ChiropracTED, LLC
871 Coronado Center Drive
Henderson, NV 89052

Welcome To Our Office

New Patient Registration

Date: ______ Dr. ______ Case Number: ______

Full Name: ______ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other

Address: ______ Injury/Illness Date: ______

City: ______ State: ______ Zip: ______ Date of Birth: ______

Employer: ______ Occupation: ______ Age: ______

Employer Address: ______ Home Phone: ______

City: ______ State: ______ Zip: ______ Work Phone: ______

Who referred you to our office: ______ Mobile Phone: ______

May we contact you by e-mail: ______ Social Security # ______

Student: ☐ Full Time ☐ Part Time School: ______ Driver's License # ______

Spouse

Name: ______ Employer: ______ Date Of Birth: ______

Employer Address: ______ Employer Phone: ______

City: ______ State: ______ Zip: ______ Social Security # ______

Insurance

☐ Auto Accident ☐ Work Injury ☐ Group ☐ Medicare ☐ Other: ______

Primary Insurance: ______ Insurance Phone: ______

Insured's Name: ______ ☐ Male ☐ Female Insured's Phone: ______

Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's DOB: ______

Insurance Address: ______ Insured's ID # ______

City: ______ State: ______ Zip: ______ Policy / Group# ______

Secondary Insurance: ______ Insurance Phone: ______

Insured's Name: ______ ☐ Male ☐ Female Insured's Phone: ______

Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's DOB: ______

Insurance Address: ______ Insured's ID # ______

City: State: Zip: Policy / Group#

Patient Agreement

Assignment & Release To Doctor: Teddy Sim, Dc

1. You are authorized to **release any information** you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I hereby authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of any proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

3. I hereby authorize the **use of this signature** on all my insurance submissions.

Signature Of Insured: ______ Date Signed: ______

AUTHORIZATION, ASSIGNMENT & ACKNOWLEDGEMENT

AUTHORIZATION AND ASSIGNMENT

TO: ____

Print Patient's Full Name

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to **release any information** you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statue of limitations on collection and/or recovery in this state of Nevada.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed Teddy Sim, DC are paid in full.

__________________ Date

____ Signature

ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or about to receive) healthcare services at, ChiropracTED, LLC and that I have been advised that the doctor(s) providing the services is/are willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to ChiropracTED, LLC or make other provisions for the protection of the interest of; "Click, type name" or
2. If a liability claim exists, and my attorney refuses to agree to protect the interest of, ChiropracTED, LLC or if I have not engaged the services of an attorney;

then payment for services rendered by ChiroracTED, LLC at ChiropracTED, LLC will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

Dated the ________ day of ________________ 20 ___

____ Witness

____ Patients Signature

PERTINENT DATA

Patient's insurance company ______________________________ policy / claim no. ____________________________

Third party's insurance company ______________________________ policy / claim no. ____________________________

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PAIN ASSESSMENT RECORD

In order for us to best serve you, and so that we may determine the progress of your present condition, please provide us with the following information. **PLEASE PRINT**

Name: ____________________ File No: __________ Date: __________

Current Pain Record

1. List present complaints: ____

   ____

2. Is your condition: ☐ Improved ☐ Staying the same ☐ Getting worse

3. How does your pain interfere with your work: ______________________

   home activity: ______________________ school activity: ______________________

4. Type Of Pain:

   ☐ A: Sharp ☐ B: Tingling ☐ C: Throbbing ☐ D: Numbness ☐ E: Aching ☐ F: Shooting

   ☐ G: Dull ☐ H: Burning ☐ I: Cramping ☐ J: Stiffness ☐ K: Swelling ☐ L: __________

5. Please mark your area(s) of pain with the letter (A, B, C etc.) associated with the Type Of Pain you checked above. Indicate the degree of pain by using a scale from 1 (discomfort) to 10 (extreme pain) as seen in the example below:

Example	Show Us Where It Hurts
GGGG 4 FFFF 6	

Doctor/Patient Comments:

Patient's Signature: ______________________________ Date: ____________________

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AUTHORIZATION FOR CHIROPRACTIC CARE

ChiropracTED, LLC
871 Coronado Center Drive, Suite 200
Henderson, NV 89052

702-277-1371

Please discuss any questions or concerns with Teddy Sim, DC before signing this authorization.

