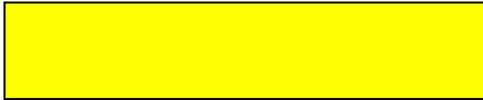
851 S. Colorado Ave.
Republic, MO 65738

(417) 732-4000
Fax: (417) 732-9706



Welcome To Our Office!

Patient Information

Thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to assist you. ***(Please Print)***

Name____ Date of Birth: _____________________

First Middle Initial Last

Date___________ SSN____________________ Sex: Female Male

Address____ City ________________________________

State_________ Zip_____________ email____

Cell (_____)________________Work (_____)________________

Married Widowed Single Minor Separated Divorced Partnered for _____ years

Patient Employer/School __________________________________ Occupation__________________________

Address____ City ____________ State____ Zip________

Spouse or parent's name ___________________________ Employer _________________________________

Whom may we thank for referring you to us? ____

Emergency Contact ____ Phone (_____)____________________

Medication Allergies: No Yes____

____

Are you currently taking any medications? No Yes (**If yes please list them with dosages**)

____

____

____

____

(For additional room for medications use back)

Please circle where your pain is located:

Neck Low Back Upper back Headache Other:________________ Car Accident

Responsible Party: (If you are listed as primary on insurance you can just put "**SELF**" on the first line)

Name of person responsible for this account ____

Relationship to patient ____

Employer____ DOB ____________________

SSN________________________ DL#_________________ Phone (____) ___________________

Address_______________________________________ City ________ State________ Zip__________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health insurance.
I certify that I, and my dependent(s), have insurance coverage with_____________________________
and assign directly to Dr. Vance's all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance company.** I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ___________________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____ ___________________________

Please print name of Patient, Parent, Guardian or Personal Relationship to Patient

Authorization to release Medical Information

I_____________________________, hereby give Vance Chiropractic permission to give the following information to the people listed below. The information I have checked will be the only information released unless otherwise changed by my permission only. I do understand my personal information will be protected by HIPAA Policy and will only be release to the approved list below. 0

Signature: _____________________________________

Date: ____________________________

Approved Names for Personal Information Release:

1.____ Phone Number: _________________________

2.____ Phone Number: _________________________

3.____ Phone Number: _________________________

Please mark which information you approve to be released.

- Billing
- X-Rays
- Personal Information of Any Type
- Copies of File (Any Information) to be picked up
- Calling to make or cancel appointments

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Vance Chiropractic

Effective: 4-01-2021

- By signing this form, you acknowledge that you were presented with a copy of our Notice of Privacy Practices which is information about how we may use and disclose your protected health information. We encourage you to read it in full.

- Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official: **Kristen Copeland, Privacy Official**

Mail: **Vance Chiropractic & Wellness Center, 851 Colorado, Republic, MO 65738**
Phone: **(417) 732-4000**

- By supplying your mobile phone number, email address, and any other personal contact information and signing below, you authorize **Vance Chiropractic & Wellness Center** to employ a third-party automated outreach and messaging system to use your personal information, the name of your care provider, the time and place of your scheduled appointment(s), and other limited information, for the purpose of notifying you of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. You also consent to the receiving multiple text messages and/or emails per day from the automated outreach and messaging system, when necessary.

Please complete for authorization:

-Your Email address to receive emails: ___________________________________

-Your mobile phone number to receive text messages: _____________________________________

-Print Patient Name: ____

-Signature Patient/Personal Representative: ____

-Relationship of Personal Representative: ____

-Date of Signature: __________________

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

□ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

□ Other:

Staff Signature: ____ Date: ____________________