Valor Medical New Patient Form

Patient's Name (First, Middle, Last): _____ Maiden Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____
Main Phone #: _____ Alternate #: _____ Work#: _____
Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Other SS#: _____ - _____ - _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Occupation: _____
Patient Referred By: _____
Spouse's Name: _____ Spouse's Date of Birth: _____
Main Phone #: _____ Alternate Phone #: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone #: _____

Other Patient Information

Which racial category does the patient most closely identify with?

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other

Ethnicity: What is the patient's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is the patient's language of choice? ☐ English ☐ Spanish ☐ Other: _____

Insurance Information

Primary Insurance: _____
Policy/ID#: _____ Group/Acct#: _____
Name of Policy Holder: _____ Date of Birth: _____
Employer: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____
Policy/ID#: _____ Group/Acct#: _____
Name of Policy Holder: _____ Date of Birth: _____
Employer: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____

Complete Only if Patient Is a Minor

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____

Sibling: _____ Date of Birth: _____

Other Sibling: _____ Date of Birth: _____

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Patient Name: _____ Date of Birth: _____

Assignment of Benefits: I authorize Valor Medical, or "VM" to submit claims on my behalf directly to Medicare/ Medicaid/ my private health insurance carrier. This means that VM will collect payment for supplies and services provided. I understand that I am financially responsible to the Provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment: I consent for VM to administer treatments, tests, and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF): or if a medical or surgical procedure could expose another individual to my/the patient's BBF. VM may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at VM's expense.

Patient Initials: _____

Electronic Prescription: I understand VM utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Patient Initials: _____

Phone Calls: By providing contact information, I authorize VM, its assignees, and third-party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/ cellular/ employment telephone: leave voicemail or text messages: and use pre-recorded/ artificial/ voice messages and/or auto-dialing in connection with any communication to me.

Patient Initials: _____

Name	Date of Birth (For ID to safeguard your PHI)	Relationship	Phone

X ____ I DO NOT wish to add an additional contact(s) to discuss my/patient's needs. **Patient Initials:** _____

May We Contact You by Phone and Leave a Message About Your Care?

Main Phone #: _____

☐ Leave a message with contact number only.
☐ Leave a message with detailed information.
☐ Do not leave a message.

Alternate #: _____

☐ Leave a message with contact number only.
☐ Leave a message with detailed information.
☐ Do not leave a message.

Patient Financial Policy **Patient Initials:** _____
I acknowledge receipt of the "Patient Financial Policy"

Notice of No-Show Policy **Patient Initials:** _____

Notice of Chronic Care Policy **Patient Initials:** _____

Notice of Privacy Practices **Patient Initials:** _____
I acknowledge that I have been offered a copy of our privacy practices.

Minor Patient Photograph (when applicable) **Patient Initials:** _____
I consent for VM to photograph the minor patient for identification purposes only.

_____
Print Name of Patient or Parent/Guardian

_____ _____
Signature of Patient or Parent/Guardian Date

Valor Medical New Patient Form

Date: _____

Name (First, Middle, Last): _____ Date of Birth: _____

Occupation: _____

Reason For Your Visit Today: _____

_____

Allergies (Include medications, foods, X-Ray dyes) or ☐ None Known

Name of Allergen	Type of Reaction	Approximate Date Started
1		
2		
3		

Current Medications (include prescription, over the counter, and herbal medications. Attach extra sheet if needed) or ☐ None

Name of Medication	Reason for Medication	Approximate Date Started
1		
2		
3		

Pharmacy (list pharmacy most frequently used for prescriptions)

Pharmacy Name: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

OB/GYN History: # of Pregnancies: ☐ _____ # of Deliveries: ☐ _____ Last Menstrual Cycle: _____

Tobacco History

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of _____ packs per day for _____ years. ☐ I quit in _____ (year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify: _____

Name (First, Middle, Last): _____ Date of Birth: _____

Alcohol and Drug History

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes ☐ No

If yes, approximately how many drinks per week (beer, wine, or liquor): _____

Have you ever used intravenous drugs? ☐ Yes ☐ No

Family History

Is there a history of:	**Yes**	**No**	**Affected Relative(s)**
Heart Attack			
Diabetes			
Prostate Cancer			
Kidney Cancer			
Kidney Stones			
Other Significant Disease			

