Vance Medical
1001 N. Meridian Rd.
Meridian, ID 83642
Ph 208-258-7558 Fax 208-717-9595

# 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

_____ Lab test results

_____ Appointment information

_____ Medications I am taking

_____ Mental Health

_____ All of the Above

**With the following people**:

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: _____

This form is valid until three (3) years from the date it's signed.

## 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 | ☐ |

| 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 all that apply)

| | | |
|---|---|---|
| Abdominal / digestive issues | Allergies | Annual physical exam |
| Asthma / other breathing concerns | Blood pressure concerns | Diabetes |
| Dizziness | Ear / Nose / Throat / Sinus issues | Fatigue |
| Eye health - cataracts | Eye health - diabetic retinopathy | Eye health - floaters |
| Eye health - LASIK dry eye | Eye health - Macular degeneration | Eye health - Retinitis pigmentosa |
| Eye health - other | Headaches | Hormones |
| Skin problems | Thyroid | Women's health |
| Chronic Pain (please specify location): | | |
| Mood Problems (please specify): | | |
| Other (please specify): | | |

## Questions and Comments - Your main concerns for this visit

#1:

#2:

#3:

**PLEASE CONTINUE ON REVERSE**

## Additional Medical Information

**Any Known Allergies:**

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

**Ongoing Medical Conditions:**

**Past Surgical History:**

## Women's Health (for female patients only)

| Date of last women's exam: | Date of last PAP: | Have you ever had any abnormal results? If so, what/when? |
|---|---|---|
| | | |

## 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:**

**Insurance and "Superbills" (for NON-Medicare/Medicaid patients)**

- Vance Medical is not affiliated with any insurance company, and our providers are not in-network providers for any insurance company.
- As a courtesy to our patients, we offer an itemized Superbill which may be submitted to your non-Medicare/non-Medicaid insurance only for potential reimbursement.
- We will only provide a Superbill for office visit and blood work paid for in our office. We will NOT provide superbills for alternative treatments, therapies and supplements as most insurance companies do not reimburse for those treatments.
- You will NOT automatically be provided with a Superbill for your appointment. Please ask for your Superbill at the time of your visit.
- Our staff does not work with any insurance companies and does not know the possible amounts or percentages you may receive as reimbursement for our services. This is your responsibility as a patient.
- Some of the services we provide may be covered by Health Savings Accounts, Flexible Spending Accounts and Idaho Medical Savings Accounts. It is your responsibility as a patient to know what your account covers.

**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 dismiss you as a patient and to no longer provide medical care for you at Vance Medical.

**Requests for End of Year Superbills and Tax Information**

- Please be respectful of our staff's time. It is much easier for us to provide you with a Superbill at each visit than to provide group superbills. If you require Superbills, please notify us at the time of each visit.
- If you ask for Superbills or itemized lists of payments in bulk it may take up to 30 days to fulfill your request.

**Fee Structure**

- New Patient Appointments are 45, 60, 75, or 90 minutes, depending on the complexity of the case. It is your responsibility to help keep the appointment to the scheduled time. Your visit is timed and if the appointment goes over the allotted time, you will be billed accordingly.
- Established Patient Consults are priced per 15 minute increments. Please plan on follow up visits taking 30-60 minutes. Also, Please be aware that 15 minutes is the minimum appointment time that we offer. If you take 5 or 10 minutes, you will be charged for 15. If the appointment goes over the allotted time by more than 5 minutes, you will be billed for the additional time.
- Please come prepared with a list of questions at each visit, written in order of priority to discuss with the provider. Please understand that if you have more questions than time allows that you may need to set up a separate appointment to address those other issues.

**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 any brand, that remain sealed and unopened. We DO NOT offer a credit on opened products.

**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 supplements, office visits or treatments that we offer.

**Distance Patients**

- All patients that are long-distance MUST have their initial visit with their provider 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.

