

**Valor Medical Intake Form**

**Patient Name (First, Mid, Last):** \_\_\_\_\_ **Maiden Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** Male \_\_\_ Female \_\_\_ Other: \_\_\_\_\_

**SSN (required):** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:** Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Main Phone:** \_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Emergency Contact Phone:** \_\_\_\_\_

**Patient Referred By:** \_\_\_\_\_

**Pharmacy Name (most frequently used):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Other Patient Information**

**Which racial category does the patient most closely identify with?**

- \_\_\_ African American      \_\_\_ Asian      \_\_\_ Caucasian      \_\_\_ Hispanic or Latino
- \_\_\_ Native American      \_\_\_ Native Hawaiian      \_\_\_ Pacific Islander      \_\_\_ Not Hispanic or Latino
- \_\_\_ Other: \_\_\_\_\_

**What is the patient's language of choice?**      \_\_\_ English      \_\_\_ Spanish      \_\_\_ Other: \_\_\_\_\_

**Insurance Information**

**Primary Insurance:** \_\_\_\_\_

**Policy/ ID:** \_\_\_\_\_ **Group/ Acct:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Policy/ ID:** \_\_\_\_\_ **Group/ Acct:** \_\_\_\_\_

**Policy Holder Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Complete Only if Patient Is a Minor**

**Parent/Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Parent/Guardian Contact Phone:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Parent/Guardian Contact Phone:** \_\_\_\_\_

## Valor Medical Contact and Notices Form

**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	Relationship	Phone	OK to discuss HIPAA PHI or ER Contact Only?

\_\_\_ 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 #** \_\_\_\_\_

**Alt Phone #** \_\_\_\_\_

- \_\_\_ Leave a message with contact number only.
- \_\_\_ Leave a message with detailed information.
- \_\_\_ Do not leave a message.

- \_\_\_ Leave a message with contact number only.
- \_\_\_ Leave a message with detailed information.
- \_\_\_ Do not leave a message.

**Valor Medical Contact and Notices Form**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Financial Responsibility Notice**

I acknowledge receipt of the "Patient Financial Responsibility Notice"

**Patient Initials:** \_\_\_\_\_

**Notice of No-Show Policy**

**Patient Initials:** \_\_\_\_\_

**Chronic Care Management Patient Agreement **\*\*Medicare ONLY\*\*****

**Patient Initials:** \_\_\_\_\_

**HIPAA Notice of Privacy Practices**

I acknowledge that I have been offered a copy of VM's privacy practices.

**Patient Initials:** \_\_\_\_\_

**Patients' Rights and Responsibilities**

I acknowledge that I have been offered a copy of VM's patient rights and responsibilities.

**Patient Initials:** \_\_\_\_\_

**Minor Patient Photograph (when applicable)**

I consent for VM to photograph the minor patient for identification purposes only.

**Patient Initials:** \_\_\_\_\_

\_\_\_\_\_  
Print Name of Patient or Parent/Guardian

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

## Valor Medical History Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Allergies** (Include medications, foods, X-Ray dyes) or \_\_\_ No Known Allergies

Name of Allergy	Type of Reaction	Approximate Age of Onset

**Current Medications** (Include prescription, over the counter, and supplements) or \_\_\_ No Current Medications

Name of Medication	Reason for Medication	Dosage / Frequency	Approx. Date Started

**OB/GYN History:** \_\_\_ N/A (Male) or Last Pap Smear: \_\_\_\_\_ Results: Normal Abnormal  
 Last Menstrual Cycle: \_\_\_\_\_ Pregnancies (#): \_\_\_\_\_ Live Births (#): \_\_\_\_\_

**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: \_\_\_\_\_

**Alcohol and Drug History**

Do you currently drink alcohol? \_\_\_ Yes     \_\_\_ No  
 If yes, approximately how many drinks per week (beer, wine, or liquor): \_\_\_\_\_  
 Have you ever been diagnosed with alcoholism? \_\_\_ Yes     \_\_\_ No  
 Do you use any illicit or recreational drugs? \_\_\_ Yes     \_\_\_ No  
 If yes, what and approximately how often: \_\_\_\_\_