Valor Medical History Form

Name (First, Middle, Last): _____ Date of Birth: _____

Please check the complaint{s}, or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	*Fatigue/ Tired*	☐ *Yes*	☐ *No*
	Fever/ Chills	☐ *Yes*	☐ *No*
	Headache	☑ *Yes*	☑ *No*
	Weight Loss	☑ *Yes*	☐ *No*
	Weight Gain	☑ *Yes*	☐ *No*
	Other: _____		
Eyes	*Difficulty Seeing*	☑ *Yes*	☐ *No*
	Other: _____		
Head	*Dry Mouth*	☐ *Yes*	☐ *No*
Ears	*Hearing Problems*	☑ *Yes*	☐ *No*
Nose	*Hoarseness*	☑ *Yes*	☐ *No*
Throat	*Lump/Swelling in Neck*	☑ *Yes*	☐ *No*
	Trouble Swallowing	☑ *Yes*	☑ *No*
Cardiac (Heart)	*Chest Pain*	☑ *Yes*	☑ *No*
	Irregular Heartbeat Pain with Walking	☑ *Yes*	☑ *No*
	Shortness of Breath	☑ *Yes*	☑ *No*
	Swelling in Feet/Ankles	☐ *Yes*	☐ *No*
Neuro	*Dizziness*	☐ *Yes*	☐ *No*
	Fainting	☐ *Yes*	☐ *No*
	Headache	☑ *Yes*	☑ *No*
	Memory Loss	☑ *Yes*	☑ *No*
	Numbness	☑ *Yes*	☑ *No*
	Weakness	☑ *Yes*	☑ *No*
	Other: _____		
Respiratory	*Cough*	☑ *Yes*	☐ *No*
	Shortness of Breath	☑ *Yes*	☐ *No*
	Use of Inhalers	☑ *Yes*	☐ *No*
	Wheezing	☑ *Yes*	☐ *No*
	Other: _____		
Gastro-Intestinal	*Abdominal Blood in Stool*	☑ *Yes*	☐ *No*
	Change in Bowel Habits	☑ *Yes*	☐ *No*
	Constipation	☑ *Yes*	☑ *No*
	Heartburn	☐ *Yes*	☑ *No*
	Loss of Appetite	☑ *Yes*	☑ *No*
	Nausea/Vomiting	☑ *Yes*	☑ *No*
	Other: _____		

Males	*Blood in Urine*	☐ *Yes*	☐ *No*
	Difficulty Achieving Erection	☐ *Yes*	☐ *No*
	Foul Odor of Urine	☐ *Yes*	☐ *No*
	Pain in Testicles	☐ *Yes*	☐ *No*
	Trouble Urinating	☐ *Yes*	☐ *No*
	Other: _____		
Females	*Breast Discomfort*	☐ *Yes*	☐ *No*
	Irregular Bleeding	☐ *Yes*	☐ *No*
	Painful Intercourse	☐ *Yes*	☐ *No*
	Post-Menopausal Bleeding	☐ *Yes*	☐ *No*
	Trouble Urinating	☐ *Yes*	☐ *No*
	Vaginal Discharge	☐ *Yes*	☐ *No*
	Last Menstrual Cycle Date: _____		
Skin	*Bruising*	☐ *Yes*	☐ *No*
Hair	*Hair Loss*	☐ *Yes*	☐ *No*
Nails	*Nail Problems*	☐ *Yes*	☐ *No*
	Rash	☐ *Yes*	☐ *No*
	Skin Changes	☐ *Yes*	☐ *No*
	Other: _____		
Musculoskeletal	*Back Pain*	☐ *Yes*	☐ *No*
	Joint Pain	☐ *Yes*	☐ *No*
	Muscle Pain	☐ *Yes*	☐ *No*
	Swelling	☐ *Yes*	☐ *No*
	Other: _____		
Mental Health	*Anxiety/Depression*	☐ *Yes*	☐ *No*
	Difficulty Sleeping or Concentrating	☐ *Yes*	☐ *No*
	History of Mental/ Physical Abuse	☐ *Yes*	☐ *No*
	Mood Swings	☐ *Yes*	☐ *No*
	Stress	☐ *Yes*	☐ *No*
	Suicidal	☐ *Yes*	☐ *No*
	Other: _____		

