THE LAS VEGAS PAIN AND WELLNESS CENTER

Welcome To Our Office

Please fill out completely

Patient Information

First: Name*

Last Name*

Date Of Birth*

Home Phone*

Mobile Phone

Work Phone

Email

Preferred Communication

☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email

Last 4 of SSN

Gender*

☐ Male ☐ Female

Race and Ethnicity

☐ Prefer Not to Answer _____

Preferred Language

☐ Prefer Not to Answer _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widow

Street Address 1*

Street Address 2

Zip*

City*

State*

Emergency Information

Emergency Contact Name

Emergency Contact Phone

Relationship

Insurance Information

PAYMENT: ☐ Cash / Self-Pay ☐ Insurance

Name of Insured:_____ Relationship to Patient:_____

Insurance Co.:_____ ID# _____

Group #_____

Is Patient Covered by Additional Insurance? ☐Yes ☐No

Name of Insured:_____ Relationship to Patient:_____

Insurance Co.:_____ ID# _____

Group #_____SS#_____ Birthdate:_____

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 KEVIN L. KALDY, DC, PC 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 KEVIN L. KALDY, DC, PC . 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.

Patient signature / responsible party:

CLICK TO SIGN

Relationship:

Date:

Patient Name:_____ Date:_____

Chief Complaint

Reason for Visit:_____

What date did your complaint first start? _____

Rate your pain on a scale of 1(least) to 10 (worst):0____Is it getting worse? □Yes □No

Frequency of your complaint: □Constant □Off and On

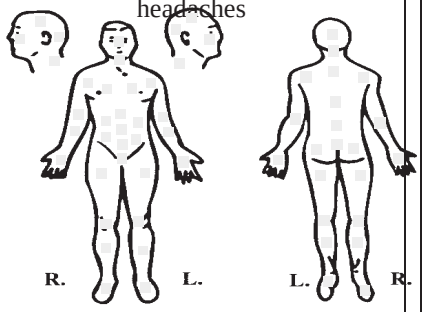
Nature of complaint: □Sharp □Dull □Throbbing □Numbness
□Tingling □Aching □Shooting □Burning

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 below where you are having pain, numbness, tingling, spasm, headaches



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

Claim #:_____ Adjuster Name:_____ Phone #:_____

Attorney Name (if Applicable):_____ Phone #:_____

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:_____

Other Doctors Names: _____

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: _____

_____

Height ft in Weight_____lbs Dominant Hand: ___Right ___Left

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

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

Do you exercise regularly? □Yes □No

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

Recent Radiology Dates & Location: □X-ray _____□MRI_____

□CT Scan_____ □Ultrasound_____

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:_____ CLICK TO SIGN Date_____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☒ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

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

Section 4 – Walking

- ☒ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

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 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score **0** x 2) / (**10** Sections x 10) = **0** %ADL

Reset

CLICK TO SIGN

Section 6 – Standing

- ☒ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

- ☒ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☒ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☒ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

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 the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which 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 the worst 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 weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ 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 slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want 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 headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score **0** x 2) / (**10** Sections x 10) = **0** %ADL_____

Reset

CLICK TO SIGN

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 to.
- ☐ I can only do 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 do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☑ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☑ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

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

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

THE LAS VEGAS PAIN AND WELLNESS CENTER

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702-232-4610
www.LVPWC.com

Financial Policy

This policy applies to services rendered by Kevin L. Kaldy, DC, PC, doing business as The Las Vegas Pain and Wellness Center. It does not obligate a patient to continue a recommended course of treatment.

APPOINTMENTS

1. **Copayments and balances**
   Copayments and outstanding balances are due at the time of service. If payment cannot be made, the appointment may be rescheduled, subject to applicable law and payer contracts.
2. **Procedure prepayment**
   Estimated patient responsibility is due when a procedure is scheduled. The estimate is not a guarantee of coverage or payment. The patient remains responsible for lawful unpaid balances after insurance processes the claim. Facility and assisting physician fees are billed separately.
3. **Missed appointments and cancellations**
   Please give at least 24 hours' notice. A missed office appointment or arrival more than 15 minutes late may result in rescheduling and a $25 fee. A procedure cancelled with less than 24 hours' notice may result in a $500 fee. These fees are not billed to insurance.

Patient initials: _____

INSURANCE

4. **Financial responsibility**
   Insurance coverage is a contract between the patient and insurer. The patient remains responsible for lawful patient balances after insurance processes the claim, subject to payer agreements and applicable law.
5. **Coverage changes and timely submission**
   The patient must promptly report insurance or billing changes. If a claim cannot be submitted on time because correct information was not provided, the patient may be responsible for the charges, subject to applicable law and payer agreements.
6. **Cash / self-pay**
   A patient selecting Cash / Self-Pay agrees to pay the current self-pay rate at the time of service. A good-faith estimate will be provided when required by law.

