New Patient Registration Information

Primary Care at Home

Patient Registration

Last Name: ____________________ First Name: __________________ M.I. ____________

Previous Name (if applicable): ____
Mailing Address:
____
City/State/Zip:
____

Home Phone: ______________________________ Cell Phone: ________________________

Work Phone: ______________________________ Other: ____________________________

I prefer __ Voice __ Text contact for reminder calls & other messages
on my __ Home __ Cell __Work number.

May we leave a message regarding your medical care & test results? __ Yes __ No

Are you interested in tele-health visits? ______Yes _____No. If no please skip next two questions.

Do you have a smart phone for possible tele-health visits? ______Yes _____No

If yes, please list the number: (______)________________

Do your Medical Power of Attorney (POA) have a smart phone for possible tele-health visits? _____Yes ____No

If yes, please list the number: (______)________________

Date of Birth: ____________ Sex: __ Male __ Female Marital Status: ____________

Primary Physician: ____

Employer Name: ____

Emergency Contact
Emergency Contact Name: ____

Emergency Contact Phone #: ________________

Relationship to Patient: ______________________

Medical Power of Attorney [Please prove a copy of POA Document]

Last Name: ______________________________ First Name: ________________________

Date of Birth: ____________

Address of POA: ____

City/State/Zip: ____

Additional Information (Please Fill Out All Sections Below)
Race (Please Select):
__ White __ American Indian __ Alaska Native __ Asian __ Hispanic
__ Black or African American __ Native Hawaiian or Pacific Islander __ Other __ Decline

Ethnicity (Please Select One): __ Hispanic/Latino __ Not Hispanic/Latino __ Decline

Preferred Language (Please Select One): __ English __ Spanish Other: ________________

Preferred Pharmacy Name: ____

Pharmacy Location: ____

Primary Medical Insurance Company Name: ____

Policy Holder Name: ____

Policy Holder's Date of Birth: ________________

Policy Holder's ID #: _______________________

Patient Relationship to Policy Holder: __________

Secondary Insurance Company Name: ____

Policy Holder Name: ____

Policy Holder's Date of Birth: ________________

Policy Holder's ID #: _______________________

Patient Relationship to Policy Holder: __________

I have read and agree to Valor Health Services (VHS) Financial policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign VHS to all money which I am entitled for medical expenses related to the services performed by VHS, but not to exceed my indebtedness to VHS. I authorize VHS to release any medical information to my insurance carrier or third party payer to facilitate processing my health insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and /or email as a communication method, I acknowledge that Valor Health Services is not liable for any wireless charges I may incur and that an encrypted email or text solution will be utilized.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to VHS. I authorize any holder of medical information about me to be released to CMS and its agents to determine benefits or benefits payable for related services.

Signature of Responsible Party:

X____

Printed Name of Responsible Party:

X____

Financial Policy

Valor Health Services wants to provide our community with healthcare services and, at the same time keep costs under control. To do this we need your help. We ask you to read our payment policy listed below:

Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all of the costs.
What your health insurance covers is based on an agreement between you and the insurance company.
You need to contact your insurance company with any questions about what they will cover.
Any bill not paid by the date it is due will be sent to a collection agency.

<u>If you DO NOT have health insurance</u>
Your Responsibility
- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility
- Valor Health Services will provide the services you need.
- Patient Financial Representatives are available to discuss financial options with you.

<u>If you HAVE health insurance</u>
We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your health benefits.

<u>If we DO participate with your insurance plan (including Medicare)</u>:
Your Responsibility
- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance. Payment is due upon receipt of the statement. If you do not pay within the designated time frame, we will begin collection efforts.

Our Responsibility
- We will send a bill to your insurance company for all services performed by Valor Health Services.

<u>If we DO NOT participate with your insurance plan:</u>
Your Responsibility
- You must pay for the service at the time it is given.
- To make it simple, we accept cash, checks, VISA and MasterCard.
- We will charge a $25.00 fee for any returned checks.

Our Responsibility
- After you have paid us, we will give you a form to send to your insurance company. Your insurance will then pay you.

<u>STATEMENT OF FINANCIAL RESPONSIBILITY</u>
The patient who receives care and treatment from Valor Health Services must pay any charges that are not paid by the insurance or any other party.
Other providers, such as x-ray or laboratory, will bill the patient separately.
The patient must pay any amount not paid by insurance upon receipt of the statement.

INSURANCE SIGNATURE ON FILE

PATIENT NAME: ____ DOB: _______________________

INSURANCE COVERAGE

I request that payment of authorized Commercial Benefits, Medicare or Secondary Medicare coverage benefits be made directly to Valor Health Services for any services furnished to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine payable amounts for related services.

___________________________________	___________________________________
Primary Identification Number	Secondary Identification Number
___________________________________	___________________________________
Primary Insurance	Secondary Insurance
___________________________________	___________________________________
Date	Signature of Patient (or Guardian)

CONSENT AND UNDERSTANDING

This consent is required by the Health Information Portability & Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent to Privacy Notice:
I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:
I, ________________________________, with my signature, authorize Valor Health Services, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devises, equipment or other items required and in accordance with the prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent to Release Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:
We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure the financial obligation is fulfilled for the health care services received.

> I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance pan and state regulations.
> I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
>
> I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer/group. Valor Health Services, L.L.C. is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving services. For example, not all health plans include screening as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Valor Health Services, L.L.C. is a privately owned and operated entity.

I have read and understand the consents and Financial Policy stated above and agrees to accept full responsibility as described above.

Patient/Responsible Part: ________________________________ Date: __________________

Patient Name if different from Responsible Party: ____