**Payment Cards on File**

- For convenience to both patients and staff, we require a debit/credit card number to keep on file, in the event that you need to pay for appointments, supplements, or lab orders while not physically in our office. We do our best to get in contact with you prior to running your card in order to confirm charges. 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 at the end of the business day. Having a card on file does not negate the need to bring a physical card; we always prefer to run a physical card.

**After-Hours Appointments**

- We do charge a fee for any appointments that take place after hours (i.e. starting 5:30pm or later) or as an addition to days we would be otherwise closed (i.e. Fridays)
- We do not always have staff available after hours. 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 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 when we are fully staffed, but we will do our best to take care of all your needs in full.

**Timely Appointments**

- We try to be timely with our appointments and to give you the quickest and best service that we can. In order to help keep our schedule running smoothly, we ask that you arrive at your appointment 5 minutes early so that we can get your vitals and check you in.

**Questions for your Practitioner**

- Phone calls, emails, and other communications outside of formal appointments take up staff time. Please read the information below to find out which contacts may require a fee, as you may be charged for communications requiring more practitioner attention. Please allow 24 - 48 business hours for your message to be reviewed by an appropriate staff member and understand that we will not respond on the weekends.
- Communications to our office with 1-2 simple and clear questions relating to your current medical plan, including medication and treatment plans, can be answered quickly at no charge.
- Communications requiring additional consideration will be referred for a 15 minute phone conversation with your practitioner, billed at their usual rate. This enables us to enhance the quality of your medical care, and allows us to devote the necessary amount of time to your requests.

**Prescription Refills**

- If you need a prescription refill, please ask your pharmacist to send the refill request to our office via **fax at 208-717-9595**. This allows us to avoid any miscommunication regarding the refill.
- It is your responsibility to inform us of which pharmacy you use and update us if this should change.
- Please allow one to two business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time if needed.
- We do not handle prescription refills over the weekend or after hours, so please plan ahead. No refills will be made after 12:00 pm on Friday. Please allow our office 24 - 48 hours to respond to the pharmacist.

**Forms/Authorizations**

- It is the patient's responsibility to pay in advance for any form that needs to be filled out by the practitioner. Please inform the front office of any forms needing to be filled out prior to your appointment. You will be charged a minimum of a 15 min. appointment for any forms that cannot be filled out by your provider during your appointment time or that must be completed outside of an office visit.
- Because forms can be time consuming, please allow 7 - 10 days for completion if a form needs to be filled out by the provider outside of the appointment time.
- If you require a prior authorization through your insurance for labs, imaging, medication or procedures that require the provider's time, and you want us to proceed with the authorization, you will be charged for time spent. These can often require your providers to be on the phone for 30 minutes or more, and will result in being billed as such.

**Behavior**

- We make every effort to make your visit as pleasant and comfortable as possible. In turn, we ask that your behavior is respectful towards our staff and other patients. This includes vocabulary and behavior. There is a zero tolerance for abuse of any kind and this behavior may lead to dismissal from our practice.
- If you have any problems associated with your visit, please contact LaNita Vance in writing at 1001 N. Meridian Rd., Meridian, ID 83642. In order to provide you with the best possible care, if we need to end our provider-patient relationship, we will provide emergency medical care and prescriptions for one month or until the patient finds a new provider whichever comes first.

**Cancellations and No Shows**

- There will be no charge for cancellations made at least 48 hours before the time of the appointment.
- Any cancellation with less than 24 hours notice will incur a $65 cancellation fee.
- No shows (failure to present at the time of appointment) will be charged a full appointment fee. Three (3) no shows within a calendar year may result in a suspension of service.
- Appointments scheduled for Monday must be cancelled by noon on the preceding Friday or you will be charged a $65 cancellation fee. Cancellation calls made on Saturday and Sunday do not give us adequate time to fill your appointment time on Monday.
- We will always take into account the circumstances behind the patient cancelling or not showing for an appointment. Occasionally your fee may be waived based on these circumstances.
- If you confirm with our staff that you will be coming in for your IV appointment, the bag will be drawn up the morning of. If you do not make it to your appointment after you have confirmed it will be considered a no show and you will still be charged for the full amount of the IV.

