West Valley REHABILITATION CTR.

Patient Information

Date:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Sex:_____ Age:_____ Birthdate:_____

Marital Status: □Single □Married □Widowed □Divorced

Social Security Number:_____

Occupation:_____

Employer:_____

Employer Address:_____

Employer Phone:_____

Spouse's Name: _____

Spouse's Birthdate: _____

Spouse's Occupation:_____

Spouse's Employer:_____

If applicable: Have you ever been to a chiropractor before:

Y/N Name of chiropractor:_____

Date last seen: _____

Insurance Information

Name of Insured:_____

Relationship to Patient:_____

Insurance Co.:_____

Group #_____

ID# _____

Is Patient Covered by Additional Insurance? □Yes □No

Subscribers Name:_____

SS#_____ Birthdate:_____

Relationship to Patient_____

Insurance Co. _____

ID #_____

Assignment, Release and Certification Signature

I, the undersigned certify that I or my dependent have insurance coverage with the above insurance company and assign directly to West Valley Rehabilitation Ctr or Dr. Kaldy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize West Valley Rehabilitation Ctr. or Dr. Kaldy and staff to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance forms.

_____

Responsible Party Signature (If necessary):

_____ _____

Relationship Date

Contact Information

Home_____ Mobile_____

Work_____ Ext._____

Best Time To Reach You:_____

Email Address:_____

In Case Of An Emergency Contact:

Name:_____

Relationship:_____

Home Telephone:_____

Work Telephone:_____Extension:_____

Injury Information

Is condition due to an accident? □Yes □No

Type of accident: □Auto □Work □Home □Other

Who have you made a report of your accident?

□Auto Insurance □Employer □Worker Comp. □Other

Attorney Name (if Applicable):_____

_____

Chief Complaint

Reason for Visit:_____

What date did your complaint first start? _____

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

Frequency of your complaint: □Constant □Off and On

Nature of complaint: □Sharp □Dull □Throbbing □Numbness

□Tingling □Aching □Shooting □Burning

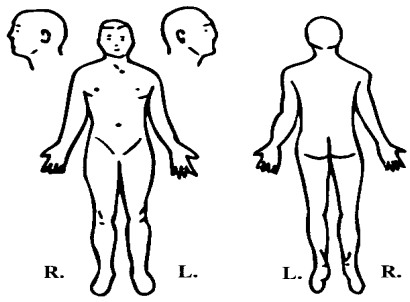
Does your complaint interfere with: □Work □Play □Daily Routine □Sleep

Activities or movements difficult to perform: □Sitting □Standing □Walking

□Bending □Lying Down

Additional Comments:_____

Mark an (X) below where you are having pain, numbness, or tingling



Patient Name:_____ Date:_____

Health History

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

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

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

Family Doctors Name:_____

List all drug allergies that you have:_____

List all surgeries you have had:_____

List any fractures you have had:_____

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

_____

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

_____

_____

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

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

Do you exercise regularly? □Yes □No

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

For women only

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

Signatures

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

Signature:_____ Date_____

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date:_____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is worse than imaginable at the moment.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

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

SECTION 3 - LIFTING

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

SECTION 4 - READING

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

SECTION 5 - HEADACHES

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

SECTION 6 - CONCENTRATION

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

SECTION 7 - WORK

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

SECTION 8 - DRIVING

- ❑ I can drive without any neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive at all.

SECTION 9 - SLEEPING

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

SECTION 10 - RECREATION

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

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I----------I Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ I do not have to change my way of washing or dressing to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

SECTION 6 - STANDING

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

SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I Extreme

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas, NV 89117
www.LasVegasChiro.com

Release of Records Request

Date: _____

To: _____
Doctor or Hospital Name

_____
Address City State Zip Code

_____ _____
Phone # Fax #

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

West Valley Rehabilitation Center
7670 W. Sahara Ave., Ste. 2
Las Vegas, NV 89117
(702) 212-3333
Fax: (702) 212-3300

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

Patient's Name Printed: _____

Patient's Signature: _____

_____ _____
Social Security # Date of Birth

Parent/Guardian Name Printed: _____

Parent/Guardian Signature: _____

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas,NV 89117
www.LasVegasChiro.com

PATIENT FINANCIAL AGREEMENT

The following agreement applies only to the services actually rendered by WEST VALLEY REHABILITATION CTR. and in no way obligates a patient to continue the course of treatment recommended.

In the event any unpaid balance is placed for collections, with a 3rd party collections agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly by these individuals to collect amounts owed under this agreement such as court cost, sheriff/constable fees, and interest and late fees.

I,_____, understand that I am fully, financially responsible for all services rendered to me by WEST VALLEY REHABILITATION CTR. I elect to use the following payment plan to finance my care and course of treatment at WEST VALLEY REHABILITATION CTR.

____ CASH – Payment is due at time of service.

____ INSURANCE – WEST VALLEY REHABILITATION CTR. will, as a courtesy to me, determine benefits available and submit my insurance claim on a case by case basis. However, I understand that I am responsible for my charges incurred and agree to participate in the collection process of my insurance benefit. I also agree to assign benefits to WEST VALLEY REHABILITATION CTR, for services rendered to me.

