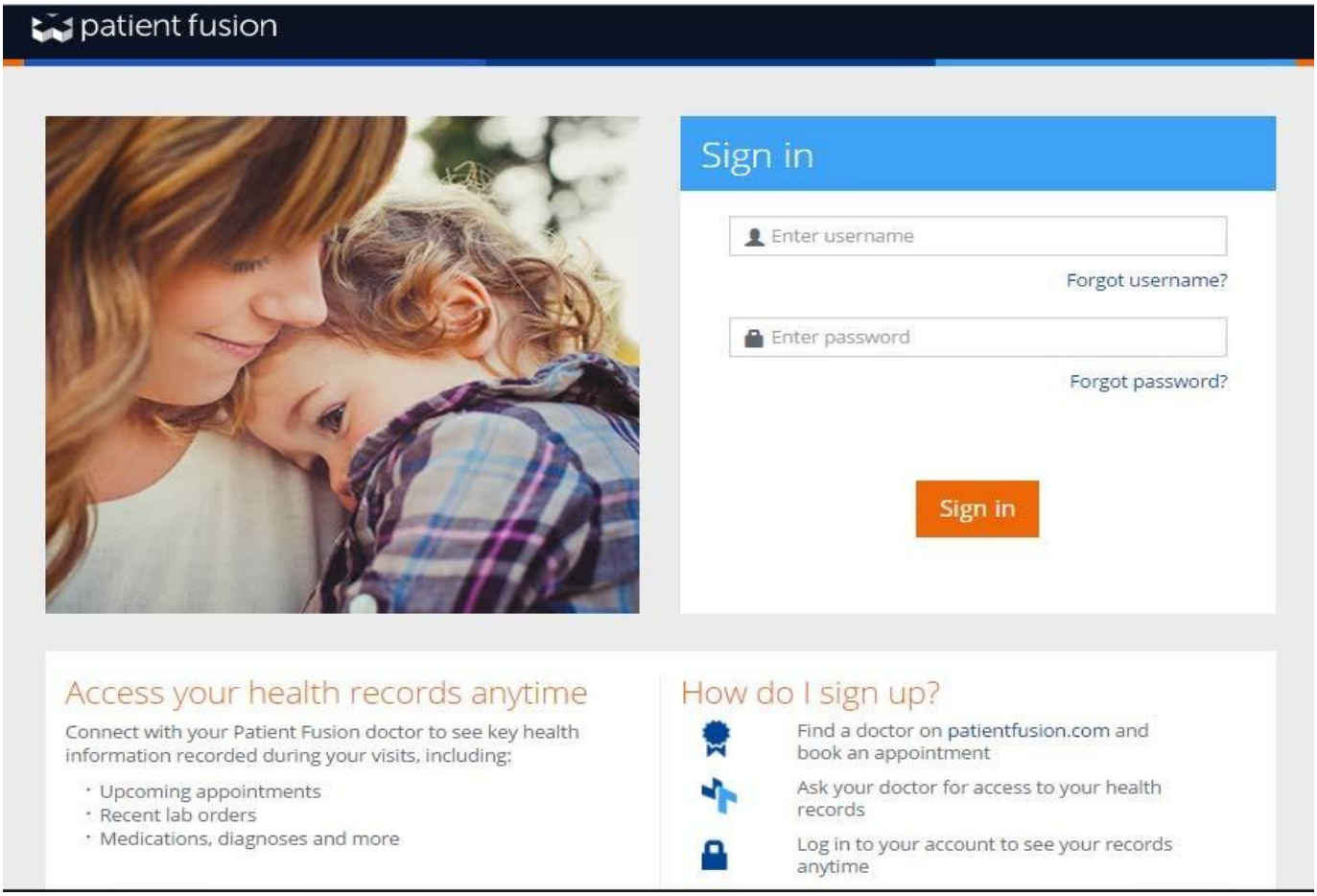
If you would like to be Set Up with Practice Fusion



Be sure to put your email and/or cell phone number on the registration packet if you would like access to the patient portal to see key health information!

Links to the portal can be found on our website at: www.SV-HC.com

Copies of Patient's Bill of Rights & Notice of Health Information Practices is available by request or on our website at: www.SV-HC.com

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Surprise Health Center, PLLC SVHC SUN VALLEY HOUSE CALL

Cellular Device OPT-IN Consent
For Cellular Calls and/or SMS/Text Messages

By providing your cell phone number, you expressly consent to receiving calls and/or SMS/text messages on your cellular device placed by Surprise Health Center PLLC ("the Clinic"), its affiliates, business associates, and/or its service providers, from an **automatic telephone dialing system and/or using an artificial or pre-recorded voice**. This could result in charges to you according to your data plan. These calls and messages will be for health care and related purposes including but not limited to, for the purpose of appointment reminders and office closure announcements, and for the purpose of servicing your account, payment and billing, and collecting any amounts you may owe.

If at any point you change or obtain a new cell phone number, or if you no longer maintain the cell phone number you originally provided to us, you agree to notify the Clinic immediately of such change by completing the Cellular Device OPT-IN Consent form at **www.surprisehealthcenter.com/appointments**. If you do not have internet access, you agree to notify the Clinic immediately of such change in writing, at the following address: **14973 W. Bell Rd., Suite 100, Surprise, AZ 85374, attention: Front Office Manager**. You agree to provide your full name, address, date of birth, and Clinic number in your notification.

You may be held liable for failure to do so, as outlined in the following provision:

Indemnity Provision - *READ CAREFULLY*:

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.

Opt-In

I, _____ expressly consent to receiving calls and/or SMS/text
(PATIENT NAME)

messages on my cellular device: _____ placed by the Clinic, its affiliates, business
(PATIENT CELL PHONE NUMBER)

associates, and/or messages 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, and expressly acknowledge that I may be held liable for failure to do so, as outlined above.

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 SIGNATURE DATE

_____ _____
DATE OF BIRTH CLINIC #

_____
LEGAL REPRESENTATIVE PRINTED NAME IF SIGNING FOR PATIENT (PARENT/GUARDIAN OF MINOR)

DESCRIPTION OF AUTHORITY TO SIGN FOR PATIENT: _____

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