PATIENT INFORMATION

Date:_____ First Name:_____ MI:_____ Last Name:_____ Age:_____

Street Address:_____Unit #:_____

City:_____ State: _____ Zip: _____

Social Security #:_____ Marital Status: S M W D Spouse:_____

DOB:_____ Home Phone: _____ Work Phone: _____ Cell:_____

Email: _____ Emergency Contact/Phone:_____

How did you hear about our office?_____

Occupation:_____Employer:_____Address:_____

INSURANCE INFORMATION

We will make copies of your insurance cards, however, please complete the following information.

Name of Primary Insurance Carrier:_____ Policy ID#:_____

Are you the policy holder? Y N If no, who is the policy holder: Spouse Parent Employer Other_____

Policy Holder's First Name:_____ MI:_____ Last Name:_____ DOB:_____

Policy Holder's SS#:_____ *Policy Holder's* Employer:_____

Secondary Insurance Carrier (if applicable):_____Policy ID#:_____

Are you the policy holder? Y N If no, who is the policy holder: Spouse Parent Employer Other_____

Policy Holder's First Name:_____ MI:_____ Last Name:_____ DOB:_____

Policy Holder's SS#:_____ *Policy Holder's* Employer:_____

ASSIGNMENT & RELEASE

Insurance Clause: I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that I authorize direct payment to this office to be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that ultimately I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will remain my responsibility. If my current policy prohibits direct payment to the doctor, then I hereby authorize and direct that payment be mailed to me in care of (c/o) this office.

Consent for Treatment & Release of Information: I hereby authorize and release the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; I furthermore authorize him to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's Signature:_____ Date:_____

Guardian's Signature (giving consent to treat a minor):_____ Date:_____

PATIENT COMPLAINT

Name:_____ Date:_____

Is your visit due to a: *car accident* *work injury* *slip & fall* (circle one if applicable and inform the front desk before continuing)

List your complaints (ex. neck pain, headache) from most to least significant & rate each by circling a spot along the scale.

1)_____

No Pain — Worst Pain Imaginable

2)_____

No Pain — Worst Pain Imaginable

3)_____

No Pain — Worst Pain Imaginable

Describe any other complaints and explain what you hope our clinic may accomplish for you:_____
_____
_____

Place one of the following letters over your areas of complaint:

S = sharp & stabbing

B = burning

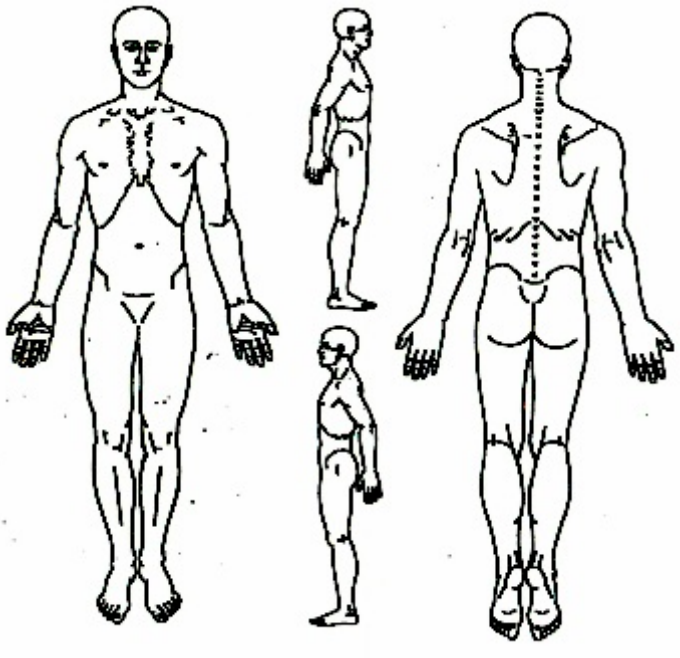
D = dull & achy

T = tingling (pins & needles)

N = numb

C = cramping

O = other_____



List any health care providers you have seen for this complaint:_____

Who is your primary care physician?_____ Have you ever seen a Chiropractor? Y N

List any significant past traumas, work injuries, or car accidents and please list at least an approximate date:_____
_____

Summarize any other past medical history including dates (ex. surgeries, conditions, hospitalizations, etc.):_____
_____

List any medications you are taking:_____

Is there a possibility you are pregnant? Y N Date of your last menstrual period:_____

Do you smoke, have high blood pressure, take birth control pills, or have history of stroke? Y N Please explain:_____
_____

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motion.balance.strength.

Kelly E. Murie, DC Lucas Odahlen, DC Jeff Prince, DC Emily Haugen, DC Jamie Warner, DC Angelika Knopp, DC John Vigil, DC

Diagnostic Imaging/X-Ray Pregnancy Consent

Patient Name:_____
Patient DOB: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS: **FEMALE ONLY 12-55**

Are you pregnant or any chance you may be: _____ YES _____ NO

The exam your doctor has ordered uses Ionizing radiation which can have a severe health effect during pregnancy to an unborn baby. The possibility of severe health effects depends on the gestational age of the unborn baby at the time of exposure and the amount of radiation it is exposed to. Unborn babies are particularly sensitive to radiation during their early development, between weeks 2 and 15 of pregnancy. Such consequences can include stunted growth, deformities, abnormal brain function, or cancer that may develop sometime later in life. You should contact your doctor if you believe you may be pregnant to discuss possible side effects and the risks and benefits of the procedure.

Please initial each line as they apply to you.