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

**Patient's Signature (or Parent/Guardian if patient is a minor): _____**

**Patient's Name (Printed): _____ Today's Date: _____**

# PATIENT CONDITIONS OF TREATMENT AND INFORMED CONSENT TO TREAT

**Clinic Treatment(s)** This document is a binding agreement (the "Agreement") between Vance Medical and/or Dr. Mark Vance dba Vance Medical (We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows:

**1. Consent for Treatment.** You hereby consent to and authorize Us to provide You with health care treatment, including but not limited to medical, diagnostic, nutritional/supplement treatment, PEMF, Intravenous and Intramuscular Micronutrient Therapy, Ultraviolet Blood Irradiation, Major Autohemotherapy, Chelation, Plaquex, Nicotinamide Adenine Dinucleotide (NAD) Therapy, Manual Therapies, Low Dose Immunotherapy and Low Dose Allergen Therapy, Low Dose Naltrexone, PTSD Treatments, Ozone Treatments (Including Ozone Insufflation, Nozone, and Otozone), Biodentical Hormone Therapy, Hormone Pellet Therapy, RHP/EBOO or Ozone Dialysis, Neural Therapy, Trigger Point Injections, Perineural Injection Therapy and Prolozone(together the "Treatments") administered by Us, our physicians, assistants, consultants and staff. You understand that the practice of health care/medicine is not an exact science and that diagnosis and treatment may involve risk of injury or death. You acknowledge that we have not made any guarantees or promises as to the outcome or the safety and efficacy of the Treatment.

**2. Experimental Nature of Treatment.** You acknowledge and agree that the evaluation, diagnosis and treatments may consist in whole or part of experimental procedures and methods, including but not limited to PEMF, Intravenous and Intramuscular Micronutrient Therapy, Ultraviolet Blood Irradiation, Major Autohemotherapy, Chelation, Plaquex, Nicotinamide Adenine Dinucleotide (NAD) Therapy, Manual Therapies, Low Dose Immunotherapy and Low Dose Allergen Therapy, Low Dose Naltrexone, PTSD Treatments, Ozone Treatments (Including Ozone Insufflation, Nozone, and Otozone), Biodentical Hormone Therapy, Hormone Pellet Therapy, RHP/EBOO or Ozone Dialysis, Neural Therapy, Trigger Point Injections, Perineural Injection Therapy and Prolozone(together the "Treatments") on which no governmental (including the U.S. Food and Drug Administration ("FDA")), scientific or medical authority has issued any guidelines or statements as to the safety or efficacy thereof. You acknowledge that the safety record of the Treatments is based only on empirical and anecdotal evidence, which only shows that the Treatments appear to be relatively safe. We have informed you that the Treatments MAY alter, address or decrease your pain, symptoms or complaints, but also may have no effect.

**3. Risks, Side Effects, Complication.** We hereby inform You that there are certain unavoidable risks and potential side effects and complications to the Treatments, including but not limited to infection; swelling; increased pain; bleeding; vein irritation and hardening; temporary numbness; lightheadedness; nausea; vomiting; dizziness; allergic or anaphylactic reaction; bruising; pain at IV site; acute vs. chronic liver or kidney dysfunction; scarring; headaches; gastrointestinal upset; shortness of breath; chest tightness; transient blindness; blood clots; embolism; fluid overload; a flushed feeling; warmth in the body; low or high blood pressure; low or high blood sugar; temporary or permanent alteration in sensation; discoloration; the need for additional surgery; soreness, itching, injury to nerves; spinal cord injuries; numbness; tingling; dural leaks; positional headaches (feel worse when sitting up, better when lying down); neck pain or stiffness; change in hearing (muffled sounds, ringing ears, etc); sense of imbalance; photophobia; phonophobia; pain between shoulder blades; drainage from nose; drainage from ears; salty or metallic taste in mouth; sense of drainage down back of throat; cutaneous sinus tract drainage; loss of smell; spinal fluid leaks; pneumothorax (air on the outside of the lung); paralysis; no benefit from Treatments; any other known or unknown complications or side effects; or other serious or debilitating injuries or death. You understand that other complications and risks are possible and that healing does not always proceed in a predictable manner and may take many weeks or months to experience full effect.

