Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

Patient Information

_____ _____

Patient Name Date of Birth

_____

Address City State Zip

Phone Numbers: _____ _____ _____

(Home) (Work) (Cell)

_____ _____ _____

Email address SS# Employer

_____ _____

Relationship to Insurance Subscriber How did you hear about us?

_____ _____

Other Healthcare Providers Caring for You Provider City Telephone#

Insurance Information

_____ _____

Insurance Company Name Insurance Phone Number

_____ _____ _____ _____

Subscriber (Policy Owner) Subscriber DOB Subscriber ID# Group ID#

_____ _____

Secondary Insurance Company Secondary Insurance Phone #

_____ _____ _____ _____

Subscriber (Policy Owner) Subscriber DOB Subscriber ID# Group ID#

Authorizations

☐ I authorize Dr. Joseph Vance to treat me.

☐ I authorize all insurance payments to be made directly to Dr. Joseph Vance. I consent to the release of all information the insurance company may request to aid in filing their claim. I understand that Dr. Joseph Vance will bill my insurance as a courtesy to me, but many insurances do not cover all charges that are deemed not medically necessary by my insurance company.

☐ I have received and reviewed the Patient Health Information Consent form. I understand that I can ask for further information if needed.

Patient or Responsible Party Signature: _____ Date:_____

Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

Health History

Name:_____ DOB:_____ Age:_____

Occupation:_____

When was your last medical visit/evaluation? _____

Current Medication (prescription and non-prescription, include dosage)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Supplements & Herbs

_____ _____

_____ _____

_____ _____

_____ _____

Do you use tobacco products? If yes, how much/many per day? _____

& For how many years have you used tobacco? _____

Do you drink alcohol? If yes, how many drinks per week? _____

Do you drink caffeinated beverages (coffee, tea, soda?) How many per day? _____

Do you exercise regularly? Please describe: _____

Do you follow a special diet? Please describe: _____

Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

Your Name:_____

Medical History

Please list any surgeries:

_____

_____

Yes No

Do you have issues with depression? ☐ ☐

If yes, what types of treatment has helped you? _____

Yes No

Have you had any recent accidents or injuries? ☐ ☐

If yes, please describe: _____

Current/Past illnesses: Please mark the appropriate box

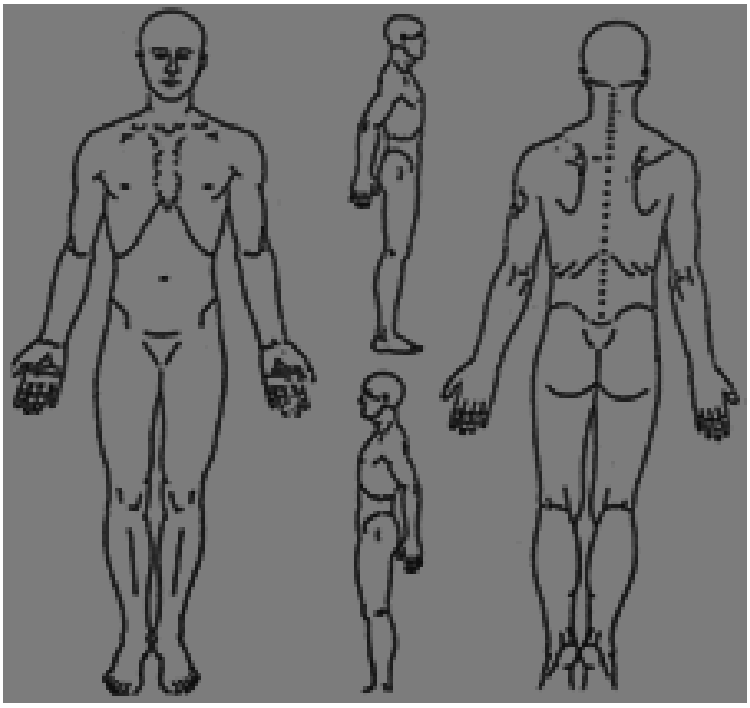
	Yes	No		Yes	No
High blood pressure:	☐	☐	Bladder infections:	☐	☐
High cholesterol:	☐	☐	Incontinence/bladder control:	☐	☐
Heart disease:	☐	☐	Kidney disease:	☐	☐
Stroke:	☐	☐	Anemia:	☐	☐
Bleeding/clotting disorder:	☐	☐	Skin disorder: (What type?) _____	☐	☐
Stomach ulcer:	☐	☐	Cancer: (What type?) _____	☐	☐
Gastrointestinal disorder:	☐	☐	Asthma:	☐	☐
Irritable bowel:	☐	☐	Respiratory problems:	☐	☐
Acid reflux:	☐	☐	Seasonal allergies:	☐	☐
Pain: (Where is pain located?) _____	☐	☐			

Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

Please mark where you have symptoms P=Pain, W=Weakness, N=Numb T=tingling

Name:_____



Family Medical History:

	Relationship to you		Relationship to you
Stroke	_____	Breast cancer	_____
High blood pressure	_____	Prostate cancer	_____
Heart disease	_____	Other cancer	_____
Diabetes	_____	Depression	_____

Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

Informed Consent

All medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation must obtain informed consent before commencing treatment.