If you feel that you may be pregnant, please inform the radiologic technologist before your exam. _____

To the best of my knowledge, I am not pregnant or believe there is any possibility that I may be pregnant. _____

I know or believe that I may be pregnant and fully understand the risk and health effects radiation may cause to my unborn baby. _____

Signature: _____ Date: _____

8475 S. Eastern Ave, Suite 101; LV, NV 89123 600 S. Rancho Dr, Suite 110; LV, NV 89106 5506 S. Fort Apache Rd; LV, NV 89148
Phone: (702) 898 3311 Fax: (702) 898-3383

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MASSAGE CANCELLATION POLICY

Unfortunately, life sometimes gets in the way of keeping an appointment. If you need to cancel or reschedule your massage and do not wish to be billed for the appointment, we must be notified at least 4 hours prior the appointment time. **If less than 4 hour notice is provided, or client does not show up, a $30 fee will be charged.** Emergency cancellations are determined at the practitioner's discretion.

If you are a personal injury patient being treated on a lien under an attorney or medpay case, attendance is also critical to your case. **If you miss 3 appointments** without calling at least 4 hours prior your appointment to cancel or reschedule, **you will no longer be scheduled for muscle therapy.**

MASSAGE TERMINATION

Massage therapists have a right to refuse service. Muscle therapy services will be terminated immediately if a client makes any sexual advances or requests. Even questionable sexual discussion may be cause for termination. Massage is therapeutic in nature and any interactions and communications must remain professional. If the therapy is terminated for the above-mentioned reasons, payment is still required.

We have a zero-tolerance sexual harassment policy!

A session will not be conducted if the client is intoxicated, using drugs, or threatening the safety of the massage therapist, others in the building, or themselves.

MASSAGE GUIDELINES

1. Sessions are intended to begin and end at the scheduled times. Sessions that begin late due to the client's late arrival will end at the scheduled time and will be billed at the full rate.
2. If a client has a cold, flu, sore throat, stomach virus, poison ivy, skin rash, or any other contagious condition, we ask that you please reschedule your appointment.
3. Clients must be present and not under the influence of alcohol or drugs.
4. Clients must provide a health history and related health update, as deemed necessary.
5. Sexual harassment is not tolerated, and the session will be terminated if this occurs or if the practitioner's safety is compromised in any way.
6. This office is a non-smoking, odor-neutral environment.
7. Clients are expected to be clean, having showered the same day as the massage.
8. Clients are asked not to eat a heavy meal less than two hours prior to the massage.

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CLIENT EXPECTATIONS

1. We provide our clients with a competent and professional session which is customized and focuses on the individual needs of each client.
2. Clients are draped with a sheet at all times during the session. Only the parts of the body being worked on are exposed at any time. The genital area is never exposed or massaged.
3. Clients are treated with respect and dignity.
4. Personal and professional **boundaries** are respected at all times.
5. We treat all clients equally regardless of their age, gender, race, national origin, sexual orientation, religion, socio-economic status, body type, and political affiliation, state of health, or personal habits.
6. Privacy and confidentiality are maintained at all times.
7. We take pride in staying current with muscle therapy techniques and are committed to providing "state-of-the-art" bodywork.
8. The massage therapist performs services which he/she is able and qualified, both physically and emotionally, to perform.
9. Equipment and supplies are kept clean and safe.

CLIENT ACKNOWLEDGMENT

I have read, fully understand, and will abide by the muscle therapy policies and guidelines included herein.

PATIENT SIGNATURE_____ **DATE**_____

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PATIENT REQUEST FOR RECORDS

PATIENT NAME _____

TODAY'S DATE _____ **DATE OF BIRTH**_____

For office use only:

TO _____

ADDRESS_____

CITY _____**STATE**_____ **ZIP**_____

FAX NUMBER _____

I hereby authorize and release of my medical records, imaging reports, and any other pertinent information, or copies of such, and request that they be transferred via FAX to:

Max Health Center
F 702.898.3383
www.maxhealthlv.com

PATIENT SIGNATURE_____

If patient is a minor:

GUARDIAN NAME _____

GUARDIAN SIGNATURE _____

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Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the heal care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence, giving rise to any claim. This agreement is intended to bind the patient while employed by, working or associated with or servicing as a back up for the health care provider, including those working at the healthcare provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful deal, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share pf the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The party's consent to the intervention and joinder in the arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____ Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. With my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature:_____ Date:_____

(Include relationship if signing as a guardian.) Relationship:_____

Office Signature:_____ Date: _____

HIPAA Notice of Privacy Practices

MaxHealth Center

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

If you have any questions about the above notice, please contact our Office at

702-898-3311

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes,
we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's
privacy officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health
related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

Special Situations

As required by law. We will disclose Health Information when required to do so by international, federal, state, or

local law.

To Avert a Serious Threat to Health of Safety. We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

Military and Veterans. If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation. We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date

Kelly E. Murie, DC Lucas Odahlen, DC Jeff Prince, DC Emily Haugen, DC Jamie Warner, DC Angelika Knopp, DC John Vigil, DC

Worker's Compensation Notice

Patient Name: _____

DOB: _____

- ○ I do NOT currently have an open Worker's Compensation case.
- ○ I currently have an open Worker's Compensation case.

Initial: _____ I understand that if I have an open Worker's Compensation case now or in the future, I will be responsible to inform the MaxHealth staff immediately.

Initial: _____ I understand that if I want MaxHealth to bill my treatment to my Worker's Compensation policy, I must provide a C4 form and the following information prior to treatment:

Claim Number: _____

Adjuster's Name: _____

Adjuster's Phone Number: _____

Patient Signature: _____

Date Signed: _____