**4. Description of Treatments.** You acknowledge that the Treatments may involve insertion of needles into your skin and veins and the injection of standardized formulas which may include various nutritional substances, homeopathic medicines, and FDA approved prescriptive medicines, local anesthetic (Procaine, Lidocaine, lidocaine w epinephrine, bupivacaine or ropivacaine), sugar water or dextrose, and, on occasion ozone therapy and local subcutaneous anesthetic infiltration. The exact solution and site of injection for Your Treatment, as well as the recommended sequence of Treatments, will be explained to you when we actually administer the Treatments.

**5. Health Care Staff.** You are aware that among those who attend you on our behalf may be medical, nursing, and other health care personnel in training, who unless requested otherwise, may participate in patient care as part of their education. You further consent to the presence of service representatives and/or technicians from manufacturers of equipment or devices to assist in performing and/or operation of such equipment and/or devices during operation, procedure and Treatments.

**6. Information You Provide Us.** You have provided Us with a Complete list of all prescription and non-prescription medications and dietary supplements You are currently taking, and You agree to update Us periodically should this list change. You have provided us with a complete list of all known allergies you may have, and all allergic or adverse reactions you have had in the past to any medicines, dietary supplements or medical treatments of any kind. You covenant that all the information You provide Us during the course of Treatments, including without limitation the information required by this Section 6, is true, accurate, complete and up-to-date to the best of Your knowledge.

**7. Assumption of Risk.** You hereby acknowledge that after having read carefully and understood fully the terms of this Agreement, and after having adequate time to ask any question about this Agreement or the Treatments that you have, you are willing to assume any and all risks associated with the Treatments, including without limitation those described in this Agreement. You acknowledge that no explanation or description of the Treatments can ever fully explain every possible risk, side effect or complication that may or could arise from the Treatments, but that by signing this Agreement, You nevertheless acknowledge Your willingness to assume such risks and that Your consent to the Treatments is willing, voluntary and informed.

**8. Alternatives.** You have been informed that there are alternatives to the Treatments including surgery, other types of injections, prescription medications and taking no action. You further acknowledge that You have not been advised against seeking any other medical examinations or treatments.

**9. Miscellaneous.** You agree that this Agreement constitutes the entire agreement between You and Us regarding the subject matter hereof. No promise, representation, guarantee or warranty not included in this Agreement has been or is being relied upon by you. This Agreement shall be binding on you and your successors, heirs, legal representatives and assigns. In case any one of the provisions of this Agreement is held invalid or illegal, such provision shall be curtailed, limited or severed only to the extent necessary to remove such illegality or invalidity. This Agreement shall be governed by the laws of the state of Idaho without regard to any choice of law principal. Any dispute between you and Us shall be adjudicated in state or federal court in Boise, Idaho, and You submit to the jurisdiction of any such court.

**10. Email Consent**: I consent to receive communications sent from Vance Medical and/or Dr. B. Mark Vance, MD, via U.S. mail and/or email. I understand that I may unsubscribe from any automated communication at any time.

**11. Acknowledgement and Voluntary Consent.** I have read the Patient Conditions of Treatment and Informed Consent to Treat or have had it read to me, and agree to be bound by the terms therein. I have not signed this declaration without first reading it or having it read to me and I may ask any questions useful in helping me to understand it. I further understand my agreement to the provision of this declaration is an entirely voluntary and informed choice to which my signature attests.

**12. Intent to Seek Services.** By your signature You attest that You have not engaged in the service of Dr. Vance or those employed by Vance Medical in order to file a malpractice suit or further any investigation or prosecution by any government entity or medical association. Your sole purpose and intent in seeking the services of Dr. Vance and Vance Medical is to get help for Your personal health issues.

