5445 W Sahara Ave.
Las Vegas, Nevada 89146
P: 702-368-0508
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THE PAIN CLINIC
-Chiropractic-Acupuncture-Massage Therapy-

Roper Dollarhide, D.C.
Fawod Majidi D.C.
Lisa Berger, D.C.
Mathias Backus, D.C.
Khai Nguyen, O.M.D.

CONFIDENTIAL PATIENT CASE HISTORY

WELCOME TO OUR OFFICE!

Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

PERSONAL INFORMATION

Last Name/ Apellido: _____ Middle Name/ Segundo Nombre: _____

First Name/ Primer Nombre: _____ Date of Birth/ Fecha de Nacimiento:_____/_____/_____

Age/ Edad: _____ Sex: Male Female Marital Status/ Estado Civil: S / M / D / W

Address/ Direccion: _____

City/ Ciudad: _____ State/ Estado: _____ Zip/ Codigo Postal: _____

Social Security/ Seguro Social: _____-_____-_____ Home Phone/ Teléfono (Casa): (_____) _____-_____

Cell Phone/ Teléfono (Celular): (_____)_____-_____ Carrier/ Campañia de Cel: _____

E-mail/ Correo Electronico: _____

May we send you appointment reminders via cell phone or email? Yes _____ No _____ Please Initial: _____

***¿Podemos nosotros enviarle recordatorios de citas via cellular o correo electrónico*? Si _____ No _____ Please Initial: _____**

Occupation/ Ocupaciòn: _____ Employer/ Empleador: _____

Employer Address/ Direccion del Empleador:_____ Work / Trabajo:(_____)_____-_____

Emergency Contact/ Contacto de Emergencia: _____ Phone/ Teléfono /:(_____) _____-_____

How did you hear about us? ¿Comò se entero de nosotros? _____

What are you being seen for today in this office? ¿Razon de su visita?

Chiropractic/ Quiropractico _____ Acupuncture/ Acupultura _____ Massage Therapy/ Terapia de Masaje _____

INSURANCE INFORMATION

How do you plan to pay for your visits?

____Cash ____Health Insurance ____Auto Insurance ____Attorney Lien

PLEASE INDICATE BY CHECKING YES OR NO IF YOU HAVE HEALTH BENEFITS AVAILABLE THROUGH H.E.R.E.I.U./ CULINARY HEALTH FUND WHICH INCLUDES LOCAL 226-CULINARY, LOCAL 369-MUSICIANS, LOCAL 165-BARTENDERS, LOCAL 720-STAGE HANDS: _____ YES _____ NO

Subscriber's Name/ Nombre del Asegurado: _____ Relationship/ Relaciòn: _____

Insurance Company/ Compañia de Seguro: _____

Patient ID/ N◦ ID: _____ Group #/ N◦ Groupo : _____

Is the patient covered by additional or secondary insurance? ____Yes ____No

If yes, what is the name of your secondary insurance company? _____

CURRENT PRIMARY HEALTH CONCERN

HEALTH COMPLAINTS/ COMPLAINTS DE SALUD

Please check the specific complaints you are experiencing at this time and CIRCLE the location on the diagram. Then rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.

__ Headache Pain/ Dolor de Cabeza

__ Neck Pain/ Dolor de Cuello

__ Upper-Mid Back Pain/ Dolor de espalda superior/ Media

__ Low Back Pain/ Dolor de espalda baja

__ Leg Pain/ Dolor de pierna

__ Arm Pain/ Dolor de braso

__ Other/ Otro: _____

Rate Your Pain Intensity:

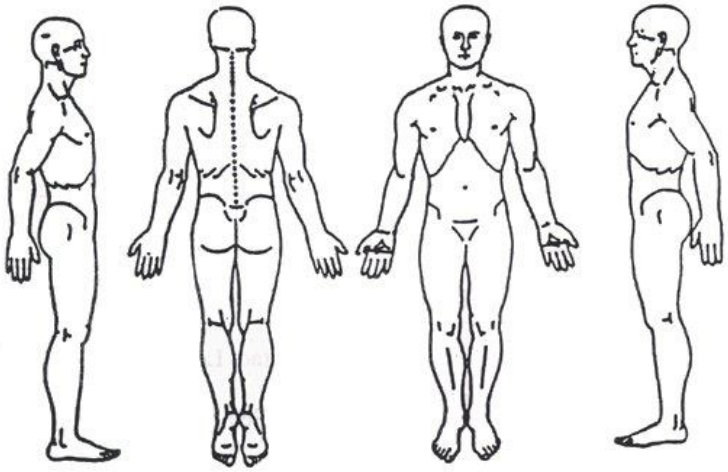
Current Pain: 0 1 2 3 4 5 6 7 8 9 10

At Its Worst: 0 1 2 3 4 5 6 7 8 9 10

At Its Best: 0 1 2 3 4 5 6 7 8 9 10

Use the Key below to describe your type of pain & location:

