HIPAA Agreement

HIPAA NOTICE OF PRIVACY PRACTICES

This notice outlines your protected health information, how it may be used, and what your rights are. Please review carefully and ask any questions prior to signing. Questions about this notice can be directed to Valor Spine Solutions, LLC.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

We, at Valor Spine Solutions, LLC understand that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all of the records of your care generated by Valor Spine Solutions, LLC whether made by Valor Spine Solutions, LLC personnel or your personal doctor or other health care provider. This Notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

- Make sure that protected health information that identifies you is kept private.
- Notify you about how we handle protected health information about you.
- Explain how, when and why we use and disclose protected health information.
- Follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- Posting the revised Notice in our office.
- Making copies of the revised Notice available upon request.
- Posting the revised Notice on our website.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information without your written authorization.

For Treatment: We may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. Valor Spine Solutions, LLC staff may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected health information about you to people outside Valor Spine Solutions, LLC office who may be involved in your medical care. We may use and disclose protected health information to contact you as a

reminder that you have an appointment for treatment or medical care at Valor Spine Solutions, LLC. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services.

For Payment of Services: We may use and disclose protected health information about you so that the treatment and services you receive at Valor Spine Solutions, LLC may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations: We may use and disclose protected health information about you for Valor Spine Solutions, LLC health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care. We may also combine protected health information about many Valor Spine Solutions, LLC patients to decide what additional services Valor Spine Solutions, LLC should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Valor Spine Solutions, LLC personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study healthcare and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort. Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.

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

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Health Risks: We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.

Business Associates: We may disclose information to business associates who perform services on our behalf (such as billing companies); however, we require them to appropriately safeguard your information. Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, which may be necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement: We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

Organ and Tissue Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Special Government Functions: If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans' activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Correctional Institutions and Other Law Enforcement Custodial Situations: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

Workers' Compensation: We may disclose information as necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Food and Drug Administration: We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES. Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

We may share with a family member, relative, friend, or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. We may also share information to notify these individuals of your location, general condition or death.

We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

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

Right to Inspect and Copy: You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to Valor Spine Solutions, LLC. 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, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Right to Amend: If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information. To request an amendment, your request must be made in writing and submitted to Valor Spine Solutions, LLC. In addition, you must provide a reason that supports your request. We will act on the/ your request for an amendment no later than 60 days after receiving the request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the protected health information kept by Valor Spine Solutions, LLC Is not part of the information which you would be permitted to inspect and copy, or We believe is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of protected health information about you. To request this list or accounting of disclosures, you must submit your request in writing to Valor Spine Solutions, LLC. You may ask for disclosures made up to six years before your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 4-5. To request restrictions, you must make your request in writing to Valor Spine Solutions, LLC

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to Valor Spine Solutions, LLC. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time by contacting Valor Spine Solutions, LLC

OTHER USES AND DISCLOSURES

We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with Valor Spine Solutions, LLC, or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence of the complaint or violation. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

Acknowledgement Confirming Receipt of HIPAA Privacy Notice

I acknowledge I have received a copy of the HIPAA Privacy Notice. Please sign and date below.

Patient signature _____ Print name _____ Date _____

POST-OPERATIVE INSTRUCTIONS AND DISCHARGE INFORMATION

If you received intravenous conscious sedation for your procedure you may feel normal, yet legally you are under the influence of drugs. You may fall asleep easily and you may be forgetful at times. You are hereby directed to follow these instructions:

- ✓ Limit your activity for 24 hours
- ✓ Do not drive, return to work or perform any activity that requires quick reaction time or mental alertness such as operating machinery for at least 12 hours and a full night's sleep
- ✓ Avoid making critical decisions or signing legal documents
- ✓ Do not drink alcohol for 24 hours
- ✓ You may return to your normal diet as tolerated
- ✓ Allow at least 14 days to obtain maximum benefit from your injection

Report the following physical conditions to your doctor immediately:

- ✓ Increased or persistent redness or swelling around IV site or procedure site
- ✓ Persistent fever or chills
- ✓ Persistent or increasing nausea, vomiting, or headache
- ✓ Weakness or numbness of your arms or legs or difficulty urinating
- ✓ Difficulty breathing or shortness of breath
- ✓ Excessive or abnormal bleeding
- ✓ Excessive pain without relief from the pain medication prescribed
- ✓ If you cannot urinate within 6 hours after your procedure, go to the Emergency Room.
- ✓ If you are a diabetic, closely monitor your blood glucose level for the next two weeks.

