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:_____

Have **YOU** (○) or **A FAMILY MEMBER** (❐) ever been diagnosed with any of the following conditions:

○ ❐ AIDS/HIV	○ ❐ Heart Disease	○ ❐ None
○ ❐ Cancer	○ ❐ Diabetes	○ ❐ Unknown
○ ❐ High Blood Pressure	○ ❐ Stroke	○ ❐ Other _____

ACCIDENT INFORMATION:

Date of accident ____/____/____ Time of Day _____ Location of accident _____

Was the accident reported to your employer? ❐ No ❐ Yes, name of person reported accident to _____

What type of work were you doing at the time of the accident? _____

Please describe the accident in your own words: _____

_____

_____

Did you lose consciousness? ❐ No ❐ Yes, for how long? _____

What was your mental and emotional state immediately following the accident? _____

Where did you go immediately following the accident? _____

Have you been treated by another doctor since the accident? ❐ No ❐ Yes , If yes…

Please list the name of the doctor and address: _____

Please explain what type of treatment you received: _____

What type of X-rays were taken if any? _____

Was there any other imaging done? (i.e., MRI, CT, etc.) _____

Do you have any congenital (from birth) factors that may relate to this problem? ❐ No ❐ Yes, _____

Do you have any previous illnesses which relate to this case ❐ No ❐ Yes, _____

Have you ever been involved in a work comp accident before? ❐ No ❐ Yes, _____

Have you lost time from work as a result of this accident? ❐ No ❐ Yes, If yes Last day worked: ____/____/____

JOB DESCRIPTION:

In a typical 8-hour work day, I: (circle the number of hours/ activity)

Sit	1 2 3 4 5 6 7 8	hours
Stand	1 2 3 4 5 6 7 8	hours
Walk	1 2 3 4 5 6 7 8	hours

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Bend/stoop	❐	❐	❐	❐
Squat	❐	❐	❐	❐
Crawl	❐	❐	❐	❐
Climb	❐	❐	❐	❐
Reach above head	❐	❐	❐	❐
Kneel	❐	❐	❐	❐
Balancing	❐	❐	❐	❐
Pushing/pulling	❐	❐	❐	❐
Lifting	❐	❐	❐	❐
Typing	❐	❐	❐	❐

Please add any other information that you feel is pertinent: _____

_____

_____

PLEASE LIST YOUR CURRENT AREAS OF COMPLAINT:
(chief complaint)

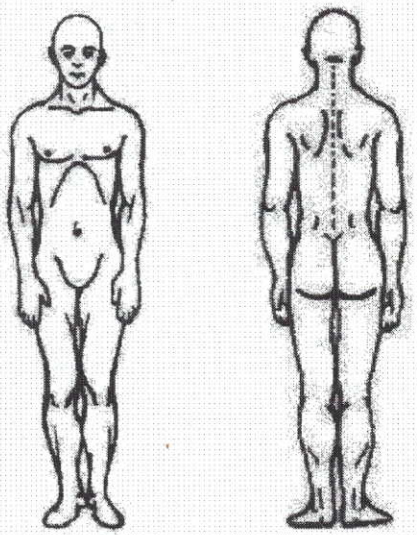
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



How often do you notice your symptoms? ❒ Constantly ❒ Frequently ❒ Occasionally

Does anything relieve your pain? _____

What activities are difficult to perform? ❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down

Please describe any other activities that are restricted due to this injury? _____

_____

Is the condition getting worse? ❒ No ❒ Yes

Have you had this problem before? ❒ No ❒ Yes, When? _____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

I am currently taking the following medications for the following reasons: ❒ None

_____

_____

List Allergies: _____

Surgical History: _____

For Women Only: Is there a possibility that you may be pregnant? ❒ No ❒ Yes

I certify that the above information is true and accurate to the best of my knowledge

DATE: ___/___/___ **SIGNATURE:** _____

PARENT/GUARDIAN: _____

WHAT HAPPENED RIGHT AFTER THE ACCIDENT?