A= ACHING/ DOLOR
B= BURNING/ ARDIENTE
D= DULL/ DOLOR LEVE
N= NUMBNESS/ ENTUMIDO
P= PINS AND NEEDLES/ ALFILERES Y AGUJAS
S= SHARP OR STABBING/ DOLOR AGUDO
T= THROBBING/ PUNSANDO
X= SHOOTING/ DOLOR RADIANTE
Z= SPASMS/ ESPASMOS
O= OTHER/ OTRO : _____



What is your main symptom? ¿Cual es su principal sintoma? _____

How long have you had this condition? ¿Cuanto tiempo ha tenido esta condiciòn? _____

What do you think caused this condition? ¿Que piencas que causo el pròblema? _____

Over time, is this condition: (Circle One)/ Con el tiempo, esta condiciòn (Circule Uno):

Improving/ Mejorando Unchanged/ Sin Cambios Getting Worse/ Cada vez peor

Is this condition interfering with your/ Esta condiciòn interfiere con su: (Check all that apply)

____Work/ Trabajo ____Sleep/ Durmiendo ____Exercise/ Ejercicio ____Daily Routine/ Rutina Diaria

MEDICAL HISTORY

Have you had in the past or currently have any of the following: (Check all that apply)

___ Arthritic Conditions ___ Cancer ___ Diabetes

___ Heart Problems ___ High Blood Pressure ___ Vascular Condition

___ Lung Problems ___ Usual Childhood Diseases ___ Unusual Childhood Diseases

___ Low Back Pain ___ Upper/ Mid Back Pain ___ Neck/ Shoulder Pain

___ Allergies: Explain? _____

___ Surgeries: Explain? _____

Acupuncture- Patient History Form

Please indicate the following symptoms which you have experienced in the past or present.

Digestive Disorder

( ) Indigestion
( ) Diarrhea
( ) Constipation
( ) Heartburn
( ) Diabetes
( ) Ulcer
( ) Hemorrhoid
( ) Hepatitis
( ) Stomach
( ) Intestinal
( ) Gallstone

Cardiovascular Disorder

( ) Stroke
( ) H. Cholesterol
( ) Angina Pectoris
( ) Heart Trouble
( ) Hypercipidemia
( ) Genital Herpes
( ) Venereal Disease
( ) HPV
( ) Impotency
( ) Pain During Intercourse
( ) Pain After Intercourse

Skin Disorder

( ) Acne
( ) Rash
( ) Itching
( ) Warts
( ) Psoriasis
( ) Shingles

Respiratory Disorder

( ) Chest Pain
( ) Asthma
( ) Bronchitis
( ) Pneumonia
( ) Tuberculosis
( ) Emphysema
( ) Cold/ Influenza
( ) Shortness of Breath
( ) Cough
( ) Sore Throat
( ) Sinusitis
( ) Allergies
( ) Drug Allergies
( ) Eye Disease
( ) Hearing Loss
( ) Ringing Ears

Gynecology

( ) Benign Breast
( ) Pelvic Inflammation
( ) Vulvovaginitis
( ) Discharge/ Itching
( ) Ovaritis
( ) Infertility
( ) Fibroids
( ) Ovarian Cysts
( ) Obstruction
( ) Dysmenorrhea

Pain Disorder

( ) Head/ Neck
( ) Migraine
( ) T.M.J.
( ) Shoulder/ Arm
( ) Elbow/ Wrist
( ) Hand/ Finger
( ) Back/ Lumbar
( ) Hip/ Leg/ Thigh
( ) Knee/ Ankle
( ) Foot/ Toes
( ) Sciatic Nerve
( ) Pain In Joint
( ) Gout
( ) Rheumatic
( ) Arthritis
( ) Intervertebral Bulging Disk
( ) Multiple Sclerosis

Urinary Sexual Disorder

( ) Kidney Stone
( ) Chronic Nephritis
( ) Urethragia
( ) Prostate
( ) Urinary Infection
( ) Bladder Infection
( ) Epsteinbarr
( ) Herpes Zoster
( ) Systemiclupus

