Helium Medical Services PLLC

New Patient Registration MRN: Admin official Enter MRN here

Patient Information

First Name	Last Name	MI	Date of Birth
Patient First name here	Patient Last name here	Patient Middle I	DD/MM/YYYY

Address	City	State	Zip
Patient address here	Patient city here	Enter state here	Enter Zip here

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
	Home phone	Work phone	Cell phone

Other Name(s) Used	E-mail Address
Other name(s) used	E-mail address

Gender	SSN	Preferred Language	Driver's License
☐ M ☐ F ☐ Nonbinary	Enter SSN here	Select from list	Enter DL/issuing State

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married	☐ Mail	☐ Hispanic/Latino	☐ American Indian or Alaskan Native
☐ Single	☐ Home	☐ Non-Hispanic	☐ Asian
☐ Divorced	☐ Day Phone		☐ Black or African American
☐ Separated			☐ Native Hawaiian/Other Pacific Islander
☐ Widowed	☐ Cell Phone		☐ White
☐ Life Partner			☐ Other

Primary Care Provider	Referring Provider
Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as Patient

First Name	Last Name	MI	Date of Birth
First Name	Last Name	Middle Initial	DD/MM/YYYY

Address	City	State	Zip
Address	City	Choose State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
	Home Phone	Work Phone	Cell Phone

SSN	Relationship to Patient	Preferred Language	Driver's License
SSN	Rel. to Patient	Pref. Language.	Driver's Lic #

Emergency contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth
First Name	Last Name	Middle Initial	DD/MM/YYYY

Address	City	State	Zip
Address	City	Choose State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
	Home Phone	Work Phone	Cell Phone

I/We do hereby consent to and authorize the performance of all treatments, and medical services deemed advisable by the physicians and staff of Helium Medical to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Helium Medical to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of Patient /Responsible Party	DD/MM/YYYY
Signature of Patient /Responsible Party	Date

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Name of Patient/Responsible Party (Please Print)	Relationship to Patient
Name	Rel to Patient

Pharmacy Information

Preferred Pharmacy		Secondary Pharmacy	
Name	Pharmacy Name	Name	Pharmacy Name
Address	Pharmacy Address	Address	Pharmacy Address
Phone	Phone	Phone	Phone
Fax	Fax	Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney _____ ☐ Living Will ☐ HC Proxy

Date Reviewed: DD/MM/YYYY

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medication

	Medication Name	Dosage
1	Medication	Dosage
2	Medication	Dosage
3	Medication	Dosage
4	Medication	Dosage
5	Medication	Dosage
6	Medication	Dosage
7	Medication	Dosage
8	Medication	Dosage
9	Medication	Dosage
10	Medication	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

1	Known Allergies	3	Known Allergies
2	Known Allergies	4	Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset

Condition	Year	Condition	Year
☐ None	0	☐ Gallbladder Disease	0
☐ Allergies	0	☐ GERD (Reflux)	0
☐ Anemia	0	☐ Hepatitis C	0
☐ Angina	0	☐ Hyperlipidemia	0
☐ Anxiety	0	☐ Hypertension	0
☐ Arthritis	0	☐ Irritable Bowel Disease	0
☐ Asthma	0	☐ Liver Disease	0
☐ Atrial Fibrillation	0	☐ Migraine Headaches	0
☐ Benign Prostatic Hypertrophy	0	☐ Myocardial Infarction	0
☐ Blood Clots	0	☐ Osteoarthritis	0
☐ Cancer Enter type	0	☐ Osteoporosis	0
☐ Cerebrovascular Accident	0	☐ Peptic Ulcer Disease	0
☐ Coronary Artery Disease	0	☐ Renal Disease	0

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☐ COPD (Emphysema)	0	☐ Seizure Disorder	0
☐ Crohn's Disease	0	☐ Thyroid Disease	0
☐ Depression	0	☐ Other Enter other condition not listed	0
☐ Diabetes	0	☐ Other Enter other condition not listed	0

Surgical History – Check if you have received the following procedures, and enter the year performed