I hereby authorize:

Teddy Sim, DC, and whomever he may designate, to administer chiropractic care as is necessary, and to perform therapy and adjustments that are considered therapeutically necessary on the basis of findings during the course of treatment.

I understand that I will be receiving the following treatment as prescribed by Teddy Sim, DC:

____

____

____

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Care, the reasons why the above named treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained by Teddy Sim, DC.

I also certify that no guarantee or assurance has been made by Teddy Sim, DC or his staff as to the results that I may obtain from the prescribed chiropractic care.

Date Signed:	________________	Doctor's Signature:	________________
Patients Name:	________________	Patient's Signature:	________________
Guardian Signature:	________________	Witnessed:	________________

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SYSTEM REVIEW

Please check all conditions you currently have or have had

General Questions
- ☐ Weight loss
- ☐ Weight gain
- ☐ Change in sleep patterns
- ☐ Change in activity capacity

Neurologic and Psychiatric
- ☐ Anxiety
- ☐ Headaches
- ☐ Depression
- ☐ Meningitis
- ☐ Paralysis
- ☐ Seizure
- ☐ Stroke
- ☐ Tingling
- ☐ Tremors
- ☐ Memory Loss
- ☐ Fainting spells, dizziness
- ☐ Head injuries
- ☐ Blackouts or near blackouts
- ☐ Change in sensation anywhere on your body
- ☐ Localized weakness or numbness

Ears, Eyes, Nose & Throat
- ☐ Hay fever
- ☐ Glaucoma
- ☐ Polyps
- ☐ Allergy
- ☐ Cataracts
- ☐ Goiter
- ☐ Hoarseness
- ☐ Double vision
- ☐ Gum problems
- ☐ Eye problems
- ☐ Ear Infections
- ☐ Glasses/contacts
- ☐ Hearing Loss
- ☐ Ear discharge/pain
- ☐ Frequent nosebleeds
- ☐ Ringing in your ears
- ☐ Sinus infections
- ☐ Swollen glands

Cardiovascular
- ☐ Angina
- ☐ Chest Pain
- ☐ Leg cramps
- ☐ Murmurs
- ☐ Ankle swelling
- ☐ Awakening short of breath
- ☐ Cardiac catheterization
- ☐ Cold hands or feet
- ☐ Congenital heart defects
- ☐ Dizziness when standing quickly
- ☐ Heart attacks
- ☐ Heart failure
- ☐ High or low blood pressure
- ☐ Irregular heart rate
- ☐ Purple fingers or lips
- ☐ Leg pain that resolves with rest
- ☐ Heart palpitations
- ☐ Varicose veins

Respiratory
- ☐ Pleurisy
- ☐ Wheezing
- ☐ Asthma
- ☐ Breathlessness when lying flat
- ☐ Prolonged cough
- ☐ Coughing up blood
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Frequent infections (bronchitis)

Skin
- ☐ Abscess
- ☐ Dandruff
- ☐ Acne
- ☐ Oily skin
- ☐ Boils
- ☐ Rashes
- ☐ Hives
- ☐ Dry skin
- ☐ Lumps
- ☐ Jaundice
- ☐ Psoriasis
- ☐ Athlete's foot
- ☐ Excessive body odor
- ☐ Excessive sweating
- ☐ Fungal infections
- ☐ Nail problems
- ☐ Moles- irregular
- ☐ Moles - change/new

Kidneys & Urinary Tract
- ☐ Blood in urine
- ☐ Brown urine
- ☐ Dribbling after urination
- ☐ Painful urination
- ☐ Excessive thirst
- ☐ Involuntary urination/incontinence
- ☐ Urinating frequently (day)
- ☐ Urinating frequently (night)
- ☐ Urine hesitancy
- ☐ Weak flow
- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Kidney stone