**Patient Name/Signature: _____ Date: _____**

**(If Patient is a Minor)**

**Guardian Signature _____ Date: _____**

**Relationship to Minor :_____**

# Vance Medical

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. B. Mark Vance dba Vance Medical ("we", "us", "our", "Practice"), understands that our patient's ("you", "your") privacy is important. This Notice of Privacy Practices ("Notice") applies to us and each of our Business Associates, as applicable.

### Protected Health Information

Protected health information ("PHI") relates to information about you and your health, which could be used to identify you.
Each time that you visit us, we create a medical record of your PHI and services that you receive.

### Our Obligations Regarding Your Protected Health Information

We recognize that information about you and your health is confidential, and we are committed to protecting this information. This Notice applies to all your health records that we create.
We are required by law to preserve the privacy and security of your PHI. While there is no absolute guarantee of privacy, we are committed to protecting your privacy. We have established reasonable and appropriate measures to protect your PHI against unauthorized use and disclosure.
Federal law mandates that we make this Notice available to you, and that we make a good faith effort to obtain a signed document acknowledging your receipt of this Notice. We are also required to follow the terms of this Notice. In the event that we are involved in a breach of your PHI, we will immediately notify you.

### Notice Effective Date and Potential Changes

This Notice became effective on May 13th, 2019, and it applies to health records that we create for you. We reserve the right to change this Notice after the effective date. We can change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request.

### How We May Disclose Your Protected Health Information

Applicable state and federal law allow disclosures of your PHI. Some of these disclosures do not require your verbal or written permission. The following information describes how we may share your PHI. We may typically use or share your PHI in the following ways:

**Treat you -** We can use your PHI and share it with other professionals who are treating you.
- Example: A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization -** We can use and share your PHI to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

**Bill for your services -** We can use and share your PHI to bill and obtain payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

**Help with public health and safety issues -** We can share your PHI for certain situations such as:
- Preventing disease;
- Helping with product recalls;
- Reporting adverse reactions to medications;
- Reporting suspected abuse, neglect, or domestic violence; and
- Preventing or reducing a serious threat to anyone's health or safety.

**Perform research -** We can use or share your PHI in a non-identifiable way for health research.

**Comply with the law -** We will share your PHI if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

**Respond to organ and tissue donation requests -** We can share your PHI with organ procurement organizations. We can share your PHI with a coroner, medical examiner, or funeral director when an individual dies.

**Address other government requests -** We can use or share your PHI:
- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law; and
- For special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions -** We can share your PHI in response to a court or administrative order, or in response to a subpoena.

## How else can we use or share your PHI?

We are allowed or required to share your PHI in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We have not listed every use and disclosure in this Notice. For more information see: www.hhs.gov/ocr/privacy/hipaa/ understanding/consumers/noticepp.html.

## Use and Disclosure of Your PHI with Your Verbal Agreement

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation; and
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

## Use and Disclosure of Your PHI Requiring Your Written Permission

If there are situations that have not been described above, we will obtain your written permission. In these cases, we never share your PHI unless you give us written permission:

- Marketing purposes;
- Sale of your information; and
- Most sharing of psychotherapy notes.

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.
If you provide us with written permission, you may change your mind at any time. Please let us know in writing if you change your mind.

## Your Rights Regarding Your PHI

You have the following rights regarding your PHI that is created in our practice. This section explains some of your rights and our responsibilities to assist you.

### Get an electronic or paper copy of your medical record

- You can ask to see or receive an electronic or paper copy of your medical record and other PHI that we have about you. Ask us how to do this.
- We will provide a copy or a summary of your PHI, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct your medical record

- You can ask us to correct PHI about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone), or to send mail to a different address.
- We will say “yes” to all reasonable requests.

### Ask us to limit what we use or share

- You can ask us not to use or share certain PHI in connection with our services.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- Because you are privately paying for some medical or health services, you may ask us to refrain from sharing information related to those private pay services with your health insurance plan. We will respect that request unless we are legally obligated otherwise under applicable laws.