Surgical Procedure	Year	Surgical Procedure	Year
☐ None	0	**Male Only**	
☐ Angioplasty	0	☐ Prostate Biopsy	0
☐ Angioplasty w/Stent	0	☐ TURP(Trans-urethral resection of Prostate)	0
☐ Appendectomy	0	☐ Vasectomy	0
☐ Arthroscopy Knee	0	☐ Other Enter other surgery not listed	0
☐ Back Surgery	0	☐ Other Enter other surgery not listed	0
☐ CABG (heart bypass)	0		
☐ Carpal Tunnel Release	0	**Female Only**	
☐ Cataract Extraction	0	☐ Augmentation Mammoplasty	0
☐ Cholecystectomy	0	☐ Bilateral Tubal Ligation	0
☐ Colectomy	0	☐ Breast Biopsy	0
☐ Colostomy	0	☐ Cesarean Section	0
☐ Gastric Bypass	0	☐ D and C	0
☐ Hernia Repair	0	☐ Hysterectomy	0
☐ Hip Replacement	0	☐ Mastectomy	0
☐ Knee Replacement	0	☐ Myomectomy	0
☐ LASIK	0	☐ Reduction Mammoplasty	0
☐ Liver Biopsy	0	☐ TAH/BSO	0
☐ Pacemaker	0	☐ Vaginal Hysterectomy	0
☐ Small Bowel Resection	0	☐ Other Enter other surgery not listed	0
☐ Thyroidectomy	0	☐ Other Enter other surgery not listed	0
☐ Tonsillectomy	0		

Health Maintenance – Check if you have received the following, and the date of most recent exam

Exam	Year	Exam	Year
☐ None	0	☐ GYN Exam	0
☐ Breast Exam	0	☐ Influenza Vaccine	0
☐ Cardiac Stress Test	0	☐ Lipid Panel	0
☐ Colonoscopy	0	☐ Mammogram	0
☐ DEXA Scan	0	☐ PAP Test	0
☐ Echocardiogram	0	☐ Physical Exam	0
☐ EKG	0	☐ Pneumococcal Vaccine	0
☐ Eye Exam	0	☐ Pulmonary Function Test	0
☐ FOBT (stool card for hidden blood)	0	☐ Sigmoidoscopy	0
☐ Foot Exam	0	☐ Tetanus Vaccine	0

Family History – Check if any family member(s) has had any of the following conditions

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other

Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer Enter type	☐	☐	☐	☐	☐	☐	☐
Family History - continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other Enter other	☐	☐	☐	☐	☐	☐	☐
Other Enter other	☐	☐	☐	☐	☐	☐	☐
Other Enter other	☐	☐	☐	☐	☐	☐	☐

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Social History for Adult Parents			
Occupation	Enter occupation here	Employer	Enter employer here
Do you have children? Yes ☐ No ☐		How many? Enter number ; No. of female(s) ; No. of male(s)	
Tobacco Use ☐ Daily ☐ Weekly No ☐ ☐ Less ☐ Former: Enter Year quit		☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless: Enter brand	
Alcohol Use ☐ Daily ☐ Weekly No ☐ ☐ Less ☐ Former: Enter Year quit		☐ Beer ☐ Wine ☐ Liquor ☐ Other: Enter brand	
Exercise ☐ Moderate ☐ Vigorous Activity ☐ Sedentary Days/Week Enter times		Sleep Pattern ☐ Changes ☐ No Changes	
Caffeine Use ☐ Daily ☐ Weekly No ☐ ☐ Less ☐ Former: Enter Year quit		☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other: Enter brand	

For Pediatric Patient						
Patient Reside with:	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other	
	Secondary	☐ Mother	☐ Father	☐ Other		
Mother's Occupation: Enter occupation			Father's Occupation: Enter occupation			
Parents Relationship ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed			Childcare ☐ Mother ☐ Father ☐ Sibling ☐ Grandparent ☐ Nanny ☐ Daycare			
Tobacco Exposure: Yes ☐ No ☐ Smokers at home: Yes ☐ No ☐			Patient is current smoker: Yes ☐ No ☐			

ACKNOWLEDGEMENT OF RECEIPT

Joint Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of Helium Medical Joint Notice of Privacy Practices on the date and time indicated below.

If you have any questions regarding the information contained in Helium Medical's Joint Notice of Privacy Practices, please contact us at 713-714- 6488

Printed Name: Enter name here

Signature: Enter signature here

Relationship to Patient: Enter relationship to patient here in not you

Date and Time Received: Click or tap to enter a date.

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of our Joint Notice of Privacy Practices, but acknowledgement could not be obtained from the patient for the following reason:

Individual Refused to Sign: ☐
If emergency situation was prevented, sign here: Enter signature here
Patient Requested Above Individual Sign on His / Her Behalf: ☐
Other (please specify) State here

Registration Representative Signature: Enter signature here Date: Click or tap to enter a date.