**Family History**

Is there a history of:	Yes	No	Type	Affected Relative(s) (specify Maternal / Paternal)
Anxiety / Depression				
Asthma				
Cancer				
Emphysema / COPD				
Diabetes				
Heart Disease				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Stroke				
Substance Abuse / Addiction				
Thyroid Disease				
Other Significant Disease				

## Valor Medical History Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Surgical History:** \_\_\_ N/A

Type of Surgery (specify Left / Right)	Date Surgery Performed	Location / Facility

### GAD-7 Anxiety Screening

Over the last <u>two weeks</u> , how often have you been bothered by the following problems?	Not at All	Several Days	More than half of the days	Nearly Every Day
Feeling nervous, anxious, or "on edge"	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble Relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
<b>Column Totals</b>				

**Total Score:** \_\_\_\_\_

If you marked any problems - How difficult have they made it for you to do your work, take care of things at home, or get along with other people? Not Difficult at All \_\_\_\_ Somewhat Difficult \_\_\_\_ Very Difficult \_\_\_\_ Extremely Difficult \_\_\_\_

### PHQ-9 Screening

Over the last <u>two weeks</u> , how often have you been bothered by the following problems?	Not at All	Several Days	More than half of the days	Nearly Every Day
Little interest or pleasure doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or having let yourself or others down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people have noticed the difference, or the opposite – being so fidgety or restless that you move around more than usual	0	1	2	3
Thoughts that you would be better off dead or of causing yourself harm in some way	0	1	2	3
<b>Column Totals</b>				

**Total Score:** \_\_\_\_\_

If you marked any problems - How difficult have they made it for you to do your work, take care of things at home, or get along with other people? Not Difficult at All \_\_\_\_ Somewhat Difficult \_\_\_\_ Very Difficult \_\_\_\_ Extremely Difficult \_\_\_\_

## Valor Medical History Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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