____ PERSONAL INJURY – I will be utilizing my Medical payment portion of my auto insurance or have hired an attorney to assist me in settlement of my case. I agree to provide the necessary documents and information required tO WEST VALLEY REHABILITATION CTR, necessary for the collection of services rendered.

____ WORKER'S COMPENSATION – I have been injured while working and have completed the documents necessary to open a worker's compensation claim with my employer. I agree to furnish WEST VALLEY REHABILITATION CTR, with the information needed to establish the work relatedness of my injury.

Keeping your appointments is very important to the your treatment progress. We hold an appointment time for you each day, therefore, should you find it necessary to reschedule, cancel or are unable to keep a scheduled appointment, please notify our office 24 hours in advance. Failure to do so may result in a $100.00 charge that is NOT covered by your insurance plan.

There are NO refunds for monies collected for services rendered, except if West Valley Rehabilitation Ctr. errors in the collected amount. Should in the event your account shows a credit, it will be applied to future treatment, services or supplies only.

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

PATIENT SIGNATURE: _____ **DATE:** _____

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas, NV 89117
www.LasVegasChiro.com

Date Faxed: _____

NOTICE OF LIEN

I do hereby authorize **Dr. Kevin L. Kaldy of WEST VALLEY REHABILITATION CTR.,** to furnish you, my attorney/Insurance Carrier, with a full report of the case history, examination, diagnosis, treatment, prognosis of myself in regard to my accident/illness in which I was recently involved.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to **pay directly** to said doctor such sums for chiropractic and physiotherapeutic services rendered me by reason of this accident/illness from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately. I also, hereby, further give lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic and physiotherapeutic bills submitted by him/her for services rendered me, even in the event I dismiss my attorney or my attorney dismisses me, and I settle directly with the insurance company, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated:_____ Patient Signature:_____

The undersigned, being attorney of record or authorized representative of Insurance Carrier for the above patient, does hereby acknowledge receipt of the above lien, and does agree to honor the agreement to protect adequately said doctor above named to the extent of any settlement, claim, judgment, or verdict. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated_____ Attorney/Authorized Signature: _____

NOTICE: Please date, sign, and return one copy to doctor's office at once by faxing to:

(702) 212-3300

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas, NV 89117
www.LasVegasChiro.com

Our office is treating _____for an accident that occurred on _____.

This treatment is being performed pursuant to a lien signed by the patient. A signed copy of the lien is attached to this letter. Pursuant to the lien, the patient has assigned his/her rights regarding payment of his/her medical bills to our office. Given this assignment, we ask that our office be included on any settlement checks or that your company issue our office a separate check for the medical bills when this case is settled.

If settlement is made without honoring the signed lien, then pursuant to **Achrem v. Expressway Plaza Limited Partnership**, 112 Nev. 737 (Nev. 1996), we will enforce our rights to receive payment for our assignment of the settlement proceeds.

Thank you for your cooperation.

_____

Dr. Kevin L. Kaldy
Chiropractic Physician
Board Certified Chiropractic Examiner
NV. Lic# B-929

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas,NV 89117
www.LasVegasChiro.com

RESCISSION OF ATTORNEY ASSIGNMENT OF BENEFITS

PATIENT :_____
INSURED :_____
DATE OF INJURY :_____
CLAIM #/ POLICY # :_____
SOCIAL SECURITY # :_____

I, being the insured on this policy, specifically direct you, my insurance company to rescind and cancel any assignment given to you by any third party including my attorney, EXCEPT to my physician.

Name: _____

Address: _____
_____
_____

As the owner and beneficiary of this policy, I further direct that reimbursement for ALL services be paid DIRECTLY to my physician, the provider of services under the terms of my contract with this company. NO other third party, including my attorney, should receive payment of my medical bills, except the treating physician for the remainder of this claim.

Thank you for your cooperation in this matter.

_____ _____
Patient Insured Signature **Date**

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas,NV 89117
www.LasVegasChiro.com

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

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

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

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

TREATMENT RESULTS

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

ALTERNATIVE TREATMENTS AVAILABLE

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

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

I have read or have had read to me the above explanation or chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

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

_____ Signature of patient / patient representative if unable to sign

_____ Date

West Valley REHABILITATION CTR.

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas, NV 89117
www.LasVegasChiro.com

Provider Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the equality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.
We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.
We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notices in the waiting area. You can also request a copy of our notices at any time. For more information about our privacy practices, contact the person below.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees ($0.60 per page). You may also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

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

Our Legal Duty

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

If you have any questions or complaints, please contact:

Office Manager: Dr. Kevin Kaldy
Address: 7670 W. Sahara Ave. Suite 2 Las Vegas, NV 89117
Phone: 702-212-3333

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

West Valley REHABILITATION CTR.

Dr. Kevin L. Kaldy
Chiropractic Physician | Palmer West Graduate
Board Certified Independent Chiropractic Examiner
DrKaldy@LasVegasChiro.Com
702.212.3333 • Fax 702.212.3300
7670 W. Sahara Ave. Ste. #2 Las Vegas, NV 89117
www.LasVegasChiro.com

Acknowledgment Of Receipt Of Notice Of Privacy Practices

I acknowledge that I have received and understand West Valley Chiropractic Ctr. Notices of Privacy Practices.

Signatures:_____

Printed Name:_____

Date:_____