Endocrine
- ☐ Diabetes
- ☐ Sickle cell
- ☐ Abnormal body hair
- ☐ Changes in skin texture
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ History of "borderline" diabetes
- ☐ Increased loss of hair
- ☐ Rheumatism
- ☐ Thyroid disease

Male & Female
- ☐ Painful sexual intercourse
- ☐ Loss of sexual interest
- ☐ Unprotected sex
- ☐ Groin itching
- ☐ Sexually transmitted diseases

☐ Males Only
- ☐ Hernia
- ☐ Bloody ejaculation
- ☐ Inability to complete intercourse
- ☐ Lump on testicle
- ☐ Penile discharge
- ☐ Sterility
- ☐ Sores on penis or warts
- ☐ Prostate disease
- ☐ Testicular pain
- ☐ Testicular swelling

Musculoskeletal
- ☐ Anemia
- ☐ Arthritis
- ☐ Back pain
- ☐ Bursitis
- ☐ Gout
- ☐ Joint aches
- ☐ Neck pain
- ☐ Tendonitis
- ☐ Abnormal Blood Counts
- ☐ Blood clots in legs/lungs
- ☐ Bone Marrow Biopsy
- ☐ Easy Bleeding
- ☐ Easy bruising
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle aches

Gastrointestinal
- ☐ Diarrhea
- ☐ Gallstones
- ☐ Reflux
- ☐ Vomiting
- ☐ Ulcers
- ☐ Heartburn
- ☐ Hepatitis
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Anal fissures
- ☐ Black tarry stools
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Nausea
- ☐ Problems swallowing
- ☐ Hiatal Hernia
- ☐ Intestinal obstruction
- ☐ Liver disease
- ☐ Hemorrhoids
- ☐ Red blood after bowel movement

☐ Females Only
- ☐ D + C
- ☐ Hot flashes
- ☐ Hernia
- ☐ Fibroids
- ☐ Endometriosis
- ☐ PMS
- ☐ Abn. bleeding between cycles
- ☐ Abnormal pap smear
- ☐ Bleeding after intercourse
- ☐ Complications with pregnancy
- ☐ Heavy bleeding during cycles
- ☐ Ovarian cysts
- ☐ Pelvic Inflammatory Disease
- ☐ Postmenopausal symptoms

Provider Notes:

Patient Name ______ Age ______ ID# ______

Patient Signature ______ Date ______ Provider Signature ______ Date ______

ChiropracTED, LLC
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702-277-1371

Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by ChiropracTED, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

______________________________________ ____________
Patient or Legally Authorized Individual Signature | Date

______________________________________ ____________
Print Patient's Full Name | Time

______________________________________ ____________
Witness Signature | Date

ChiropracTED, LLC
871 Coronado Center Drive, Suite 200
Henderson, NV 89052

CASE HISTORY

Name: ______________________________ ☐ Male ☐ Female Age: ____ Date: __________

Have you ever received Chiropractic Care: ☐ Yes ☐ No If yes, when? ______________________________

1. CHIEF COMPLAINT: ______________________________

____

Complaint began when: __________________ Duration of complaint: ______________________________

Have you had this before: ______________________________

Did you hurt yourself: ______________________________

Is condition getting worse: ___________ Condition interferes with: ______________________________

How frequent is it and how long does it last: ______________________________

Circle the Quality of the pain: dull aching sharp shooting burning throbbing deep nagging other: ______________

Does any pain radiate or travel to any areas of your body: ______________________________

Do you have any numbness or tingling in your body: ______________________________

Grade pain Intensity/Severity: (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst possible pain)

Does anything aggravate the complaint: ______________________________

Does anything make the complaint better: ______________________________

Previous doctors, treatments, medications, or surgery you've sought for your complaint: ____________________