Patient Name: _____ **Date:** _____

YES	NO	
☐	☐	Did you go to the emergency room afterward? If yes, date and time:_____ Name of the emergency room? City:
☐	☐	Did you go to emergency room in an ambulance? If yes, Name of ambulance:
☐	☐	Did you or another person drive you to emergency room? Name of other person:
☐	☐	Were you hospitalized after being seen in the Emergency Room? If yes, how many days:
☐	☐	Did the emergency room doctor take X-rays? Check what regions x-rays were taken: ☐ Skull/Face x-rays ☐ Ribs/Chest ☐ Neck or Middle back x-rays ☐ Collar bone ☐ Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand ☐ Leg or Foot ☐ Other
☐	☐	Did the hospital or clinic take MRI or CT of your body? If yes, indicate where taken: ☐ Skull, ☐ Neck, ☐ Low back or hip/pelvis, ☐ Other
☐	☐	Did you have any broken bones/fractures? If yes, where:
☐	☐	Did you have any cuts or lacerations? If yes, where:
☐	☐	Did you have any skin abrasions? If yes, where:
☐	☐	Did you require any stitching for cuts? If yes, where:
☐	☐	Did you have any visible bruises or lumps? If yes, where:
☐	☐	Did you have any visible bruises along the shoulder or lap portions of your seatbelt?
☐	☐	Did the emergency room doctor give you pain medications or any other prescriptions?
☐	☐	Were you given a neck collar or back brace to wear?
☐	☐	Did you require any surgery after the accident? If yes, describe type and date:
☐	☐	Were you hospitalized overnight? If yes, indicate dates hospitalized:

HOW SOON DID YOU FIRST NOTICE ANY PAIN-SORENESS AFTER YOUR INJURY?

☐	Immediately (less than 30 min)	☐	_____ Hours after injury	☐	_____ Days after injury

HAVE YOU BEEN UNABLE TO WORK SINCE INJURY?

☐ YES ☐ NO If yes, you were off work: ☐ Partially ☐ Completely

Please list all dates off work: From _____ to _____.

OTHER COMMENTS:

_____

_____

_____

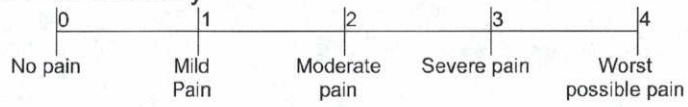
_____

Functional Rating Index

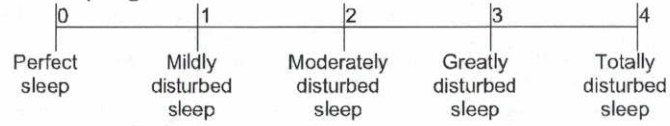
For use with **Neck and/or Back Problems** only

To properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number that most closely describes your condition right now.

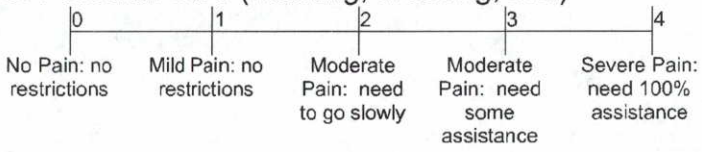
1. Pain Intensity



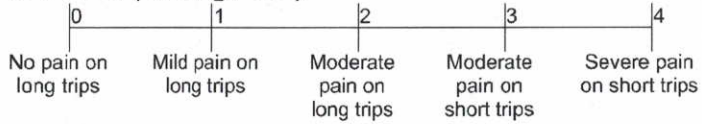
2. Sleeping



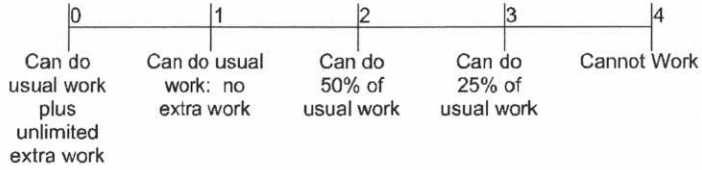
3. Personal Care (washing, dressing, etc.)



