THE LAS VEGAS PAIN AND WELLNESS CENTER

Welcome To Our Office

Please fill out completely

Patient Information

First: Name*

Last Name*

Date Of Birth*

Home Phone*

Mobile Phone

Work Phone

Email

Preferred Communication

☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email

SSN

Gender*

☐ Male ☐ Female

Race and Ethnicity

☐ Prefer Not to Answer _____

Preferred Language

☐ Prefer Not to Answer _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widow

Street Address 1*

Street Address 2

Zip*

City*

State*

Emergency Information

Emergency Contact Name

Emergency Contact Phone

Relationship

Insurance Information

Name of Insured:_____ Relationship to Patient:_____

Insurance Co.:_____ ID# _____

Group #_____

Is Patient Covered by Additional Insurance? ☐Yes ☐No

Name of Insured:_____ Relationship to Patient:_____

Insurance Co.:_____ ID# _____

Group #_____SS#_____ Birthdate:_____

Assignment, Release and Certification Signature

I, the undersigned certify that I or my dependent have insurance coverage with the above insurance company and assign directly to KEVIN L. KALDY, DC, PC or Dr. Kaldy 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 hereby authorize KEVIN L. KALDY, DC, PC . or Dr. Kaldy and staff to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance forms.

_____

Responsible Party Signature (If necessary):

_____ _____

Relationship Date

Patient Name:_____ Date:_____

Chief Complaint

Reason for Visit:_____

What date did your complaint first start? _____

Rate your pain on a scale of 1(least) to 10 (worst):0____Is it getting worse? □Yes □No

Frequency of your complaint: □Constant □Off and On

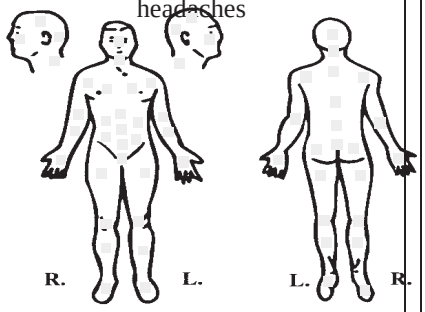
Nature of complaint: □Sharp □Dull □Throbbing □Numbness
□Tingling □Aching □Shooting □Burning

Does your complaint interfere with: □Work □Play □Daily Routine □Sleep

Activities or movements difficult to perform: □Sitting □Standing □Walking
□Bending □Lying Down

Additional Comments:_____

Mark below where you are having pain, numbness, tingling, spasm, headaches



Injury Information

Is condition due to an accident? □Yes □No Type of accident: □Auto □Work □Home □Other

Who have you made a report of your accident? □Auto Insurance □Employer □Worker Comp. □Other

Claim #:_____ Adjuster Name:_____ Phone #:_____

Attorney Name (if Applicable):_____ Phone #:_____

Health History

How long can you sit without pain:_____minutes Do you have pain while lying on your back? Y/N

How long can you stand without pain:_____minutes Do you experience pain going to the bathroom? Y/N

Can you get dressed without pain: Y/N Are you experiencing sharp pain with deep breathing? Y/N

Family Doctors Name:_____

Other Doctors Names: _____

List all drug allergies that you have:_____

List all surgeries you have had:_____

List any fractures you have had:_____

List all prescription or over the counter medications you are taking:_____
_____

List all health problems or other diseases that you currently have: _____
_____

Height ft in Weight_____lbs Dominant Hand: ___Right ___Left

Do you smoke? □Yes □No How many packs per day? ____

Do you drink alcohol? □Yes □No # of drinks per day_____ □ Socially

Do you exercise regularly? □Yes □No

Type of work: □ Clerical □ Light Labor □ Moderate Labor □ Heavy Labor

Recent Radiology Dates & Location: □X-ray _____□MRI_____
□CT Scan_____ □Ultrasound_____

For women only

Is there any possibility that you may be pregnant? □Yes □No

Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of their staff responsible for any errors or omissions that I my have made in the completion of this form.