<b>General</b>	Fever	<input type="checkbox"/> Yes	<b>Genito- Urinary</b>	Incontinence	<input type="checkbox"/> Yes
	Night Sweats	<input type="checkbox"/> Yes		Difficulty Urinating	<input type="checkbox"/> Yes
	Weight Gain	<input type="checkbox"/> Yes		Blood in Urine	<input type="checkbox"/> Yes
	Weight Loss	<input type="checkbox"/> Yes		Increased Frequency	<input type="checkbox"/> Yes
	Exercise Intolerance	<input type="checkbox"/> Yes		Incomplete Emptying	<input type="checkbox"/> Yes
	Chills	<input type="checkbox"/> Yes			
	Fatigue / Malaise	<input type="checkbox"/> Yes			
<b>Eyes</b>	Glasses/Contacts	<input type="checkbox"/> Yes	<b>Males</b>	Blood in Urine	<input type="checkbox"/> Yes
	Dry Eyes	<input type="checkbox"/> Yes		Erectile Dysfunction	<input type="checkbox"/> Yes
	Vision Changes	<input type="checkbox"/> Yes		Foul Odor of Urine	<input type="checkbox"/> Yes
	Irritation	<input type="checkbox"/> Yes		Pain in Testicles	<input type="checkbox"/> Yes
	Eye Disease / Injury	<input type="checkbox"/> Yes		Trouble Urinating	<input type="checkbox"/> Yes
<b>Ears Nose Mouth Throat</b>	Difficulty Hearing	<input type="checkbox"/> Yes	<b>Females</b>	Breast Discomfort	<input type="checkbox"/> Yes
	Ear Pain	<input type="checkbox"/> Yes		Irregular Bleeding	<input type="checkbox"/> Yes
	Frequent Nosebleeds	<input type="checkbox"/> Yes		Painful Intercourse	<input type="checkbox"/> Yes
	Nose Problems	<input type="checkbox"/> Yes		Post-Menopausal Bleeding	<input type="checkbox"/> Yes
	Sinus Problems	<input type="checkbox"/> Yes		Trouble Urinating	<input type="checkbox"/> Yes
	Sore Throat	<input type="checkbox"/> Yes	Vaginal Discharge	<input type="checkbox"/> Yes	
	Bleeding Gums	<input type="checkbox"/> Yes			
	Snoring	<input type="checkbox"/> Yes	<b>Musculo Skeletal</b>	Muscle Aches	<input type="checkbox"/> Yes
	Dry Mouth	<input type="checkbox"/> Yes		Muscle Weakness	<input type="checkbox"/> Yes
	Mouth Ulcers	<input type="checkbox"/> Yes		Arthritis / Joint Pain	<input type="checkbox"/> Yes
	Oral Abnormalities	<input type="checkbox"/> Yes		Back Pain	<input type="checkbox"/> Yes
	Teeth Problems	<input type="checkbox"/> Yes		Extremity Swelling	<input type="checkbox"/> Yes
	Ringing in Ears	<input type="checkbox"/> Yes		Neck Pain	<input type="checkbox"/> Yes
Sinusitis	<input type="checkbox"/> Yes	Difficulty Walking		<input type="checkbox"/> Yes	
		Cramps		<input type="checkbox"/> Yes	
<b>Cardiac (Heart)</b>	Chest Pain	<input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> Yes	
	Arm Pain on Exertion	<input type="checkbox"/> Yes	Fractures	<input type="checkbox"/> Yes	
	Shortness of Breath (walking)	<input type="checkbox"/> Yes			
	Shortness of Breath (laying)	<input type="checkbox"/> Yes	<b>Skin Hair Nails</b>	Abnormal Mole	<input type="checkbox"/> Yes
	Palpitations	<input type="checkbox"/> Yes		Jaundice	<input type="checkbox"/> Yes
	Heart Murmur	<input type="checkbox"/> Yes		Rash	<input type="checkbox"/> Yes
	Ankle/Foot Swelling	<input type="checkbox"/> Yes		Itching	<input type="checkbox"/> Yes
		Skin Changes		<input type="checkbox"/> Yes	
		Growths / Lesions		<input type="checkbox"/> Yes	
		Lacerations		<input type="checkbox"/> Yes	
<b>Respiratory</b>	Cough	<input type="checkbox"/> Yes	Non-Healing Areas	<input type="checkbox"/> Yes	
	Wheezing	<input type="checkbox"/> Yes	Changes in Hair/ Nails	<input type="checkbox"/> Yes	
	Shortness of Breath	<input type="checkbox"/> Yes	Psoriasis	<input type="checkbox"/> Yes	
	Coughing Up Blood	<input type="checkbox"/> Yes	Changes in Skin Color	<input type="checkbox"/> Yes	
	Sleep Apnea	<input type="checkbox"/> Yes	Breast Lump	<input type="checkbox"/> Yes	
	Use of Inhalers	<input type="checkbox"/> Yes			
<b>Gastro- Intestinal</b>	Abdominal Pain	<input type="checkbox"/> Yes	<b>Neuro</b>	Loss of Consciousness	<input type="checkbox"/> Yes
	Nausea	<input type="checkbox"/> Yes		Weakness	<input type="checkbox"/> Yes
	Vomiting	<input type="checkbox"/> Yes		Numbness	<input type="checkbox"/> Yes
	Constipation	<input type="checkbox"/> Yes		Seizures	<input type="checkbox"/> Yes
	Change of Appetite	<input type="checkbox"/> Yes		Dizziness	<input type="checkbox"/> Yes
	Diarrhea	<input type="checkbox"/> Yes		Migraines	<input type="checkbox"/> Yes
	Black or Tarry Stools	<input type="checkbox"/> Yes		Tremor	<input type="checkbox"/> Yes
	Vomiting Blood	<input type="checkbox"/> Yes		Gait Dysfunction	<input type="checkbox"/> Yes
	Dyspepsia	<input type="checkbox"/> Yes		Paralysis	<input type="checkbox"/> Yes
	GERD	<input type="checkbox"/> Yes			

<b>Mental Health</b>	Depression	__ Yes
	Sleep Disturbances	__ Yes
	Restless Sleep	__ Yes
	Feeling Unsafe	__ Yes
	Alcohol Abuse	__ Yes
	Anxiety	__ Yes
	Hallucinations	__ Yes
	Suicidal Thoughts	__ Yes
	Mood Swings	__ Yes
	Memory Loss	__ Yes
	Agitation	__ Yes
	Dementia	__ Yes
	Delirium	__ Yes
	History of Physical / Mental Abuse	__ Yes