BENEFITS AND AUTHORIZATION

7. **Plan participation and verification**
   The patient should confirm plan participation, referrals, deductibles, copayments, authorization requirements, and out-of-network benefits directly with the insurer. Benefit verification is not a guarantee of payment.

AUTHORIZATION AND CLAIMS

8. **Prior authorization and non-covered services**
   Some services may be excluded, require prior authorization, or be described incorrectly by an insurer. The practice may assist, but authorization and benefit information do not guarantee payment.
9. **Out-of-network payments**
   If an out-of-network insurer pays the patient directly for services rendered by the practice, the patient agrees to promptly forward that payment to the practice.
10. **Personal injury**
    Patients using medical-payments coverage or legal representation must keep claim, insurer, and attorney information current and provide documents needed to collect for services rendered. Available benefits may not cover the entire balance.
11. **Workers' compensation**
    Patients seeking workers' compensation coverage must provide the employer, insurer, adjuster, claim, and authorization information needed to establish coverage and work-relatedness.

ACCOUNT BALANCES AND PAYMENTS

12. **Reassignment of balances**
    If an insurer does not pay within a reasonable period, the balance may be transferred to patient responsibility when permitted. Patient balances are due within 30 days after the statement date unless another written arrangement applies.
13. **Collection of unpaid accounts**
    If an unpaid balance is placed with a collection agency or attorney, a collection fee equal to 50% of the unpaid balance may be added, together with lawful collection costs, court costs, service fees, interest, or late fees.

Patient initials: _____

14. **Returned checks**
    A returned check is subject to a $38 returned-check fee.
15. **Statements**
    A statement is considered correct unless the patient gives written notice of a disputed charge within 30 days after the statement date.

AGREEMENT AND ASSIGNMENT OF BENEFITS

I have read and understand this policy and agree to its terms. I assign applicable insurance benefits to the practice and authorize my insurer to pay the practice directly. I understand that I remain financially responsible for services received, subject to applicable law and payer contracts.

Patient name (printed): _____ **Date:** _____

Patient signature: CLICK TO SIGN **Date:** _____

Click the signature field in Acrobat, or use Acrobat Sign for a guided reusable signature.

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INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Chiropractic, medical, osteopathic, and physical therapy professionals who perform manipulation obtain informed consent before treatment. Please read this form carefully and ask questions before signing.

Patient name: _____

I voluntarily consent to examination and conservative, noninvasive treatment of the joints and soft tissues. Treatment may include manipulation or adjustment, manual therapy, therapeutic exercise, physiotherapy modalities, and other services discussed with me.

MATERIAL RISKS

Soreness:	Temporary soreness or stiffness may occur, especially during the first few treatments.
Dizziness:	Temporary dizziness or nausea can occur but is relatively uncommon.
Fracture or joint injury:	Underlying defects, deformities, osteoporosis, or other pathology may increase the risk of fracture or injury. The clinician will use added caution when these conditions are known.
Neurologic injury or stroke:	Nerve injury and stroke associated with neck manipulation are rare but potentially serious. Seek immediate medical attention for sudden weakness, facial droop, difficulty speaking, severe headache, loss of coordination, or other urgent symptoms.
Skin irritation or burn:	Therapy devices may rarely cause irritation, blistering, or burns even when precautions are used. Report unusual heat, pain, or skin changes immediately.

TREATMENT RESULTS

Potential benefits include decreased pain, improved mobility, and reduced muscle spasm. Results cannot be predicted or guaranteed. My condition may improve, remain unchanged, or worsen.

REASONABLE ALTERNATIVES

Medication:	May reduce pain or inflammation but can have side effects, interactions, dependence risks, or incomplete relief.
Rest and exercise:	May improve function, but prolonged rest can contribute to weakness and stiffness.
Injections or surgery:	May be appropriate for some conditions and carry separate risks, benefits, and recovery requirements.
No treatment:	May allow symptoms or the underlying condition to persist or worsen.
Referral:	Consultation with another health professional may be appropriate before or during treatment.

PATIENT RESPONSIBILITIES AND CONTINUING CONSENT

I have disclosed my health history, medications, pregnancy status, prior injuries, and other conditions that could affect treatment. I will promptly report changes, unexpected symptoms, or concerns. The clinician may modify or stop a procedure and may recommend referral or further evaluation.

I may ask questions at any time, decline a specific technique or procedure, or withdraw consent before treatment. Withdrawal does not affect care already provided.