Signature:_____ Date_____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☑ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☑ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☑ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☑ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

- ☑ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score **0** x 2) / (**10** Sections x 10) = **0** %ADL

Reset

Section 6 – Standing

- ☑ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☑ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☑ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☑ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☑ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☒ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☒ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☒ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☒ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☒ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score **0** x 2) / (**10** Sections x 10) = **0** %ADL_____

Reset

Section 6 – Concentration

- ☒ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☒ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☒ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☒ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☒ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

8821 W. SAHARA AVE. STE. 120
LAS VEGAS, NV 89117
702.212.3333 • FAX 702.212.3300
www.LVPWC.com

THE LAS VEGAS PAIN AND WELLNESS CENTER

Financial Policy

The following agreement applies only to the services actually rendered by KEVIN L. KALDY, DC, PC dba The Las Vegas Pain and Wellness Center and in no way obligates a patient to continue any course of treatment recommended.

APPOINTMENTS

1. **Copayments:** Copayments for clinic visits are due at the time of service. If you are unable to make your copayment at the time of service, LVPWC reserves the right to reschedule your appointment until a time that you are able to make your copayment. Payment for any outstanding balance is due at your appointment.

2. **Manipulation Under Anesthesia (MUA) Procedure Prepayment:** LVPWC collects your payment for the procedure at the time when the procedure is scheduled, if one is due. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed and you are also responsible for any "patient responsibility" as deemed by your insurance (if applicable). We reserve the right to reschedule your procedure until your prepayment if any has been made. There is a $500 charge if the procedure is cancelled by the patient within 24 hours.

   Separate fees: The ambulatory surgery center will discuss with you separately any fees due them and due for anesthesia. The assisting physician, if applicable; will bill you and/or your insurance separately for any fees due them.

3. **Missed Appointments and Late Arrivals:** Our doctor(s) run on time. If you do not show up to your appointment, you will be responsible for a missed appointment fee. This will also hold if you are more than 15 minutes late. Please call 24 hours before your appointment to reschedule to another date.
   If you are more than 15 minutes late you will be rescheduled and considered a missed office visit. ALL missed or late appointments are subject to a $25 charge. Missed procedure appointments are subject to a $500 charge. These charges are your responsibility and will not be billed to any insurance carrier. **Initial:____**

INSURANCE

4. **Financial Responsibility:** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all chiropractic and procedure services provided to you. Any charges not paid by your insurer or your attorney will be your responsibility, except as limited by our contract (if any) with your insurance carrier.

5. **Coverage Changes and Timely Submission:** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit within which LVPWC must submit a claim on your behalf to your insurer. If LVPWC is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.

6. **Self-Pay:** If you do not have health insurance, or if your health insurance will not pay for services rendered by LVPWC, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available from our front desk). Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

7. **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your reasonability to contact your insurance company to verify that your assigned physician participates in your plan if you wish to utilize your insurance. Out of network changes may have higher deductibles and copayments.

The Las Vegas Pain and Wellness Center Financial Policy (con't)

8. **Prior Authorization and Non-Covered Services.** LVPWC may provide services that insurance plans exclude or require prior authorization or mistakenly state as covered benefits. It is ultimately your responsibility to ensure that services provided to you are **covered** benefits and that you wish to receive them. We will make every attempt to get authorized by your insurer however they state, ***"THE FOLLOWING IS NOT A GUARENTEE OF PAYMENT AND ARE SUBJECT TO THE PLANS AND PROVISIONS OF THE INSUREDS PLAN"***. As a courtesy to our patients, LVPWC will make a good faith effort to determine if services we order are covered by your insurance plan, and, if so, whether or not prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
9. **Out of Network Payments.** If we are not part of your insurance carrier's network (out-of-network) and your insurance carrier pays you directly, you are solely responsibility for payment and agree to forward the payment to LVPWC, immediately.
10. **Personal Injury**: If you will be utilizing your Medical payment portion of your auto insurance or have hired an attorney to assist me in settlement of your case, it is your responsibility to keep all information pertaining to these entities current. You agree to provide the necessary documents and information required to THE LAS VEGAS PAIN AND WELLNESS CENTER, necessary for the collection of services rendered. You understand that the use of your Medical Payments portion of your auto insurance may not cover the entire bill and that you may owe a balance.
11. **Worker's Compensation**: If you have been injured while working and have completed the documents necessary to open a worker's compensation claim with your employer, the insurance company and adjuster must agree that you may receive care at our office. You agree to furnish THE LAS VEGAS PAIN AND WELLNESS CENTER, with the information needed to establish the work relatedness of your injury.