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<b>Endocrine</b>	Fatigue	__ Yes
	Increased Thirst	__ Yes
	Hair Loss	__ Yes
	Hair Growth	__ Yes
	Cold Intolerance	__ Yes
	Heat Intolerance	__ Yes

<b>Hematologic / Lymphatic</b>	Swollen Glands	__ Yes
	Easy Bruising	__ Yes
	Excessive Bleeding	__ Yes
	Anemia	__ Yes
	Phlebitis	__ Yes

<b>Allergic / Immunologic</b>	Runny Nose	__ Yes
	Sinus Pressure	__ Yes
	Itching	__ Yes
	Hives	__ Yes
	Frequent Sneezing	__ Yes

**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 Exam: \_\_\_\_\_  
 Eye Exam: \_\_\_\_\_  
 Mammogram: \_\_\_\_\_  
 Pap Smear: \_\_\_\_\_  
 Physical: \_\_\_\_\_  
 PSA: \_\_\_\_\_  
 Tetanus Shot: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Valor Medical Record Release Form**

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](mailto: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 on the patient's account. Valor Medical may charge the account for the missed appointments (minimum of 24 hours cancellation notice is required, as set forth in our missed appointments policy), 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.
- 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

-----  
**Physical card to be given to reception to keep your data secure**

**Please Circle One:**    \_\_\_ Visa            \_\_\_ Mastercard            \_\_\_ Discover            \_\_\_ American Express

**Name on Card:** \_\_\_\_\_

**Last 4 Digits ONLY of Credit Card Number:** \_\_\_\_\_

**Billing Address for Card:** \_\_\_\_\_

## Valor Medical Financial Responsibility Notice

### 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** - Families who must meet yearly deductibles will be required to pay for all charges at the time of service. You will only be requested to pay the anticipated reimbursement of your insurance company. A claim will be generated to your insurance company so that this amount can be credited to your deductible.
- **Balances** - Due upon receipt of invoice. 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.
- Should you have extraordinary financial pressures, we will assist you with a payment plan, agreed to in writing, prior to services being rendered.

**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.

- **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.
- **PATIENT PAYMENT PLANS:** 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.
- **NETWORK PARTICIPATION:** 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.
- **PATIENT BALANCES:** 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.**

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.

## Valor Medical Chronic Care Management Patient Agreement **\*\*Medicare ONLY\*\***

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.

## HIPAA 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.**

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

#### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500

#### **USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization, at any time**, in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to your requested restriction except if you request that the provider not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

### **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying “Acknowledgment” form.**

**Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

## Patients' Rights and Responsibilities

### Patients' Rights:

- Patients have the right to considerate, respectful care from their doctors, health plan representatives, and other health care providers that does not discriminate against them based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or genetic information.
- Patients have the right to have their privacy protected.
- Patients have the right to receive confidential treatment of all communications and records pertaining to their care.
- Patients have the right to receive accurate and easy to understand information about their health plan, health care professionals, and health facilities.
- Patients have the right to choose health care providers who can give them high quality health care when they need it.
- Patients have the right to make suggestions to their insurance company about their insurance company's patients' rights and responsibilities.
- Patients have the right to work with their doctors in making decisions about their healthcare.
- Patients have the right to file complaints and appeals about their insurance company or the care it provides.
- Patients have the right to get the facts and discuss necessary treatment options for their condition, regardless of cost or insurance coverage.

### Patients Responsibilities:

- Patients are responsible for following plans and instructions for care that has been agreed upon by their physician.
- Patient is responsible for supplying information that the insurance company, physicians, and hospital need to provide care.
- Patients are responsible for understanding their health problems and working with their physicians to come up with mutually agreed upon goals.
- Patients are responsible for notifying their physician if there is any change in their address, phone number, or insurance carrier.
- Patients are responsible for notifying their physician if they are unable to keep their appointment.
- Patients are responsible for calling their insurance company if they have any questions or problems.
- Patients are responsible for arriving on time for appointments.