I, _____(your full name) consent to examination and the performance of conservative noninvasive treatments for my condition. I understand that the procedures will likely consist of manipulations of my joints and soft tissues, along with rehabilitative exercises and physical therapy procedures/modalities.

Although manipulation of the spine and extremities is considered to be one of the efficacious and safest forms of therapy for musculoskeletal problems, I am aware that, as with any type of therapy, there are possible risks and complications associated with these procedures, which are as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness after a few treatments.

Dizziness: Temporary symptoms such as dizziness and nausea can occur but are relatively rare.

Joint injuries: I am aware that in isolated cases, underlying physical defects, deformities of pathologies like wear bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, discal degeneration, or other abnormality is detected, extra caution will be enacted.

Physical therapy burns: Some of the therapies utilized in this office create heat and may rarely cause burns. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

Strokes: Although strokes do happen with some frequency, it is noted that strokes from chiropractic manipulations are extremely rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments, the same chance as being struck by lightning or having a normal dose of Tylenol cause death.

Tests have been performed on me prior to treatments to minimize the risks of these or any other complication from treatment, and I freely assume these risks. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, reduced muscle spasm, increased mobility, and improved neurological function. However, I acknowledge that there is no certainty that I will achieve such benefits. I recognize that the practice of all forms of medicine, including chiropractic is not an exact science, and that no guarantee has been made to me regarding outcomes of these procedures.

In addition, I recognize that there are alternatives to chiropractic care, including, treatment by medical doctor or osteopath, physical therapist, acupuncturist, or naturopath. When appropriate, a referral to a separate provider of care will be given.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have regarding these procedures, or alternative treatments available have been answered to my satisfaction prior to my signing this consent form. I have made my decision voluntarily and freely.

_____ Signature of Patient
_____ Signature of legal guardian for minor
_____ Signature of witness
_____ Signature of Doctor
_____ Date

Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

Patient Health Information Consent Form

Dr. Joseph Vance wants to make you aware that your Patient Health Information (PHI) will be used in this office and what your rights are regarding those records. Before we begin a course of care, we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow Vance Chiropractic, LLC to use their PHI for the purposes of treatment, payment, healthcare operations and coordination of care.
2. The patient had the right to obtain a copy of their health records upon their request. The patient may request corrections and to know what disclosures have been made and may submit, in writing, any further restrictions on the use of their PHI. However, changes and restrictions made and agreed must be within the scope of State and Federal laws.
3. The patient's written consent need only be obtained one time for all subsequent care given by Dr. Vance.
4. The patient may provide a written request to revoke consent at any time during their care. Please note: this request would only apply to records from the date of the request forward and does not include use of records prior to the request.
5. Dr. Vance may contact you periodically regarding appointment, treatments, products, services, or payments. You have the right to "opt-out" of any marketing or fundraising communications at any time.
6. Your records are not readily available to those who do not need them. Your right to privacy is respected.
7. The patient has a right to file a formal complaint to Dr. Vance and the Secretary of HHS about any violations of these policies and procedures, without retaliation by the office.
8. Dr. Vance reserves the right to make changes to this notice effective for all protected health information that it maintains. If changes are made, you will be provided with the new notice.
9. Refusal to sign this consent form may result in Dr. Vance's right to refuse care.

I _____ have read and understand how my Patient Health Information (PHI) will be used and agree to the above policies and procedures.

_____ _____

Patient or Patient Rep's Signature Date

Joseph E Vance, DC, DACNB

Vance Chiropractic & Functional Neurology 679 Cottage St NE, Salem, OR 97301 Phone: (503) 581-1955

CANCELLATION POLICY

Thank you for choosing to enter care with us. We value your time and choice to use our office for your healthcare needs. If you have scheduled an appointment with us, we ask that you make your appointments on time, or cancel them the prior day. You can contact us by phone to let us know if a need to cancel. Unless of a true emergency nature, we reserve the right to charge you $25 fee for all missed appointments that are not cancelled the day prior.

If you feel you need it, we can text, email, and/or send phone reminders. Just let us know.

By signing this you agree to abide by our cancellation policy.

_____ _____

NAME SIGNATURE

_____

Date