



Vance Medical  
 1001 N. Meridian Rd.  
 Meridian, ID 83642  
 Ph 208-258-7558 Fax 208-258-8251

**CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION:**  
**PATIENTS 18 YEARS AND OLDER**

In order for Vance Medical to speak with anyone including a family member and/or spouse, this form must be filled out Completely.

Patients Name: \_\_\_\_\_

Patients Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ Only release information to me personally.

**I hereby authorize Vance Medical to share the following information:**

\_\_\_\_\_ My medical care and treatment plan      \_\_\_\_\_ Medications I am taking

\_\_\_\_\_ Lab test results      \_\_\_\_\_ Mental Health

\_\_\_\_\_ Appointment information      \_\_\_\_\_ All of the Above

**With the following people:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

\_\_\_\_\_ You have my permission to leave information on my answering machine regarding my medical care and test results.

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Information			
First Name	Middle Initial	Last Name	
Date of Birth ( mm/dd/yyyy )	Preferred Name or Nickname		
Contact Information			
Email Address			
Please check this box if you DO NOT wish to receive important reminders, announcements, etc. via your email			<input type="checkbox"/>
Home Phone	Cell Phone	Work Phone	
Street Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip
Emergency Contacts			
Name	Relation	Phone Number	
Name	Relation	Phone Number	
Reasons for Your Visit (please circle as many as apply)			
Abdominal / digestive issues	Allergies	Annual physical exam	
Asthma / other breathing concerns	Blood pressure concerns	Diabetes	
Dizziness	Ear / Nose / Throat / Sinus issues	Fatigue	
Feminine Concerns	Headache	Hormone Questions	
Skin problems	Thyroid concerns		
Chronic Pain (please specify location):			
Mood Problems (please specify):			
Other (please specify):			
Questions and Comments - Your main concerns for this visit			
#1:			
#2:			
#3:			
<b>PLEASE CONTINUE ON REVERSE</b>			

## Additional Medical Information

Any Known Allergies:

Current Medications / Supplementation (including dosages, if known):

Ongoing Medical Conditions:

Past Surgical History:

Which specialists (if any) have you seen previously? (please circle all that apply)

Acupuncturist

Allergist

Cardiologist

Chiropractor

Dermatologist

Massage Therapist

Mental Health Professional

Nephrologist

OB/GYN

Plastic Surgeon

Other (please specify):

How did you hear about us (Google, Facebook, etc.)?

If referred, by whom?

May we thank them?

YES

NO

# Office Policies

THANK YOU FOR ASSISTING US IN PROVIDING THE BEST POSSIBLE CARE FOR EACH OF OUR PATIENTS  
BY READING AND AGREEING TO EACH OF THE FOLLOWING:

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## Insurance and “Superbills” (for NON-Medicare/Medicaid patients)

- Vance Medical is not affiliated with any insurance company, and Dr. Vance is not an in-network provider for any insurance company.
  - As a courtesy to our patients, we offer an itemized Superbill which can be submitted to your **non-Medicare / non-Medicaid insurance only** for potential reimbursement. We will only provide a Superbill for **office visits** with Dr. Vance, and any **blood work** paid for in our office and completed through **Treasure Valley Labs**.
  - Most insurance companies do not cover or reimburse for the alternative treatments, therapies, and supplementation that we provide and we will not provide a Superbill for those services.
  - Our staff does not work with any insurance companies, and we do not know the possible amounts or percentages you may or may not receive as reimbursement for our services.
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## For Patients with Medicare/Medicaid (or Any Supplemental Medicare Insurance)

- We apologize for any inconvenience this may cause, but we WILL NOT provide you with a Superbill.
  - If a patient receives a Superbill from our office and attempts to submit it to any Medicare, Medicaid, or similar supplemental insurance that falls under these programs, we reserve the right to fire you as a patient and to no longer provide medical care for you at Vance Medical.
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## Fee Structure