WOUND AND DRESSING CARE:

- ✓ You may remove dressing in 1 hour and take a shower or bath
- ✓ You may use heat or ice for comfort. Do not apply heat or cold directly to injection site.
- ✓ Heating pad or ice compresses may be applied for 10 minutes every hour. Always place a cloth next to the skin before applying heating pad or ice compress.
- ✓ A small amount of bright red blood is to be expected
- ✓ If your bandage becomes soaked with bright red blood, place another dressing pad over your bandages. Do not remove original bandage. Call your doctor for further instructions.
- ✓ If drainage or pus is observed, please call your physician immediately.

MEDICATIONS:

- ✓ Resume taking your normal medications.
- ✓ You may take Tylenol or your prescribed pain medication for discomfort. It is recommended that you take your prescribed pain medication on a full stomach or with a snack.
- ✓ Medications containing aspirin should be avoided for 24 hours.
- ✓ DO NOT DRINK ALCOHOL WHILE TAKING PRESCRIBED PAIN MEDICATION - DO NOT DRIVE WHILE TAKING PRESCRIBED PAIN MEDICATION

Valor Spine Solutions, LLC, 825 S. Waukegan Road, Suite A8 #252, Lake Forest, IL 60045
(262) 98VALOR or (262) 988-2567

ASSIGNMENT OF BENEFIT, FINANCIAL RESPONSIBILITY AND CANCELLATION POLICIES

Last name _____ First name _____ DOB _____

Address _____ City _____ St _____ SSN _____

RELEASE OF INFORMATION: I authorize Valor Spine Solutions, LLC to disclose and release to my insurance carrier(s), as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to Valor Spine Solutions, LLC for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation. Late fees may apply.

AGREEMENT OF RESPONSIBILITY: I understand that *any patient cost share is due at the time services are scheduled* (estimated coinsurance and deductibles and cash pay). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to Valor Spine Solutions, LLC if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

CANCELLATION/NO SHOW POLICY: Valor Spine Solutions, LLC requires 72 hours' notice for cancellations of any scheduled procedure. Any cancellations made within 72 hours of scheduled procedures will be subject to a 25% penalty

Patient signature _____ Print name _____

Date _____

Preoperative Instructions

Patient Name _____ Date _____

Please arrive 15 minutes prior to your appointment to ensure your procedure begins on time. If you are more than 30 minutes late, your appointment may be rescheduled.

If you **ARE** having sedation (procedure and insurance dependent):

1. Do not eat for 4 hours prior to your injection.
2. You may drink clear liquids (water, coffee without creamer, tea, juice and carbonated drinks) for up to 2 hours before coming for your procedure.
3. If you are diabetic, hold your diabetic medication and do not eat or drink anything 4 hours prior to your appointment.
4. A responsible adult (age 18 or older) is required to come and stay in the building with you on the day of your procedure. They must also remain with you for 24 hours after your procedure.
5. Your procedure may be rescheduled if your driver leaves the building.
6. If you are being transported by public transportation, a responsible adult (age 18 or older) is required to be present and remain with you for 24 hours after your procedure.

If you are **NOT** having sedation:

1. You may eat and drink prior to your injection.
2. If you are diabetic: Please take your diabetic medicine and eat one piece of toast before coming for your procedure. Unless you are receiving sedation then, hold your diabetic medication and do not eat 4 hours prior to your appointment.
3. You DO NOT have to bring a responsible adult with you.

VERY IMPORTANT:

- If you are a diabetic, please check that your blood sugar is below 200 before your arrival. If it is not, please call. Your procedure may be cancelled, rescheduled or delayed if your blood sugar is at or above 200 upon arrival.
- If you have Hypertension (High Blood Pressure): Please take your prescribed blood pressure medication at your regular scheduled time.
- Please review the medications listed on the following page. If you are taking any of the medications listed, please coordinate with the prescribing physician to stop taking prior to your procedure.
- If you have not stopped these medications as instructed, your procedure will be rescheduled.

Do not stop any medication without advice from the prescribing physician

Lovenox	(Must stop 1 day before your procedure)
Pletal (Cilostazol)	(Must stop 3 days before your procedure)
Pradaxa	(Must stop 3 days before your procedure)
Eliquis	(Must stop 3 days before your procedure)
Xarelto	(Must stop 3 days before your procedure)
Coumadin	(Must stop 5 days before your procedure)
Brilinta	(Must stop 5 days before your procedure)
Vitamin E	(Must stop 5 days before your procedure)
Persantin	(Must stop 7 days before your procedure)
Plavix	(Must stop 7 days before your procedure)
Effient (Prasugrel)	(Must stop 7 days before your procedure)
Savaysa	(Must stop 7 days before your procedure)
Aggrenox	(Must stop 10 days before your procedure)

Must stop 6 days before your procedure:

Advil
Actiprofen (ibuprofen)
Aleve (Naproxen)
Anaprox (Naproxen)
Aspirin
Aspergum
BC Powder
Cataflam (Diclofenac)
Celebrex (Celecoxib)
Clinoril (Sulindac)
Daypro (OXaprozin)
Diclofenac (Voltaren)
Duexis (Ibuprofen/Famotidine)
Ecotrin
Emperin
Excedrin
Fenac (Diclofenac Sodium)
Feldene (Diroxicam)
Fenac (Diclofenac Sodium)
Fenopron (Nalfon)
Indocin (Indomethacin)
Genpril (Ibuprofen)
Goody's
Halfprin
Haltran (Ibuprofen)
Ibuprin (Ibuprofen)
Ibuprofen
Lodine (Etodolac)
Mobic (Meloxicam)
Midol (Ibuprofen)
Naprosyn (Naproxyn)
Motrin (Ibuprofen)
Nuprin (Ibuprofen)
Orudis (Ketoprofen)
Pamprin
Relafen (Relifex)
Toradol (Ketoralac)
Treximet (Naproxen/Somatripton)
Xylon

I have read and understand the preoperative instructions above, and have received a copy for my records.

_____ _____

Signature Date

Patient Rights and Responsibilities

At Valor Spine Solutions, we are committed to providing excellent care in the most personal, sympathetic, confidential and dignified manner possible. We make every effort to respond to our patients' and their families' psychosocial, spiritual and cultural value concerns. We believe that a patient's rights and responsibilities are an integral part of health care. You have rights as a patient, including the right to make decisions about your health care. The following information outlines our rights and responsibilities and is given to every patient and/or designated representative under Wisconsin State law. An Ethics Committee is available to support those making difficult health care decisions.

What are your rights?

1. You have the right to be informed about the care you will receive.
2. You have the right to get important information about your care in your preferred language.
3. You have the right to get information in a manner that meets your needs, if you have vision, speech, hearing or mental impairments.
4. You have the right to make decisions about your care.
5. You have the right to refuse care.
6. You have the right to know the names of the caregivers who treat you.
7. You have the right to a clean and safe environment.
8. You have the right to have your pain addressed.
9. You have the right to receive care free from all forms of verbal, physical, sexual, emotional abuse, neglect, exploitation, harassment or discrimination. This means you will not be treated differently because of:
    - ✓ Age
    - ✓ Race
    - ✓ Ethnicity
    - ✓ Religion
    - ✓ Culture
    - ✓ Language
    - ✓ Gender
    - ✓ Transgender
    - ✓ Size
    - ✓ Marital status
    - ✓ Sexual orientation
    - ✓ Newborn status
    - ✓ Socioeconomic status
    - ✓ Source of payment
    - ✓ Physical or mental disability
    - ✓ Gender identity or expression
    - ✓ Handicap

10. You have the right to be treated with courtesy and respect.
11. You have the right to have a patient representative with you during your care. Your representative can be a family member or friend of your choice.
12. You and your representative, if applicable, will have the opportunity to participate to the fullest extent possible in planning for your care and treatment.

Respect and Dignity

- You have the right to privacy when being interviewed, examined or treated.
- You have the right to be free from restraints.
- You have the right to be free from all forms of abuse or harassment.

Communication Rights

- When you do not speak or understand the predominant language of the community, you will have access to an interpreter.

Right to privacy – You have the right to:

- Refuse to talk to or see anyone not officially connected to Valor Spine Solutions (including anyone Connected with the Valor Spine Solutions who is not directly Involved in your care).
- Wear appropriate personal clothing and religious or other symbolic items, as long as they do not Interfere with diagnostic procedures or treatment.
- Have your medical record, including all computerized medical information, read only by persons directly involved in your treatment or in monitoring and evaluating your care or charges, unless otherwise requested by you. Other persons may have access only with your written consent or that of your legally authorized representative.
- Expect all communications and other records about your care, including source of payment for Treatment, to be treated as confidential.

Informed consent - you understand your treatment choices and their risk as follows:

- Except in emergencies, you or your legally authorized representative's consent will be obtained before treatment is given.
- You may refuse treatment to the extent permitted by law and will be informed of the medical consequences of the refusal.
- To the degree possible, responses to questions and requests should be based on a clear, concise explanation of your condition and of all proposed technical procedures. Explanation will include the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success.
- You should not be subjected to any procedure without your consent, or that of your legally
- Authorized representative.
- You will be informed whenever medically significant alternatives for care or treatment exist.

- You have the right to know who is responsible for authorizing and performing the procedures or treatments.
- You have a right to give informed consent to be filmed or photographed, a right to request that filming or photographing be stopped and a right to rescind the consent.

Research Studies

- You may be asked to participate in a research study. Taking part in such studies is your choice. If you decide not to participate, this will not affect the quality of the care you receive. You or your legally authorized representative will give informed consent for your participation in any form of research.

Continuity of Care

- The success of your treatment often depends on your efforts to follow medication, diet and therapy plans. Your family may need to help care for you at home. You can expect us to help you find sources of follow-up care, and as long as you agree that we can share information about your care with them, we will coordinate our activities with your caregivers outside the practice. You can also expect to receive information and, where possible, training about the self-care you will need when you go home.
- Except in the event of an emergency, you will not be transferred to another facility without being given a full explanation for the transfer, without provisions being made for continuing care and without acceptance by the facility to which you are transferred.
- You have the right to request a discharge planning evaluation. Your provider may assist you with this process.
- Consultation: You have the right, at your own request and expense, to consult with a specialist. You have the right to access protective services. Help is provided and referrals are made according to Wisconsin State law. Resource information is provided upon request.

Advance Directives

You will receive information about Advance Directives. You will have an opportunity to create an Advance Directive, and appoint a surrogate to make health care decisions on your behalf, to the extent permitted by law. Your Advance Directive will be made part of your permanent medical record, and the terms of your Advance Directive will be followed by the staff, to the extent allowed by law. You will receive care even though you may not have an Advance Directive.

Protection of your Information

You, and/or any person you authorize, have the right to obtain (from the physician or other practitioner responsible for coordinating your care) complete and current information about your diagnosis, course of treatment and any known prognosis for recovery. You, or any person authorized by law, have a right to access your medical record. You have a right to access, request changes to, and receive an accounting of disclosures regarding your own health information as permitted under applicable law. You, or your legal representative, have a right to be informed about the outcomes of care, treatment and services, including unanticipated outcomes.

What are your responsibilities and what is your role in your health care?

- Provide a complete and accurate medical history.
- Comply with practice rules and cooperate in your own treatment.
- Be considerate of other patients and staff by not making unnecessary noise, smoking, or causing disturbances.
- Refrain from physical and psychological abuse and intimidation.
- Provide required information concerning payment and charges.
- Notify your physician or nurse about any unexpected change in your condition that concerns you.
- Ask any questions when you do not understand what you have been told about your health care. If you don't understand, ask again.

Questions, Comments or Concerns

We value your feedback. If you have a concern, please contact any staff member if you would like more information on our policy and procedure on complaints.

You also have the right to file a complaint by contacting:

Wisconsin Division of Quality Assurance
P.O. Box 2969
Madison, WI 53701-2969
Phone: 608-266-8481 or 800-642-6552
Fax: 608-267-0352
www.dhs.wisconsin.gov/guide/complaints.htm

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