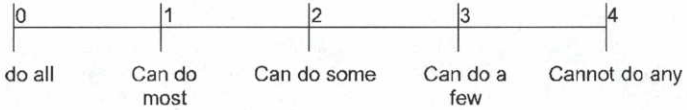
4. Travel (driving, etc.)



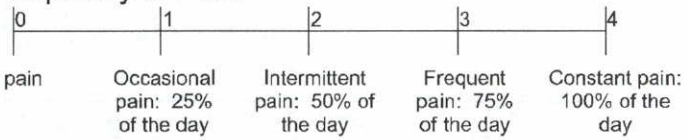
5. Work



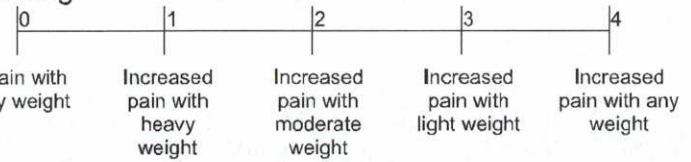
6. Recreation



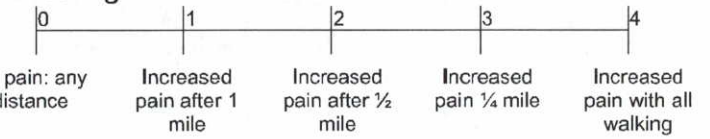
7. Frequency of Pain



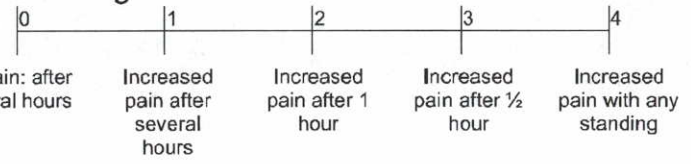
8. Lifting



9. Walking



10. Standing



Patient Signature _____ Date _____

Name: _____ **Date:** _____

NECK DISABILITY INDEX

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe neck pain.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

After Vernon & Mior, 1991 Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

Additional Comments: _____

_____

_____

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

DISABILITY INDEX SCORE: %_____

Revised 5/12/05

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I do not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain I am unable to do some washing and dressing without help.
F Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 - Walking

A I have no pain on walking.
B I have some pain on walking but it does not increase with distance.
C I cannot walk more than one mile without increasing pain.
D I cannot walk more than 1/2 mile without increasing pain.
E I cannot walk more than 1/4 mile without increasing pain.
F I cannot walk at all without increasing pain

SECTION 5 - Sitting

A I can sit in any chair as long as I like.
B I can sit only in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than 10 minutes.
F I avoid sitting because it increases pain straight away.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain, my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life, and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Travel

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling, which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

SIGNATURE: _____

Shield
Radiology Consultants Requisition

Toll Free 1-800-330-0772
Facsimile (435) 674-2588
info@shieldradiology.com

PATIENT INFORMATION & MEDICAL HISTORY

☐MVA ☐Acute Injury ☐Insidious Onset ☐Other

☐Malignancies ☐Surgeries ☐Congenital Anomalies

Patient Name (please print clearly) ☐ Female ☐ Male

Patient's Home Address

City, State, Zip Code

Social Security Number | Home Phone Number

Patient Date of Birth | Date of Injury

BILLING INFORMATION

☐Attorney ☐Insurance ☐Patient ☐Referring Physician

See Attached Paperwork ☐Past Medical History ☐Billing

Name of Attorney or Insurance Carrier

Address of Attorney or Insurance Carrier

City, State, Zip Code

Insurance Policy Number | Accident Claim Number

Name of Adjuster | Adjuster's Phone Number

INFORMED CONSENT: I understand and agree that the services of Shield Radiology Consultants "SRC", are being used to provide a secondary review and interpretation of my x-rays or other advanced imaging study for the purpose of determining the extent of any damage, diagnose and/or to determine the best course of treatment. I understand that there is a separate fee for this service and that all costs for services may be billed by SRC. In accordance with the Medicare Act, this is to advise you that this is a non-covered service.