General Disorders

( ) Menopause
( ) Osteoporosis
( ) Thyroidal Trouble
( ) Thyroidism
( ) Parkinson's Disease
( ) Facial Paralysis
( ) Numbness and Tingling
( ) Paralysis Hand/ Head/ Neck
( ) Nervousness
( ) Depression
( ) Anxiety
( ) Insomnia
( ) Fatigue
( ) Anemia
( ) Weakness
( ) Dizziness
( ) Tinnitus
( ) Swelling
( ) Fever
( ) Nausea
( ) Neurosis
( ) Seizure
( ) Cancer
( ) Quit Smoking
( ) Weight Loss/ Weight Gain
( ) Quit Drugs
( ) Quit Alcohol

***Are you interested in Herbal Medicine? Yes _____ No _____**

Please list any operations that you have had in the past:

_____

_____

Please list any medications that you are currently taking:

_____

_____

To comply with the federal standards for healthcare, please answer the following questions:

Preferred Language:

___English ___Spanish ___Chinese ___Greek ___Other: _____

Race?
___ I do not wish to provide this information.
___ White
___ Black or African American
___ Asian
___ Native Hawaiian or Other Pacific Islander
___ Other: _____

Ethnicity?
___ I do not wish to provide this information.
___ Hispanic or Latino
___ Non-Hispanic or Non-Latino
___ Other: _____

Smoking Status?
___ Current Every day Smoker
___ Current Some Day Smoker
___ Former Smoker
___ Never Smoked

Do you have any medication allergies?
___ No known medication allergies
___ Yes. If so, what?

Are you currently taking any medications?
___ Not currently prescribed any medications
___ Yes. Please list all medications below

Name: _____ Dosage: _____
Name: _____ Dosage: _____
Name: _____ Dosage: _____

Current Height: _____ft. _____in.

Current Weight: _____ lbs.

Have you recently lost or gained more than 10 lbs.?

☐ Yes ☐ No

Consent to X-ray and/or Pregnancy Release

I hereby authorize **The Pain Clinic** Staff and whomever the physician may designate as his/her assistants to take X-rays, and release **The Pain Clinic** from any and all liability.

***For Female Patients**: Are you currently pregnant?* Yes _____ No _____

Print Name:
_____

Patient Signature:
_____ Date: _____/_____/_____

Authorization/ Signature On File

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information is unlawful and may be dangerous to my health. I authorize **The Pain Clinic** to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners only. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I authorize the use of my **Signature On File** for all insurance submissions. I understand that, should I not meet my payment responsibilities, I am fully responsible for all collection fees, travel expenses, interest charges, filing fees, court cost and attorney fees associated with the collection/s of any of my outstanding debt.

Print Name: _____

Patient Signature: _____ Date: _____/_____/_____

Consent For Treatment Of Minor Child

I acknowledge that I am the parent, guardian or custodian of _____, age_____, and do hereby authorize, request and direct the doctor's office as shown above, its doctors and staff to perform examinations, diagnostic x-rays, and any treatment that is in their best judgment, which is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while the listed minor shown above is under care in the office until legal age is attained.

As legal parent/guardian, I understand that I will be fully responsibility for all charges and payments due at time of service, and/ or all charges that the insurance company will not pay under my covered plan.

Parent/ Guardian Name: _____

Parent/ Guardian Signature: _____ Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____ (your name) acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of **The Pain Clinic**, which describes the practice's policies and the procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice. I also authorize **The Pain Clinic** to send correspondence by either US Postal Service or email, if available.

Print Name:

_____

Patient Signature:

_____ Date: _____/_____/_____

FOR OFFICE USE ONLY

The practice has made a good-faith effort to obtain an acknowledgement of _____
Receipt of our privacy practices. In spite of these efforts, the practice has been unable to obtain a signed acknowledgement of receipt for the following reasons:

____ Patient Unavailable ____ Patient Physically Unable ____ Patient Unwilling

In an effort to obtain the patients acknowledgement, the practice has attempted to provide patient with a notice of privacy practices in the following manner:

____ Personally ____ Mail ____ Phone ____ Other: _____

In an effort to obtain the patients acknowledgement of _____, the patient has refused to sign the stated documentation for the following reason(s) :

_____

_____

Office Staff Signature: _____ Date: _____/_____/_____

Printed Name: _____

Witness Signature: _____ Date: _____/_____/_____

Printed Name: _____

THE PAIN CLINIC

-Chiropractic-Acupuncture-Massage Therapy-

Cancellation Policy

No Show/ No Call Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment or care. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on their scheduled time as a courtesy to everyone.

