Demographic Information:

_____ _____

Full Name (as it appears on your insurance card) Preferred Name/Nickname

_____ _____ _____ _____

Street Address City State Zip Code

_____ _____ _____

Home Phone Mobile Phone Work Phone

_____ SS# _____ DL# _____ State _____

Email address: _____ May we communicate with you by email? _____

_____/_____/_____ _____ _____ _____

Date of Birth Age Gender Identity Gender at birth

Employer _____ Occupation _____

Work Status: full-time / modified / disabled (Circle one)

Have you filed for disability? _____ Is your condition work related? _____ Is your condition due to an accident? _____
If you answered yes to any of the questions above, please *list your attorney's name and contact information below*.

_____ _____ _____

Emergency Contact Relationship Phone

Insurance Information – if your condition is due to an accident, there is a separate form you will need to complete.
See accident information and release form https://valorspine.com/patient-documents/

_____ _____ _____

Primary Insurance / Work Comp Insurance ID/Claim Number Group Number

_____ _____ _____

Provider Phone # Subscriber/Adjuster Name Subscriber Date of Birth

Adjuster's Phone # _____ Adjuster's Fax _____

_____ _____ _____

Secondary Ins / Attorney's Name ID Number Group Number

_____ _____ _____

Phone # Subscriber Name Subscriber Date of Birth

Referral Source _____ PCP _____ PH_____

CONSENT FOR MEDICAL CARE AND TREATMENT:

I, _____ hereby agree and give my consent for Valor Spine Solutions, LLC, to furnish medical care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (initial)

FOR MINORS ONLY CONSENT FOR CARE: As parent and/or legal guardian, I authorize Valor Spine Solutions, LLC, to treat the minor patient named in the attached forms while I am not present.

_____ (parent/guardian initial)

TELEHEALTH CONSENT

I understand that through an interactive video connection, telehealth might be used to perform my consultation and that we may use telehealth to connect while working together.

I understand the benefits and risks involved with telehealth technology:

- I do not need to travel to the consult location.
- I have access to a specialist through this consultation.
- There may be interruptions, unauthorized access and technical difficulties and my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
- My healthcare information may be shared with other individuals for scheduling and billing purposes.

I also understand other individuals may need to use the telehealth platform and that reasonable steps will be taken to maintain confidentiality of the information obtained.

I have read this document in it's entirety and understand the risks and benefits of telehealth consultation/post op visits and have had my questions explained. I hereby consent to participate in telehealth sessions under the conditions described in this document.

By signing below, I agree that all of the above information is correct, and that I authorize Valor Spine Solutions, LLC, to provide me with medical services and to furnish my physician, insurance company or attorney, information concerning my injury and/or treatment.

_____ _____

Patient Signature (Parent/Guardian if applicable) Date