RELEASE OF INFORMATION: I hereby authorize the SRC to obtain from, and to furnish to, my physician, attorney, and/or insurance carrier a full report of my case history, medical records, examination results, diagnosis, and prognosis as they relate to my accident, claim, treatment or illness.

DOCTORS LIEN: I hereby expressly grant to SRC a lien on any settlement, claims, judgments, verdicts or proceeds whatsoever arising from my accident or illness. I further expressly instruct, authorize and direct my attorney and insurance carrier to pay directly Shield Radiology Consultants, 168 North 100 East, Suite 102 - St. George, UT 84770 all sums due and owing SRC for the services rendered to me or on my behalf, and to withhold such sums from any settlement, claim, judgment, verdict as are necessary to pay the same. I UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE TO SRC FOR ALL CHIROPRACTIC OR RADIOLOGY BILLS SUBMITTED BY SRC FOR SERVICES RENDERED TO ME OR ON MY BEHALF, and that this agreement is made solely for SRC's protection and to insure payment. I expressly acknowledge and agree that payments for services to SRC are not contingent on any recovery, settlement, claim, judgment, or verdict being recovered by me. I understand and agree that this agreement shall be binding upon any substitute counsel retained by me and that I will promptly notify SRC of any change in counsel/attorney or changes in my home address.

SIGNATURES & COPIES: I hereby authorize SRC as my attorney-in-fact for the purposes of signing any two-party checks received by SRC any time payment is made in the form of a two-party check or when dual signatures are required for payment of services from an insurance company or third party payer. I do hereby warrant and agree that a photocopy or facsimile of this document will be as valid & binding on all parties involved as the original document.

Patient Signature or Guardian Signature Date

Referring Physician or Office

Being the Attorney of record or an authorized representative for the above named patient does hereby acknowledge this lien and does agree to honor the same to protect adequately Shield Radiology.

Attorney Signature or Authorized Representative

MaxHealth
MOTION. BALANCE. STRENGTH.

PATIENT REQUEST FOR RECORDS

PATIENT NAME _____

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

For office use only:

TO _____

ADDRESS _____

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

FAX NUMBER _____

FROM DATE OF SERVICE _____ **TO** _____

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:

MaxHealth Center
F: 702.898.3383
www.maxhealthlv.com

PATIENT SIGNATURE_____

If patient is a minor:

GUARDIAN NAME _____

GAURDIAN SIGNATURE _____

MaxHealth
MOTION. BALANCE. STRENGTH.

Kelly E. Murie, DC Lucas Odahlen, DC Jeff Prince, DC Emily Peters, DC Angelika Knopp, DC Tevin Pham, 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 2160 S. Jones Blvd, Suite 1; LV, NV 89146 5506 S. Fort Apache Rd, Suite 110; LV, NV 89148

Phone: (702) 898 3311 **Fax:** (702) 898-3383 **Web:** MaxHealthLV.com

MaxHealth
MOTION. BALANCE. STRENGTH.

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.

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.

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CLIENT ACKNOWLEDGMENT

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

PATIENT SIGNATURE_____ **DATE**_____

Phone: (702) 898-3311 **Fax:** (702) 898-3383 **Web:** MaxHealthLV.com

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Kelly E. Murie, DC Lucas Odahlen, DC Jeff Prince, DC Emily Peters, DC Angelika Knopp, DC Tevin Pham, DC

WORKER'S COMPENSATION NOTICE

Please fill out all fields even if they are not applicable to you

Patient Name: _____

DOB: _____

Do you currently have an open worker's compensation case?