- New Patient Appointments are 60 or 90 minutes, depending on the complexity of the case. If a 60 minute appointment runs over by only a little (less than 15 minutes), it will be charged as a 60 minute consult. If it ends up running longer than this, however, it will be considered a 90 minute consult and will be charged as such.
  - Established Patient Consults are priced per 15 minutes. While most followup visits are going to be between 30-60 minutes in length, 15 minutes is the minimum appointment we offer.
  - When we schedule appointments, we do our best to allow enough time for all your concerns and questions to be addressed. **If your appointment runs over the allotted time scheduled** due to an unexpected amount of discussion or extended treatment, **the fee charged to your account will reflect the time spent**.
  - The fees for specific treatments vary and are separate from the cost of the appointment. Please ask for details.
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## Supplement Returns

- We understand that there may be supplements that don't work for everyone, or that may cause an undesired side effect.
- We **DO** offer a credit on any products by the brand “**Xymogen**” - whether or not the item has been opened.
- We **DO** offer a credit on any products, by any brand, that remain **sealed and unopened**.
- We **DO NOT** offer a credit on **opened** products by any other brand.

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## Refunds for Services Rendered

- Many of our treatments come in packaged options. **Refunds are not offered on packages paid in full.**
- If you decide that you would like to discontinue a particular treatment and have pre-paid sessions remaining in your package, you are welcome to use these towards another treatment or therapy that we offer.

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## Distance Patients

- All patients that are long-distance **MUST** have their initial visit with Dr. Vance **in person**. A physical exam is required to establish medical care for you within the state of Idaho. If you are unable to make a physical visit, we will be unable to see you as a patient.
- For convenience to both patients and staff, **we require a credit card number to keep on file**. We do our best to get in contact with you prior to running your card, in order to confirm costs and to determine if we need to ship any supplements. However, if we must leave a message when we call to take care of billing, and then do not hear from you, **we will automatically charge your card for the cost of the visit** at the end of the business day.

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## After-Hours Appointments

- Dr. Vance often has appointment times available in the evening hours. However, we do not always have staff available that late in the day.
- It is our policy that Dr. Vance **will not see female patients when no one else is present in the office**. Therefore, all female patients with such evening appointments (after 6pm) are **REQUIRED** to bring with them any companion they choose over the age of 16, whether it be a family member or friend. If a patient arrives without a companion, they will not be seen and will need to reschedule.
- Please keep in mind that you may not receive the same level of staff attention as you would during the day when we are fully staffed, but that we will do our best to take care of all your needs in full.

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## Cancellations

- We understand that life happens, and that sometimes not all appointments are able to be kept. We do ask to be given **as much notice as possible**, so we are able to fill your appointment with someone on our waiting list.
- **IV treatments** are confirmed as close as possible to the day before. If you confirm with our staff that you will be coming in for your appointment, the bag will be drawn up the morning of. **If you do not make it to your appointment, you will still be charged for the IV.**

I have read and understand the policies outlined in this agreement.

Signature (of Parent/Guardian if patient is a minor): \_\_\_\_\_

Patient's Name (Printed): \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PROVIDER NOTICE  
OF PRIVACY PRACTICES**

Uses and disclosure of health information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law enforcement in specific circumstances. In any other situation, we will ask for your written authorization to disclose information. You can later revoke that authorization to stop at any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

***Individual Rights***

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your records is incorrect or if important information is missing, you have the right to request that we correct the existing information in or add missing information.

***Complaints***

If you are concerned we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person below. You also may send a written notice of complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

***Our Legal Duty***

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information that are described in this note, and obtain your acknowledgment of receipt of this notice.

If you have any questions or complaints, please contact:

Office Manager: LaNita Vance

Address: 1001 N. Meridian ID 83642

Phone: (208) 258-7558

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

# VOLUNTARY ADVANCE BENEFICIARY NOTICE

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NOTE:

Medicare/Medicaid does not cover the services we provide and they are not a Medicare/Medicaid benefit. As such we do not submit claims to Medicare/Medicaid.

This statement is provided voluntarily to make you aware of your financial responsibility upon receiving these services.

Signing below means you received and understand this notice and will not submit bills or receipts to Medicare/Medicaid for reimbursement.

**Patient/Guarantor Signature: Date:**

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