I have read this explanation, had the opportunity to ask questions, received answers I understand, and made my decision voluntarily. No guarantee has been made regarding results.

By signing below, I consent to the examination and treatment described above.

Signature: CLICK TO SIGN **Date:** _____

Patient or authorized representative

Click the signature field in Acrobat, or use Acrobat Sign for a reusable signature.

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Date: _____

Release records from:

Provider or facility: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

SEND RECORDS TO THE LAS VEGAS PAIN AND WELLNESS CENTER

5650 W. Flamingo Rd., Ste. A, Las Vegas, NV 89103

Phone: 702-232-4610 Email: DrKaldy@LVPWC.com

I, _____ authorize the release described below.

I authorize the provider or facility identified above to disclose health information reasonably needed for my care, including clinical notes, reports, imaging, laboratory results, medication records, and billing information, to The Las Vegas Pain and Wellness Center.

This authorization expires one year after the date signed unless I specify another date: _____. I may revoke it in writing except to the extent action has already been taken. Treatment, payment, enrollment, or benefits generally will not be conditioned on signing. Redisclosure may occur unless the information remains protected by law. Specially protected records may require additional authorization.

Patient name (printed): _____

Patient signature: CLICK TO SIGN

Last 4 of SSN: _____ Date of birth: _____

Parent or guardian printed name (if applicable): _____

Parent or guardian signature: CLICK TO SIGN

Click a signature field in Acrobat, or send through Acrobat Sign for a guided reusable e-signature.

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NOTICE OF PRIVACY PRACTICES

Effective date: September 6, 2026

Your Information. Your Rights. Our Responsibilities.

This notice explains how medical information may be used and disclosed and how you can access it.

HOW WE MAY USE AND SHARE YOUR HEALTH INFORMATION

Treatment: We may use and share information with physicians, therapists, pharmacies, laboratories, imaging facilities, hospitals, and other professionals who are treating you. We may contact you about appointments, treatment alternatives, and health-related services.

Payment and operations: We may use and share information to bill and obtain payment from health plans or others and to run the practice. Operations include quality review, staff training, licensing, credentialing, compliance, business management, and improving your care.

Other permitted or required disclosures: We may share information for public health and safety activities, reporting suspected abuse or neglect, health oversight, workers' compensation, organ donation, coroners and medical examiners, law enforcement, approved research, government functions, and judicial or administrative proceedings when legal requirements are met.

YOUR CHOICES AND AUTHORIZATIONS

You may tell us whether to share information with family, friends, or others involved in your care and whether to share information for disaster relief. If you cannot tell us, we may use professional judgment and act in your best interest. We will obtain written authorization for uses or disclosures not otherwise permitted, including most marketing, sale of information, and most uses of psychotherapy notes. You may revoke an authorization in writing, but revocation does not affect action already taken. You may opt out of fundraising communications.

YOUR RIGHTS

- Inspect or receive an electronic or paper copy of your medical record and other health information, usually within 30 days. Reasonable cost-based fees may apply.
- Ask us to correct information you believe is incorrect or incomplete. We may deny the request, but we will explain why in writing.
- Ask us to contact you in a specific way, request limits on uses or disclosures, and request confidential communications. We must honor certain requests to restrict disclosure to a health plan when you pay in full out of pocket and the disclosure is for payment or operations.
- Receive a list of certain disclosures made during the six years before your request, receive a paper copy of this notice, and have an authorized person exercise rights for you.
- Complain to us or to the U.S. Department of Health and Human Services without retaliation.

REQUESTS, REPRESENTATIVES, AND COPIES

We may ask you to make a request in writing and verify your identity. We generally respond to record-access requests within 30 days and may take one permitted extension with written notice. We generally respond to amendment requests within 60 days and may take one permitted extension. If someone has medical power of attorney or is your legal guardian, that person may exercise your rights after we verify the authority. You may receive this notice in paper form even if you agreed to receive it electronically.

SUBSTANCE USE DISORDER RECORDS

If we create or maintain substance use disorder records protected by 42 CFR Part 2, special confidentiality rules apply. We will not use or disclose those records in civil, criminal, administrative, or legislative investigations or proceedings against you unless you provide written consent or a court order and subpoena authorize the disclosure. If Part 2 information may be used for fundraising, you will receive advance notice and a clear opportunity to opt out.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information, give you this notice, and follow the notice currently in effect. We will notify you if a breach may have compromised your information. We may change this notice and make the revised notice effective for information already held and information received later. The current notice will be available at our office and at www.LVPWC.com.