Recent Tests: *Give month/year of last exam in the right column.* ***Health Maintenance:*** *Check the left column if the date is estimated.*

- ☐ *Bone Density:* _____
- ☐ *Colonoscopy:* _____
- ☐ *Diabetic Foot:* _____
- ☐ *Eye Exam:* _____
- ☐ *Mammogram:* _____
- ☐ *Pap Smear:* _____
- ☐ *Physical:* _____
- ☐ *PSA:* _____
- ☐ *Tetanus Shot:* _____

Name (First, Middle, Last): _____ Date of Birth: _____

Valor Medical History Form

Name (First, Middle, Last): _____ Date of Birth: _____

I, _____, do hereby authorize Valor Medical to obtain copies of my medical records.

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____

I authorize the release of my/my child's medical records or other healthcare information including forms, chart notes, reports, consult notes, imaging/imaging reports, diagnostic testing, labs, correspondence, medications, personal histories, and other pertinent information concerning my health and treatment from:

Physician/Practice Name: _____

Address: _____

City, State, Zip Code: _____

Phone: (_____) _____ **Fax:** (_____) _____

To be sent to:
Valor Medical
140 Market Place Blvd. Ste. E., Knoxville, TN 37922-2337
(P) 885-212-2211 (F) 833-314-0589 info@valor-medical.com

☐ Chart Notes ☐ Medication List ☐ Imaging / Other Diagnostics
☐ Demographics ☐ Consult Notes ☐ Therapy Notes
Other: _____

☐ This authorization is good for one (1) year from the date signed, unless otherwise specified.
☐ Other: _____

Patient/Legal Guardian Signature: _____

Relationship: _____ **Date:** _____

Valor Medical

Credit Card Pre-Authorization Form

Patient Name: _____ **Date:** _____ **Date of Birth**: _____

Address: _____

City, State, Zip Code: _____

Email Address: _____

The Undersigned Patient / Cardholder hereby authorizes Valor Medical to obtain payment of fees for services from the Patient / Cardholder's Credit Card account identified below. Valor Medical may charge the account for the missed appointments (minimum of 24 hours cancellation notice is required), without requirement of the Patient / Cardholder's signature for each payment. A Receipt of the transaction will be mailed to the physical address or email address provided by the Patient / Cardholder above.

By signing this form, the Patient / Cardholder acknowledges and agrees as follows:

- The signed form is confidential and will be kept on file at Valor Medical.
- The patient / Cardholder authorizes payments to be made on the above-named patient's account (including co-pays, co-insurances, deductibles, or missed appointment fees.)
- The Patient / Cardholder certifies, warrants, and represents that the Cardholder named below agrees to pay the credit charges(s) in accordance with the agreement described above.
- Credit Card payments will appear on your statement as Valor Medical, LLC.
- If the Patient / Cardholder agrees that the charges are valid and agrees not to dispute said charges.
- This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30-day notice of revocation.
- This authorization serves as agreement for receipts to be noted, "signature on file" when charged.

_____

Print Name of Authorized Signer

_____ _____

Patient/Cardholder Authorized Signature Date

Discard lower section of form in secure shred bin after details entered into EHR system

Please Circle One: ☐ Visa ☐ Mastercard ☐ Discover

Name on Card: _____

Credit Card Number: _____

CVV: _____ **Expiration Date (Month/Year):** _____

Billing Address for Card: _____

_____

Valor Medical New Patient Form

Please Read Prior to Receiving Services

Valor Medical, or VM, recognizes the need for a clear understanding between patient and medical provider regarding financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning payment for professional services.

- **PAYMENT:**
    - **Copays -** Copays are expected at the time of service.
    - **Deductibles / Coinsurances -** If your deductible has not been met, or you have a percentage of coinsurance, it is your responsibility to assure payment of these amounts, as communicated to our office by your insurance company. Our office will file the insurance claim for your convenience, and you will then be responsible for any balance after insurance processes your claim. All charges for treatment become due and payable no later than sixty (60 days) after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, VM will begin various collection activities including, but not limited to submitting the past due account to a collection agency.
    - **Self-Payment (Private, Cash Payment):** If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your visit. We do offer payment plans on a case-by-case basis, but we do also require a payment at time of service for all professional services.