Please write in 'Yes' or 'No'

_____

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: _____

8475 S. Eastern Ave, Suite 101; LV, NV 89123 2610 S. Jones Blvd Suite 1; LV, NV 89146 5506 S. Fort Apache Rd, Suite 110; LV, NV 89148

Phone: (702) 898-3311 **Fax:** (702) 898-3383 **Web:** MaxHealthLV.com

DOCTOR-PATIENT IRREVOCABLE ASSIGNMENT
AGREEMENT, LIEN AND POWER OF ATTORNEY

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PATIENT NAME (PRINT) _____

DATE OF INJURY_____ **OFFICE OF RECORD: MAXHEALTH CENTER**

1. I was injured on or around the date noted above. The above named office of record has agreed to provide me with treatment for the injuries I have received. The health care services provided by the doctor shall include examination, x-rays, spinal manipulation, physical therapy, rehabilitative exercises, supportive devices, written and verbal reports and other medical services as considered necessary by the doctor for my case.

2. The office has agreed to wait for payment for these health care services and take payment from any insurance coverage that may be available and/or from any money (also known as the settlement, proceeds, dispositions, judgments, awards or verdicts) that I receive from my legal case (also known as a lawsuit, cause of action or legal grounds).

3. This is an irrevocable (cannot be changed or cancelled) lien against my legal case which will act as a security for my health care service debt owed to the office of record. It cannot be set aside or ignored by any other party presented with a copy of it.

4. I understand and agree I am receiving this credit from the office only because of this lien and that the office would be unable to provide this credit without it. Therefore, I agree to fully cooperate with the office and provide whatever information the office requires including information concerning any insurance policies which may cover my health care services and information regarding my legal case.

5. I order my attorney to immediately pay the full amount owed to the office for all my health care services furnished by the doctor or his/her office or under his/her prescription from any money my attorney obtains for me as a result of my legal case.

6. I order any insurance company, third party payer or other party paying for my health care costs to pay the office directly in full for the payments of any debts owed to the office for medical services. If payment cannot be made directly to the office, all such payers shall include the office's name on any check made for such payment to myself, my attorney or any other party receiving funds as payment for damages pertaining to the injury of the patient on or about the date listed above.

7. Even though I have given this irrevocable lien to the office of record, I am still responsible for the full payment of all my debt to the office, whether or not I receive money for my legal case. The office may demand and receive full payment from me at any time at the doctor's discretion.

8. I authorize the doctor to furnish my attorney upon request a full report of my health care services including examination, diagnosis, treatment and prognosis.

9. I direct my attorney to provide the doctor with any documents he/she requests related to my case, including information on all parties connected with my case, financial and settlement records concerning proposed or actual disbursement of settlement receipts.

10. I give the office of record the power to receive, deposit and cash any checks on my behalf whether they are made out to myself, the doctor and I jointly or office in order to pay in full any amount I owe the office (this is a limited power of attorney).

11. Should I personally receive money intended to pay for medical treatment or services from an insurance company, attorney or case settlement I promise to turn these funds over to the office immediately and directly as required by law and our agreement to observe MaxHealth Center's Lien.

12. If I change my attorney at any time prior to payment in full of my debt to the office, I will notify the new attorney of this lien and require he/she to honor it fully. Further, I will notify the office of my change in attorneys. If I dismiss my attorney without replacement, I will notify the office of the change and personally and immediately pay for all services and debt owed to the office.

13. I direct my attorney or any other party receiving a notice of this lien to acknowledge within 5 business days the receipt of that notice and this Lien.

14. I understand that the office may be partially paid for fees submitted to any insurance company. The balance of any unpaid fees will be covered by this Lien and payment will be expected in accordance with paragraphs 5 & 7.

15. If I do not keep any of these agreements I agree to pay the office all of the following fees: any legal fees, court or collection agency costs required to enforce this agreement, the health care service fees owed to the office plus the highest interest rate permitted by law on the entire debt, calculated from the date the health care services were first rendered.

16. I authorize and direct the office of record to do anything and everything necessary to carry out the terms of this agreement.

17. A photocopy or fax transmission of this Lien Agreement will be as valid as the original.

18. By signing below, I agree to every part of this Lien and Agreement and will personally ensure the entire amount of all health care services provided to me by the office of record and any debt owed to the office will be paid by me in full.

_____ _____

Patient Date

_____ _____

Office Representative Date

I acknowledge receipt of this lien.

_____ _____

Attorney or Record / Representative Date

MaxHealth
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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