ACCOUNT BALANCES AND PAYMENTS:

12. **Reassignment of Balances.** If you insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
13. **Collection of Unpaid Accounts.** In the event any unpaid balance is placed for collections, with a 3rd party collections agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by these individuals to collect amounts owed under this agreement such as court cost, sheriff/constable fees, and interest and late fees. **Initial:____**
14. **Returned Checks.** Returned checks will be subject to a $38 returned check fee.
15. **Statements.** Changes shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing dates.

AGREEMENT and ASSIGNMENT OF BENEFITS

I have read and understand the financial policy of The Las Vegas Pain And Wellness Center, and I agree to abide by its terms. I hereby assign all chiropractic and surgical benefits and authorize my insurance carrier(s) to issue payment directly to The Las Vegas Pain And Wellness Center. I understand that I am financially responsible for all services I receive from LVPWC. This financial policy is binding upon you and your estate, executors and / or administrators, if applicable.

I understand this financial agreement and agree to comply with its outlined policies.

PATIENT NAME (PRINTED): _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

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THE LAS VEGAS PAIN AND WELLNESS CENTER

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Chiropractic, Medical, Osteopathic doctors and Physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercise may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculo-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from Osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from Chiropractic adjustments 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. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. 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.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits. I realized that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription and over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value and are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint instability or serious disk rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-Treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation or chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of patient / patient representative if unable to sign

_____ Date and Time

THE LAS VEGAS PAIN AND WELLNESS CENTER

8821 W. SAHARA AVE. STE. 120
LAS VEGAS, NV 89117
702.212.3333 • FAX 702.212.3300
www.LVPWC.com

Release of Records Request

Date: _____

To: _____
Doctor or Hospital Name

_____
Address City State Zip Code

_____ _____
Phone # Fax #

I _____, hereby authorize and request you to release to:

The Las Vegas Pain and Wellness Center
8821 W. Sahara Ave., Ste. 120
Las Vegas, NV 89117
(702) 212-3333
Fax: (702) 212-3300

any and all medical information, history, diagnosis, reports or x-rays in your possession concerning the undersigned.

Patient's Name Printed: _____

Patient's Signature: _____

_____ _____
Social Security # Date of Birth

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

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THE LAS VEGAS
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Provider 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.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the eeuality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers 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 reeuirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise reeuired by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop 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 notices in the waiting area. You can also reeuest a copy of our notices at any time. eor more information about our privacy practices, contact the person 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. If you reeuest copies, we will charge you only normal photocopy fees. You may 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 record is incorrect or if important information is missing, you have the right to reeuest that we correct the existing information or add the missing information.

Complaints

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

Our Legal Duty

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

If you have any questions or complaints, please contact:
Office Manager: Kevin L. Kaldy, DC
Address: 8821 W. Sahara Ave. Suite 120 Las Vegas, NV 89117
Phone: 702-212-3333

PLEASE SIGN THE ATTACHED ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND RETURN IT TO THE RECEPTIONIST. THANK YOU.

8821 W. SAHARA AVE. STE. 120
LAS VEGAS, NV 89117
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THE LAS VEGAS
PAIN AND WELLNESS
CENTER

Acknowledgment of Receipt Of Notice Of Privacy Practices

I acknowledge that I have received and understand The Las Vegas Pain and Wellness Center, Notices of Privacy Practices.

Signatures:_____

Printed Name:_____

THE LAS VEGAS PAIN AND WELLNESS CENTER

Where Pain Ends and Life Returns....

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I _____, understand that as a part of my health care, Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

X_____ _____
Patient/Legal Guardian Signature Date

THE LAS VEGAS PAIN AND WELLNESS CENTER

Where Pain Ends and Life Returns....

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center ("Practice") and Patient herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient's Personal Health Information ("PHI"). The Patient agrees to inform the Practice of any changes to Patient's authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient's privacy and takes security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or causes by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practice's, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, an may lead to the termination of the Patient's agreement for Practice services.
8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronics information. However, the Patient's PHR Support subscription fee may include 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; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive) the Practice's actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment, but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT FOR AGREEMENT FOR PERSONAL HEALTH INFORMATION

I acknowledge that I have received a copy of the Practice's Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

☐ **YES** ☐ **NO** **Email Address:** _____

Patient Name: _____

Signature: _____ Date: _____ /_____/ 20_____

Patient or Legal Guardian