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice

Helium Medical and the employees and staff of each Helium Medical Facility, provide healthcare to patients, together with other healthcare providers and other organizations. This Notice applies to the following persons and entities, who have agreed to be bound by this Notice:

• Helium Medical employees, staff and other personnel, who may need to access your information to perform their job functions.

• Members of the medical staff of Helium Medical, as well as other health care professionals who provide health care services at Helium Medical.

• Any member of a volunteer group we allow to help you while you are receiving care.

This Notice applies to all of the records related to your health care provided to you at Helium Medical.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We need this record to provide you with quality care and to comply with certain regulatory requirements. This Notice will tell you about the ways in which we may use and disclose medical information about you. This Notice also describes your rights, and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to:

• Keep medical information that identifies you private;

• Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and

• Follow the terms of the Notice that is currently

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to healthcare providers who are involved in taking care of you.

Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about care you received at a Helium Medical so your health plan will pay us
or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive or need in order to obtain prior approval or to determine whether your insurance will cover the treatment.

Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law.

Law Enforcement. If permitted by applicable law, we may release medical information if asked to do so by a law enforcement official:
• in response to a court order, subpoena, warrant, summons or similar process;
• to identify or locate a suspect, fugitive, material witness, or missing person;
• about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
• about a death we believe may be the result of criminal conduct;
• about criminal conduct at the hospital; and
• in emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Note on Other Restrictions. Please be aware that certain federal or state laws may have more strict requirements on how we use and disclose your medical information. If there are stricter requirements, even for the purposes listed above, we will not disclose your medical information without your written permission, or as otherwise permitted or required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by state law. We may also be restricted by law to obtain your written permission to use and disclose your information related to treatment for certain conditions such as mental illness, or alcohol or drug abuse.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy the information that we have about you that may be used to make decisions about you and your care, including your medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. To inspect and copy your information that may be used to make decisions about you, please submit your request in writing If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend: If you feel that information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by Helium Medical.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Right to Authorize or Refuse to Authorize Other Uses and Disclosures of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us your authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Complaints If you believe your privacy rights have been violated, you may file a complaint with us and with the Secretary of the United States Department of Health and Human Services. For information on filing a complaint with us, contact us at 713-714-6488

Helium Medical Services PLLC

New Patient Registration MRN: Admin official Enter MRN here

Assignment of Insurance Benefits/Eligibility Certification

Primary Insurance Plan		
Patient Name	Date of Birth Click or tap to enter a date.	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name (if different from patient)	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth Click or tap to enter a date.	
Subscriber Employer	Employer Phone #	
Employer Address		
For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date Click or tap to enter a date.	Part B Effective Date Click or tap to enter a date.
Other Insurance Coverage for Patient		
Patient Name	Date of Birth Click or tap to enter a date.	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth Click or tap to enter a date.	
Subscriber Employer	Employer Phone #	
Employer Address		

☐ I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Helium Medical for any medical or surgical services rendered. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

Click or tap here to enter text.
Signature of Patient /Responsible Party

Click or tap to enter a date.
Date

Click or tap here to enter text.
Name of Patient/Responsible Party (please print)

Click or tap here to enter text.
Relationship to Patient

Communication with You

In order to effectively communicate with you about your medical information, we request that you complete this form identifying the best way to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office.

We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine or voice mail.

Please check all the boxes that you give Helium Medical the permission to use for your communications:

☐	You may contact me by telephone	Phone Number: Click or tap here to enter text.
☐	You may leave a message/voice mail	Phone Number Click or tap here to enter text.
☐	You may contact me by mail at this address:	Click or tap here to enter text.
☐	You may contact me through email	Email address: Click or tap here to enter text.

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options	
Click or tap here to enter text.	Click or tap here to enter text.	☐	Billing Information
		☐	Appointment Information
		☐	Medical/Health Information
Click or tap here to enter text.	Click or tap here to enter text.	☐	Billing Information
		☐	Appointment Information
		☐	Medical/Health Information
Click or tap here to enter text.	Click or tap here to enter text.	☐	Billing Information
		☐	Appointment Information
		☐	Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Click or tap here to enter text.
Signature of Patient /Responsible Party

Click or tap to enter a date.
Date

Click or tap here to enter text.
Name of Patient/Responsible Party (please print)

Click or tap here to enter text.
Relationship to Patient

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ Click or tap to enter a date.

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient