VALLEY BEAUTIFUL
HEALTHCARE

627 N. Main Ave.
Erwin, TN. 37650
Phone: (423) 735-3405 Fax: (423) 735-3408

Mikayla Rice, FNP
Whitley Harrison, FNP
Mistie Blankenship, RMA
Ashley Ponce, Receptionist
Debra Burleson, Phlebotomist
Sharon Mason, Care Coordinator

Dear New patient,

We would like to take this opportunity to welcome you as a patient and to thank you for choosing Valley Beautiful Healthcare. It is our privilege to care for you and your family's healthcare needs, and we hope that you will find that our office is dedicated to excellence in patient care.

Enclosed, you will find the new patient paperwork to be filled out prior to your first appointment. If you have any questions, please feel free to consult a member of our staff or telephone our office at (423)735-3405.

We look forward to working with you to manage your healthcare needs.

Thank you,

Valley Beautiful Healthcare

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Patient Last Name: _____First: _____

Date of Birth: _____Social Security Number: _____

Mailing Address: _____

City: _____State: _____Zip Code: _____

Primary Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to you: _____

Pharmacy: _____ City: _____

I, _____, a patient of Valley Beautiful Healthcare (VBHC), hereby authorize VBHC and its authorized agents to administer such treatment as is necessary and such additional procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment including diagnostic studies, referrals, consultations, etc.
I hereby certify that I fully understand the advantages, risks, and potential complications of medical treatments as explained to me by VBHC. I also certify that no guarantee or assurance has been made as to the results that may be obtained through medical treatment.
I authorize the payment of medical benefits to VBHC. I authorize the release of any medical records or other necessary information to process insurance claims on my behalf.

Primary Insurance: _____Member ID: _____

Group Number: _____Name of Subscriber on Card: _____

Date of Birth of Subscriber: _____Relationship to You: _____

Secondary Insurance: _____Member ID: _____

Group Number: _____Name of Subscriber on Card:_____

Date of Birth of Subscriber: _____

Relationship to You: _____

Signature: _____Date: _____

If not signed by the patient, please indicate the relationship to the patient: _____

Valley Beautiful Healthcare

Name:_____
Date of Birth:_____

Reason for Visit:_____

Review of Symptoms (Please select all that apply):

Constitutional
__ Recent fever/chills
__ Unexplained weight loss/gain
__ Unexplained fatigue/weakness

Eyes
__ Change in vision

Ear/Nose/Throat/Mouth
__ Nausea/Vomiting/Diarrhea
__ Difficulty hearing/ ringing in ears
__ Hay Fever/allergies/ congestion
__ Trouble Swallowing

Cardiovascular
__ Chest Pain/ discomfort/pressure

Endocrine
__ Palpitations
__ Shortness of breath
__ Cold/heat intolerance

Breast/Skin
__ Lumps
__ Rash
__ Breast Discharge
__ New or change in mole

Musculoskeletal
__ Pain in joints
__ Pain in muscles

Respitory
__ Cough/wheeze
__ Coughing up blood

Gastrointestinal
__ Heartburn/reflux
__ Pain in abdomen
__ Blood or change in bowel movement

Genitourinary
__ Leaking Urine
__ Painful/bloody urine
__ Nighttime urination
__ Increased thirst/appetite
__ Discharge: Penis or Vagina
__ Unusual vaginal bleeding
__ Concern with sexual function

Neurological
__ Headaches
__ Memory loss
__ Fainting
__ Seizures

Psychiatric
__ Depression/Anxiety
__ Sleep Problems

Blood/Lymphatic
__ Easy bruising
__ Unexplained lumps

Medication: Please list ALL medications you are currently taking including vitamins and over the counter medications.
_____
_____

Allergies to medications: _____

Personal Medical History: Please check all that apply.

__ Heart Disease __ High Blood Pressure __ Diabetes __ Thyroid Problems __ Kidney Disease
__ Asthma/COPD __ Depression __ Anxiety __ Acid Reflux __ Cancer
__Other: _____

Surgical History:
_____
_____

Family History: Please indicate any family members with the following medical conditions.
__ Alcoholisn __ Heart Disease __ Cancer __ High Blood Pressure __ Diabetes
__ Stroke __ Asthma/COPD __ Genetic Disorders __ Other:_____

Social History: Please circle type and indicate usage.
__ Tobacco use (Cigarettes / Chew / Snuff) __ Alcohol Use (Beer / Wine / Liquor / Recreational)

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Occupation: _____
Employer: _____

Marital Status: _____ **Number of Children:** _____
Spouses Name: _____

Education/ Highest Degree: _____

Preventative Tests/Vaccines: Please indicate dates of testing if possible.

Mammogram_____ PapSmear_____ Colonoscopy_____ Tetanus_____
PSA(Men)_____ Flu Shot_____ Pneumonia Shot _____ Shingles Shot_____
Lab Work_____

Acknowledgment of Notice of Privacy Practices

I have been provided with a copy of Valley Beautiful Healthcare's Notice of Privacy Practices of Valley Beautiful Healthcare, detailing how my information may be used and disclosed as permitted under federal and state laws.

Signed: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient and the patient's name.

Patient: _____Relationship: _____

Acknowledgment of Receipt of Advanced Care Plan/Health Agent Forms (Adults Only)

I have been presented with copies of the Advance Care Plan and Health Agent Forms accepted by the State of Tennessee for making healthcare decisions on my behalf.

Signed: _____ Date: _____

If not signed by the patient, please indicate your relationship to the patient and the patient's name.

Patient: _____ Relationship: _____

Valley Beautiful Healthcare
Financial Policy

Thank you for choosing Valley Beautiful Healthcare as your healthcare provider. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Payment is due at the time of service. This means co-pay or self-pay. We accept. Medicare, TennCare, and a variety of commercial insurances. Please verify with the receptionist that we accept your insurance. We also accept cash, money orders, and credit/debit cards for payment of balances due from you.

Regarding Insurance: We may accept the assignment of insurance benefits after your first visit. However, we do require either a co-pay or co-insurance percentage of your bill to be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance unless you provide us with accurate insurance. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid your balance within 60 days, the balance becomes your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your healthcare insurance plan.

Signature: _____ Date: _____

Name: _____

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This form is for Valley Beautiful Healthcare to receive your medical records from your old provider's office so we can better assist you in your care.

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____

Valley Beautiful Healthcare Is authorized to receive medical information from:

Facility/Dr. Name: _____

Phone or Fax Number: _____

Purpose of the Release: At the request of the patient

__ I give permission to release ALL medical records, including information and records or copies of records relating to the history, diagnosis, treatment, or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION, which may include information concerning my treatment of mental illness, HIV, alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists if any.

__ I give permission to release only records specifically described below:

I release Valley Beautiful Healthcare, the Facility/Doctor listed above, and any of the providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Valley Beautiful Healthcare, LLC. Provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.
This Authorization expires on __ / __ / ____ **.** If no expiration date is given, then this authorization expires one year from the date that it is signed.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Authorization to use and disclose Health Information

(This form allows Valley Beautiful Healthcare to only give medical information to the person(s) listed below)

I authorize **Valley Beautiful Healthcare** to use and disclose a copy of the specific health and medical information described below regarding:
Patient: _____Date of Birth: _____

I hereby authorize the medical personnel of Valley Beautiful Healthcare to discuss my protected health information with the following:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that certain information cannot be released without specific authorization for the release of the following protected or sensitive information. (Initial below if you DO WANT this information disclosed to the above person(s).

___ Information regarding the patient's diagnosis and treatment for HIV/AIDS.
Psychotherapy notes from a psychiatrist or Psychotherapist.
Treatment for alcohol or drug abuse reports.

Patient Signature: _____ Date: _____

You have the right to revoke this Authorization at any time if you do so in writing. If you revoke this Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

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Late Arrival Policy:

In order to make sure we maintain as efficient as possible with scheduling for our patients and provide the best care possible we have implemented a late arrival policy.

Patients who arrive **15 minutes or more after their scheduled appointment time** will **not be seen** and will need to **reschedule** their appointment.

This policy ensures that we remain on schedule and provide quality care to all of our patients. Thank you for your understanding and cooperation.

Signature: _____ Date:_____

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New No Call / No Show Policy – Effective January 1, 2026

Dear Valued Patient,

At Valley Beautiful Healthcare, we strive to provide exceptional care and make sure every patient has access to timely appointments. When an appointment is missed without notice, it limits our ability to accommodate other patients in need of care.

To ensure fairness and improve scheduling efficiency, we are implementing a **No Call / No Show Policy**, effective **January 1, 2026**.

Policy Details:

- If you are unable to keep your appointment, please notify our office **at least 24 hours in advance** to cancel or reschedule.
- Failure to contact the office in advance and not attending your appointment will be considered a **No Call / No Show**.
- A **$25 No Call / No Show fee** will be charged for each missed appointment without notice.
- This fee is **not covered by insurance** and must be paid before any future appointments can be scheduled.
- **After three (3) No Call / No Show occurrences**, you will be **discharged from Valley Beautiful Healthcare** and will need to establish care with another provider.

We understand that emergencies and unforeseen circumstances can occur. If an emergency prevents you from contacting us before your appointment, please call our office as soon as possible so we can review your situation.

We appreciate your understanding and cooperation with this policy. Our goal is to provide the best possible care and access to all of our patients.

Signature: _____ Date:_____