If a patient is 7 minutes past their scheduled appointment time we will have to reschedule the appointment based on availability.

By signing this document, I fully understand the policy stated above.

Patient Signature _____ Date _____

Manager's Signature _____ Date _____

THE PAIN CLINIC
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Carlos Mantaras, D.C.
Lisa Berger, D.C.
Clayton Johnson, D.C.
Khai Nguyen, O.M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME:_____ **DATE:** _____

DATE OF BIRTH:_____ **SSN:** _____

ADDRESS:_____

I authorize _____

To furnish all medical records and other documentation regarding my healthcare to:

NAME: **THE PAIN CLINIC** **PHONE: 702-368-0508**

ADDRESS: 5445 W SAHARA AVE, LAS VEGAS, NV 89146 **FAX: 702-368-2049**

I understand these records may contain information from other health care providers, as well as information which are administrative in nature. I specifically consent to the release of any information contained in the medical records that may relate to my medical conditions and/or other related conditions.

I understand that I may revoke this authorization at any time by giving written notice to this provider. Unless revoked earlier, this authorization with terminate two years from the date authorization is obtained.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state and federal laws and regulations.

I understand that you have no responsibility for the use or distribution of this information by the party to whom it is released. I release you from all liability that may arise from your compliance with this request to release records. I authorize you to transmit this information by facsimile transmission. Any failure to receive transmission of my faxed records is the responsibility of the recipient.

_____ _____
PATIENT/LEGAL REPRESENTATIVE **SIGNATURE DATE**

_____
WITNESS

_____
IF NOT SIGNED BY THE PATIENT, LIST RELATIONSHIP OF LEGAL REPRESENTATIVE HERE

The Pain Clinic, Inc.
5445 W. Sahara Ave
Las Vegas, Nevada

Cupping Therapy Consent Form

Cupping therapy is an adaptation of an ancient technique; the purpose of this technique is to promote health and healing by loosening soft tissue and connective tissue, scarring and adhesions moving stagnation and increasing lymphatic flow and circulation. This therapy utilizes silicone or plastic cups and a vacuum pistol to create suction on the body surface. The benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them. Cupping treatments can be a "detoxifying" treatment process and as a result, you may feel nauseous or unwell following treatment. Drinking water and taking Vitamin C has been reported to relieve these symptoms quickly. In some cases headaches and minor body aches may be experienced.

Cupping therapy will leave bruise-like marks that will last several days to several weeks depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 21 days to fully clear. These areas of bruising or discoloration are typically not painful, but can on occasion have soreness, itching and there may be soreness in the surrounding muscles. Cupping therapy is a medical treatment, not a novelty and should be treated accordingly.

Potential reactions to Cupping Treatments are temporary and may include:

- Cup Kiss/ Bruising: discoloration due to toxins and old blood being brought to the surface
- Post tenderness: usually less than experienced from deep tissue work
- Redness and Itching: increased vaso-dilation and/or inflammation brought to the surface
- Decreased Blood Pressure: due to vaso-dilation and/or nervous system sedation

Suggested after care recommendations:

- ✓ Drink plenty of water, to help eliminate toxins out of the body.
- ✓ Avoid showers, steam, sauna and exercise immediately following bodywork.
- ✓ Light stretching and range of motion exercises are beneficial.
- ✓ Exercise the next day will help increase circulation to aid in fading of cup kisses/ bruising.

Contraindications:

- Hemophilia or other bleeding/clotting disorders
- Patients taking blood thinners
- Weak patients or those who have been ill.
- Abdomen on pregnant women
- Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly.
- Those who are unable to experience heat or pain properly
- Those who have circulatory conditions
- Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.

Authorization to Treat

I understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications.

I hereby authorize the Doctor of Acupuncture and/or a license Massage Therapist of The Pain Clinic to provide Cupping Therapy and/or various other therapeutic treatments to help aide in the treatment of my medical condition. I authorize this Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

PLEASE SELECT ONE OF THE FOLLOWING:

I, _____ ☐ DO ☐ DO NOT want to have cupping treatment for my condition.
Print Patient Name

Patient/ Guardian Signature: _____ Date: _____/_____/_____

OFFICE FINANCIAL POLICY

Your understanding of our financial policy is an essential part of your care and treatment. If you have any questions, please don't hesitate to discuss them with our office staff.