____

2. SECONDARY COMPLAINTS: ______________________________

____

3. PAST HEALTH HISTORY:

A. Previous illnesses you've had in your life: ______________________________

____

B. Previous injury or trauma: ______________________________

____

C. Allergies: ______________________________

D. Medications:

Medication you are now taking	Reason for taking
______________________________	____________________
______________________________	____________________
______________________________	____________________

E. Surgeries:

Date	Type of Surgery
______________	______________
______________	______________
______________	______________

F. Females:

Pregnancies/Date of Delivery	Outcome
______________	______________
______________	______________
______________	______________

What was the date of the beginning of your last menstrual period: ______________

5. FAMILY HEALTH HISTORY:

1. Associated health problems of relatives: ______________

____

2. Deaths in immediate family:

Cause of parents or siblings death	Age at death
______________	______________
______________	______________
______________	______________

6. SOCIAL AND OCCUPATIONAL HISTORY:

A. Level of Education: ☐ high school ☐ some college ☐ college graduate ☐ post graduate studies

B. Job description: ______________

C. Work schedule: ______________

D. Recreational activities: ______________

E. Level of activity: ☐ sedentary ☐ moderate ☐ active ☐ very active

E. Lifestyle (hobbies, alcohol, tobacco and drug use, diet): ______________

____

Doctors Notes:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Teddy Sim, DC to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature: ______________ Date: ______________

Doctors Signature: ______________ Date: ______________

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702-277-1371

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.

If you have any questions about this Notice please contact ChiropracTED, LCC

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www."Click & Type" , calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent
Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

  In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your

doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office. With your written, signed authorization, we may "Click & Type" . *(fill in blank- send birthday cards, newsletters etc.)*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (l) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Workers' Compensation:** We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of

© HIPAA Privacy

contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

  You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on September 2nd, 2004.

ChiropracTED, LLC
871 Coronado Center Drive, Suite 200
Henderson, NV 89052

702-277-1371

Informed Consent To Chiropractic Treatment

A doctor of chiropractic locates, analyzes and treats vertebral subluxation. The primary chiropractic treatment method is the spinal adjustment. I will use spinal adjustments to treat you.

Chiropractic Treatment:

I will locate vertebral subluxation, position my hands at these locations and administer a force to correct the subluxation. This procedure may result in an audible sound and you may feel movement.

Risk Associated With Chiropractic Treatment:

Complications may occur during the deliverance of a spinal adjustment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness.

Risk Probabilities:

The above referenced complications are rare. One authoritative source opined that there was a one in one million chance of stroke as the result of a cervical adjustment. (Haldeman, Scott, MD, DC).

Alternative Treatment Options:

1. Self treatment to include over the counter medication.
2. Medical treatment to include the use of prescription drugs and physical therapy.
3. Surgery.
4. Hospitalization.

Risks Of Alternative Treatment:

1. Overuse and improper dosage of over the counter medications may produce undesirable side effects.
2. Overuse and improper dosage of prescribed medications can lead to undesirable side effects and drug dependence.
3. Risks associated with surgery include adverse reactions to anesthesia; surgical errors and protracted periods of convalescence.
4. Risks associated with hospitalization include expense, exposure to disease, and physician and staff errors and omissions.

Risk Of Not Receiving Chiropractic Treatment:

Risks associated with not receiving chiropractic treatment may include chronic symptomatology, reduced ranges of motion, the onset of arthritis and reduced activities of daily living.

Consent To Receiving Chiropractic Treatment:

I hereby attest that Teddy Sim, DC has explained the type of chiropractic treatment to be utilized, the nature and risks of spinal adjustments, the risk probabilities, alternative treatment options and their associated risks and the risks of not receiving chiropractic treatment as described on page one of this document. I understand the risks involved in undergoing treatment and have of my own volition decided to undergo the treatment provided by Teddy Sim, DC.

I hereby give my consent to chiropractic treatment by Teddy Sim, DC.

Patient Name: ______________________ Witness Name: ______________________
Signature: ______________________ Date: ____________ Witness Signature: ______________________