The following is not a full comprehensive list and does not include any tests or medications.

Chronic Disease Management:
New Patient: $120
Existing Patient: $90

Acute Visits:
New Patients: $80
Existing Patient: $50
School / Sports Physicals Child: $50

Rapid Testing:
Rapid Flu Test: $20
Rapid Strep Test: $10

Annual Wellness Adults:
New Patients: $120
Existing: $90

Counseling - $1/Min (New Patients and Existing Patients)

- **MEDICARE:** Valor Medical Providers are participating Providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare and/or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, or Advanced Beneficiary Notice (ABN), which states that you understand that you will be responsible for these charges.
- **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-pay patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third-party insurance program.
- **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individuals involved, without the inclusion of VM.
- **NO WORKERS COMPENSATION** Valor Medical **does not** accept Workers Compensation Insurance.
- **NO SHOWS / MISSED APPOINTMENTS:** Failure to show for a scheduled appointment or notify our office of cancellations at least 24 hours prior to your appointment time, will result in a $50 missed appointment fee. This fee will be directly charged to a credit card that we will keep on file. We will send you a receipt notifying you immediately of the missed appointment charge. If you decline to provide a credit card upfront and incur a $50 missed appointment fee, we will mail you an invoice with a 10% surcharge resulting in a $55 fee. All remaining appointments will be cancelled, and you will not be rescheduled until the fee has been paid in full or payment arrangements have been made. After 3 missed visits/ late cancellations, you may be dismissed from the practice.
- We offer the opportunity to establish a reasonable payment plan if you are not able to pay in full at the time of service. If you have an outstanding balance, we expect you to make payment or payment arrangements before your next scheduled appointment. Non-payment may result in discharge from the practice.
- Before receiving services, you must verify that we are participating providers with your insurance company network. It may also be necessary that Valor Medical, or one of our Providers, is listed as your Primary Care Provider with your insurance company, if required by your contract with your insurance company. In the event we are *not* Participating Providers, or our Provider is not listed as your Primary Care Provider with your insurance company, we *will* file the initial claim as a courtesy. That said, the patient acknowledges that the services rendered may be covered at a lower percentage or not at all, and that any remaining balance is the responsibility of the patient.
- We will send a statement to the email or billing address you provide notifying you of any balances you may owe. If you have questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (865) 212-2211 and ask for the Billing Dept.
- **Failure to keep your account balance current may require us to cancel or to reschedule your appointments.**
- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of services.** If your insurance plan requires a specified Primary Care Physician (PCP), please present or ask for a "*Change of PCP*" form at your initial visit. If you request an office visit without changing Valor Medical to your PCP under these circumstances, your insurance plan may deem this as "*out of network*" or "*non-covered treatment*", and you will be responsible for a larger amount, or all, of the charges. The patient acknowledges that it is their responsibility to be aware of what services are covered and agrees to pay for any service deemed to be out of network or non-covered by the plan.

Valor Medical firmly believes that a good patient/provider relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or not clarification regarding these policies, please call us at (865) 212-2211.

Chronic Care Management Patient Agreement

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow your provider to provide chronic care management services to you.

CCM Services are only available to patients with 2 or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last more than 12 months, and that increases the risk of death, acute exacerbation of disease, or decline in function.

Benefits of CCM Services Include:

- 24/7 access to a care provider to help with your chronic health needs
- A comprehensive plan of care for health needs, available on paper or electronically
- Coordination with both home and community-based service providers
- Transition management among health providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Medication oversight and management
- Use of certified electronic health records as mandated by Medicare.

Beneficiary Acknowledgement and Agreement

By signing this agreement, you agree to the following terms:

- You consent to your provider furnishing CCM services to you
- You certify that your provider has fully explained the scope of CCM services to you
- You acknowledge that only one practitioner can furnish and be made primary provider for CCM services during a calendar month.
- You authorize electronic communication between treating providers as part of your care.
- You understand that CCM services are subject to Medicare Co-Insurance, and that you may be billed for a portion of the CCM services
- You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month.
- You may revoke this agreement by notifying us via phone, or by mailing your written revocation to 140 Market Place Blvd Ste E, Knoxville, TN 37922. Your provider will then give you written confirmation, including the date of revocation for the CCM services.