### Get a list of who we have shared information with

- You can ask for a list (accounting) of the times we have shared your PHI for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, health care operations, and certain other disclosures (such as any you asked us to make).
- We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this Notice

• You can ask for a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

**Ask questions or file a complaint if you believe your rights are violated**

• If you have questions about this Notice or you believe that your rights are being violated, please contact us immediately:

**Practice Contact Information:**
LaNita Vance
Vance Medical
1001 N. Meridian Rd. Meridian, ID 83642

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

Please provide as much information as possible so that your concern or complaint can be thoroughly investigated. We will not retaliate against you for filing a complaint with us or the Department of Health and Human Services.

**PRACTICE:**

**Dr. B. Mark Vance/Vance Medical**

By: _____

Dr. B. Mark Vance

---

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to undersigned patient ("Patient"):

Dr. B. Mark Vance dba Vance Medical ("Practice"), is required to provide Patient with a copy of Practice's Notice of Privacy Practices ("Notice"), which states how Practice may use and/or disclose Patient's health information.

Please sign this form to acknowledge receipt of the Notice.

Patient may refuse to sign this acknowledgment if Patient wishes.

---

**I acknowledge that I have received a copy of Practice's Notice of Privacy Practices.**

**Patient's name (please print): _____ Date: _____**

**Signature: _____**

# VANCE MEDICAL
# ELECTRONIC COMMUNICATIONS AGREEMENT

Dr. B. Mark Vance dba Vance Medical ("we", "us" or "Practice") and the undersigned patient ("you" or "Patient") enter into this Electronic Communications Agreement ("EC Agreement") regarding the use of e-communications/ transmissions, such as e-mail, mobile or cellular telephone, text messaging, Skype, FaceTime, internet portal-enabled communications, or any other version of electronic communication (collectively "E-Communication") with respect to Patient personalized and protected health information ("PHI"). (Practice and Patient are each individually referred to as "Party" or collectively as "Parties".)

## PATIENT AUTHORIZATION DESPITE RISKS OF PRIVACY BREACH

While electronic communication platforms and services are commonly relied upon to achieve communication immediacy, there are risks that you acknowledge that are outside the control of the Practice. You authorize all forms of E-Communications that are exchanged between the Parties unless you instruct us otherwise in writing. You acknowledge that the utilization of E-Communication is inherently risky and prone to unintentional release of data. E-Communications may incorporate or communicate references to your PHI with sensitive health and personal identification information included. You acknowledge that E-Communications lack any absolute guarantee of privacy and are subject to: system privacy failure, cookies and other tracking efforts, phishing attacks, hack attacks, data breaches, unintended misdirections, misidentifications of senders/recipients, technology failures, and user errors.

You agree to undertake efforts to protect your privacy, which includes refraining from including sensitive information in E-Communications that you do not want to be at risk of any data security breach. We will undertake reasonable efforts to protect your privacy to the extent required by applicable laws. You authorize us to respond electronically to all E-Communications that appear to be provided by you, whether or not such communications actually arrive from the electronic contact information that you provide us.

## PATIENT MUST PROVIDE ACCURATE and UPDATED CONTACT INFORMATION

You agree to provide us with your accurate electronic contact information (mobile telephone number, email address, Skype or FaceTime contact information, and any other applicable E-Communication contact information). You will immediately inform us of any changes or corrections to your electronic contact information as an effort to avoid misdirected E-Communications.

## PATIENT MUST NOT RELY ON ELECTRONIC COMMUNICATION IN EMERGENCIES: USE 911 AND GET TO THE EMERGENCY ROOM

We do not guarantee that we will read your E-Communications immediately or within any specific amount of time. You agree **not** to utilize E-Communications to contact us regarding an emergency or time-sensitive situation, as there is too much risk that the communication response may be delayed, ineffective, untimely, or inadequate. **You MUST call 911 in any emergency, and/or must immediately seek emergency medical attention.**

## PRACTICE WILL COMPLY WITH HIPAA

The Practice values and appreciates your privacy and will take commercially reasonable steps to protect Patient's privacy in compliance with the Health Insurance Portability and Accountability Act of 1996 and related laws ("HIPAA").