QUESTIONS OR COMPLAINTS

Contact Privacy Officer Kevin L. Kaldy, DC at 5650 W. Flamingo Rd., Ste. A, Las Vegas, NV 89103; 702-232-4610; or DrKaldy@LVPWC.com. You may also file a complaint with the HHS Office for Civil Rights at 200 Independence Avenue SW, Washington, DC 20201, 1-877-696-6775, or www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

NEVADA RECORD ACCESS AND RETENTION

Nevada law provides rights to inspect or obtain copies of health care records, subject to permitted fees and exceptions. Records may be destroyed after applicable retention periods and required notice. Contact the practice before destruction if you want a copy.

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Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I received or was offered The Las Vegas Pain and Wellness Center's Notice of Privacy Practices, effective September 6, 2026. The notice explains how my health information may be used and disclosed, my privacy rights, and the practice's responsibilities.

Signing only acknowledges receipt; it does not authorize any use or disclosure beyond those permitted by law.

Signature: CLICK TO SIGN

Printed name: _____ **Date:** _____

Use Adobe Acrobat or Reader for digital signatures.

OFFICE USE ONLY IF ACKNOWLEDGMENT IS NOT OBTAINED

Reason: _____

Staff member: _____ Date: _____

Good-faith effort made: _____

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PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS IN ACCORDANCE WITH HIPAA

_____, I authorize Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Kevin L Kaldy DC PC dba The Las Vegas Pain and Wellness Center to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

CLICK TO SIGN _____
Patient/Legal Guardian Signature Date

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ELECTRONIC COMMUNICATIONS AGREEMENT

FOR PERSONAL HEALTH INFORMATION

Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and all electronic communications may be utilized between the Practice and Patient that includes Patient's Personal Health Information ("PHI"). The Patient agrees to inform the Practice of any changes to Patient's authorized email address. Patient acknowledges that should Patient email exchange with the Practice from another email address, Patient authorizes the Practice to use that email address for communicating PHI as well.
2. For all other services, the Practice and the Patient may use telephone (landline or mobile), facsimile, mail, or in-person office visits.
3. Under no circumstances shall email or electronic communications be used by the Patient or the Practice in emergency or time-sensitive situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.
4. The Practice values and appreciates the Patient's privacy and takes security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Practice shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities.
5. The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Practice to communicate with the Patient as set forth in this PHI Agreement. The Patient shall hold harmless any and all demands, claims and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or causes by such technical failures that are not directly caused by the Practice. If the Patient uses non-encrypted email or instructs the Practice to use non-encrypted email containing PHI, the Patient shall hold harmless the Practice and its owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.
6. The Practice will obtain the Patient's express consent in the event that the Practice is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Practice's Notice of Privacy Practice's, or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all Responsible Parties.
7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Practice terminating the email and electronic communications relationship, an may lead to the termination of the Patient's agreement for Practice services.
8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.
9. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Practice to communicate with the Patient regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of Patient's PHI and HIPAA/HITECH compliance. Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgment.
10. The Patient shall have the right to request from the Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronics information. However, the Patient's PHR Support subscription fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and burning PHI to media and distributing the media with media costs; Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive) the Practice's actual supply costs for such equipment may be charged to the Patient.
11. This Agreement will remain in effect until the Patient provides written notice to the Practice that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Practice. The Patient may revoke this Agreement at any time, and agrees to provide the Practice with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communication database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment, but will preclude the Direct Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all present and future purposes.

ACKNOWLEDGMENT OF RECEIPT FOR AGREEMENT FOR PERSONAL HEALTH INFORMATION

ACKNOWLEDGMENT

I agree to routine electronic communications: ☐ Yes ☐ No **Email:** _____

Patient name: _____

Signature: CLICK TO SIGN **Date:** _____

Use Adobe Acrobat or Reader for digital signatures. Image selection requires the desktop application.

THE LAS VEGAS PAIN AND WELLNESS CENTER

5650 W. Flamingo Rd., Ste. A
Las Vegas, NV 89103
702-232-4610
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IDENTIFICATION AND INSURANCE IMAGES

Desktop Acrobat/Reader: click an image area to choose a file.
Phone camera or photo library requires a secure web upload or an Acrobat Sign attachment request.

Patient name: _____ **Date:** _____

DRIVER'S LICENSE - FRONT

CLICK TO CHOOSE AN IMAGE FILE

Status:

PRIMARY INSURANCE - FRONT

CLICK TO CHOOSE AN IMAGE FILE

Status:

PRIMARY INSURANCE - BACK

CLICK TO CHOOSE AN IMAGE FILE

Status:

SECONDARY INSURANCE - FRONT

CLICK TO CHOOSE AN IMAGE FILE

Status:

SECONDARY INSURANCE - BACK

CLICK TO CHOOSE AN IMAGE FILE

Status:

These image buttons require the desktop Adobe Acrobat or Reader application.