- As a courtesy we will contact your insurance carrier to verify your coverage, but this is only an estimate of what the insurance company will pay until we receive an actual payment. It is not a guarantee of payment.
- Your insurance policy is a contract between you and your insurance company. Also as a courtesy, we will file your insurance claims for you if you assign benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We are glad to assist you in billing your insurance, but you are ultimately responsible for full payment.

  Patients are encouraged to contact their carrier for clarification of benefits prior to services being rendered. You are considered a cash-based patient until we verify and determine the extent of benefits under your policy.
- Due to frequent erroneous information given to us from insurance carriers and the frequent difficulty in collecting payments from the carrier, we may ask for active assistance from you in rectifying the situation.
- All payments are due at the time of service. No personal balance is to exceed $100. We accept cash, checks, care credit, and most major credit cards.
- All deductibles and co-payments are due at the time of service or by an authorized payment plan. Most insurance does not cover 100% of services rendered. Because of this and the delay in payment common with insurance carriers, you will be asked to pay your deductible and your portion of your charges the day the service is rendered.
- After 90 days, any outstanding balances will be due in full by you. Balances over 90 days past due will be charged at a 1.5% monthly (18% annual) interest rate.
- You must inform this office of all insurance changes and referral requirements. In the event the office is not informed or the proper referral was not obtained by you in advance, you will be responsible for any charges denied by your insurance carrier as a result of not informing us or not obtaining the authorized referral.
- Insurance is designed for sick care and only reimburses for services that are deemed "medically necessary" according to their guidelines. In many cases, most insurance companies do not cover preventative care and health maintenance care and therefore may not be reimbursable.
- Non-compliance with a prescribed treatment plan may jeopardize insurance reimbursement. If you discontinue care or suspend care for any reason other than discharge by the doctor, any fees for professional services will become immediately due and payable in full by you, regardless of any claim submitted.
- There is a service fee of $25 for all returned checks. Your insurance company does not cover this fee.
- Past due accounts (those over 120 days) are subject to collection proceedings, which may affect your credit. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

Keep this copy for your information.

THE PAIN CLINIC
-Chiropractic-Acupuncture-Massage Therapy-

APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic healthcare provider. We understand that your time is as valuable as ours. Because of this, it is our goal to provide to you with our highest quality care in the most cost effective and efficient manner. An understanding of our appointment guidelines is essential for a healthy relationship.

Advanced Multiple Appointments: As you know, healing takes time. Your care will likely require repeated visits as your body progresses through the healing process. As a means of reducing your costs and improving efficiency, advanced multiple appointments are recommended in order to limit your time in our office by reducing the need to schedule visit-by-visit with the front desk staff. Any deviation from the prescribed treatment schedule may potentially jeopardize insurance reimbursement.

Rescheduling Appointments: Please remember that we have reserved appointment times especially for you and that your appointments are "written in pencil", meaning that it is okay to reschedule if something unexpected arises. Please let us know at least 24 hours in advance of the need to reschedule an appointment. Giving us advance notice will allow time to fill in that appointment with someone else who needs it.

Cancelling Appointments: Please let us know at least 24 hours in advance of the need to cancel an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Canceled appointments will be recorded in your medical record.

Missed Appointments "No-Show": An appointment that is missed without at least a 24-hour advance notice to cancel or reschedule, is considered a missed appointment. It is the policy of this office to assess a $25 missed/ no-show appointment fee. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits after your second missed appointment. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. This fee is not reimbursable by any insurance plan and therefore you will be responsible. Missed appointments will be recorded in your medical record.

Arriving Early: You are more than welcome to arrive early for any appointment; however, you will be seen by the doctor at your reserved appointment time.

Arriving Late: If you arrive more than 7 minutes after your scheduled appointment time you will be worked into the schedule at the next available time slot in order to honor the appointment times of others.

Walk-In Appointments: As a patient of our clinic, we do accept walk-ins based on availability. You are welcome to come in at any time during our office hours and we will do our best to fit you in the schedule. We are obligated to get our scheduled patients back to see the doctor first based on their appointment time. We encourage you to call and schedule an appointment in advance to avoid any wait time if you choose to walk in without a scheduled appointment time.

Open Door Promise: We understand that life can get busy. So if at any time you get "side- tracked" and decide to put your healthcare on hold, please know that you are always welcome back at any time. Our door is always open to you whenever you decide to start again.

Keep this copy for your information.

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