We will obtain your express written or electronic consent (to the extent required by applicable law) if we are required or requested to forward your identifiable PHI to any third party other than as authorized in our Notice of Privacy Practices or as authorized or mandated by applicable law.

You hereby consent to the use of E-Communication of Patient's information as we consider helpful to coordinate care and schedule office visits with you and all parties responsible for providing or overseeing your care. You agree to identify individuals or entities authorized to receive your PHI from us in connection with authorized consulting, education, and all other aspects of your care, and we may share your PHI with such parties without additional written or electronic consent from you.

You have the right to ask us for a copy of your PHI, including an explanation or summary. The following services that we perform will not be the subject of additional charges to you: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information.

We may charge you fees for actual costs that we incur to provide such electronic PHI, but only to the extent authorized by applicable laws. Such fees may include to the extent lawful: skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs charged to you; and time spent by our administrative staff preparing additional explanations or summaries of PHI. If you request PHI on a paper copy, or portable media (such as compact disc (CD), or universal serial bus (USB) flash drive), we may charge you for our actual supply costs for such equipment, and you agree to pay us any such costs.

## PATIENT ACCEPTS RESPONSIBILITY FOR ELECTRONIC COMMUNICATION RISKS

You will hold Practice (and our owners, officers, directors, agents, and employees) harmless from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney fees, arising out of or caused by E- Communication (whether encrypted or not) losses or disclosures caused by any of the risks outlined above, or caused by some person or entity other than Practice, or not directly caused by us. Patient acknowledges and understands that, at our discretion, E- Communication may or may not become part of your permanent medical record. Practice is not

relieved by these terms from Practice's obligations to comply with all applicable E-Communication laws.
You acknowledge that your failure to comply with the terms of this EC Agreement may result in our terminating the use of E-Communication methods with you, and may result in the termination of your agreement for our services.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

We are required to provide you a copy of our Notice of Privacy Practices, which states how we may disclose your PHI. You hereby acknowledge receipt of the Notice of Privacy Practices.

**Consent to disclosure of billing information -** By signing this EC Agreement, you consent to the disclosure of all information relevant to billing, insurance and reimbursement regarding any and all substance abuse disorders that you might have, for the purpose of obtaining reimbursement from private or public insurers.

**ADDITIONAL TERMS**

This EC Agreement will remain in effect until either Party provides written notice to the other Party revoking this EC Agreement or otherwise revoking consent to E-Communications between the Parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation.

Revocation of this EC Agreement will preclude us from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by you. Either Party may use a copy of this signed original EC Agreement for all present and future purposes.

Parties agree to take such action as is necessary to amend this EC Agreement from time to time as is necessary for us to comply with the requirements of the Privacy Rule, the Security Rule, and other provisions of HIPAA, or other applicable law. Parties further agree that this EC Agreement cannot be changed, modified or discharged except by an agreement in writing and signed by both Parties.

If any term of this EC Agreement is deemed invalid or in violation of any applicable law or public policy, the remaining terms of this EC Agreement shall remain in full force and effect, and this EC Agreement shall be deemed amended to conform to any applicable law. The construction, interpretation, and performance of this EC Agreement and all transactions under this EC Agreement shall be governed by the laws of the state where the Practice is located, excluding choice-of-law principles.

Each participating patient over the age of 21 is required to sign this EC Agreement. Your signature represents that you understand and agree to the terms and conditions described within this EC Agreement.

## PRACTICE:

### Dr. B. Mark Vance dba Vance Medical

By: _____ Dr. B. Mark Vance

Date: _____

## PATIENT (OR AUTHORIZED REPRESENTATIVE OF PATIENT):

Sign: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

# VOLUNTARY ADVANCE BENEFICIARY NOTICE

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:** _____

**FOR OFFICE USE ONLY**

Practice made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from Patient but it could not be obtained because:

Patient refused to sign.

Due to an emergency situation, it was not possible to obtain an acknowledgment.

Practice was unable to communicate with Patient.

Other:

_____

_____

_____