Uptown Painstop,

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Operations Manager
Heather Swanson
3724 N. 3rd St
Suite 301
Phoenix, AZ 85012
602-892-9667

For more information about HIPAA, please contact:

The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Signature below is acknowledgment that you have received this Notice of our Privacy Practices.

Minor Patient's Name (if applicable): _____

Printed Name: _____

Date: _____ **Signature:** _____

MM/DD/YYYY

Treatment Attestation for Pain Management

Patient Name: _____ **Date of Birth:** _____
First Last MM/DD/YYYY

I, _____, am seeking healthcare services for the treatment of my painful condition from Pain Stop Clinics and I understand that my accuracy, completeness and truthfulness in reporting my history and symptoms will directly contribute to the development of my treatment plan and the improvement in my painful condition. I acknowledge that I intend to provide all necessary releases for healthcare information so Pain Stop Clinics may receive my previous healthcare records from other clinicians. I know that if I am not accurate, complete and truthful in providing my history and symptoms, Pain Stop Clinics providers cannot safely treat me for my painful condition.

Patient Initials: _____

I intend to disclose the names of all prior treating practitioners and to inform Pain Stop Clinics about all current prescribers of controlled substances. I do not intend to seek medications for any purposes other than my personal medical needs. I will not deliberately misrepresent my history, prevent Pain Stop Cinics from obtaining my previous medical records, fail to inform Pain Stop Clinics about the existence of other sources of prescription medication, or allow anyone other than myself to take medications prescribed to me.

Patient Initials: _____

I understand that obtaining controlled substances (prescription medicines) through false representations is a crime and that I will be reported to law enforcement officials for attempting to fraudulently obtain these medications for non-therapeutic purposes.

Patient Initials: _____

I am seeking treatment for the purpose of reducing or relieving my pain. I am not appearing to seek care from Pain Stop Clinics or any of its' providers as part of an ongoing investigation of Pain Stop Clinics or any if its' providers. I am a legitimate patient voluntarily seeking healthcare services for a painful condition.

Patient Initials: _____

Date: _____ **Signature:** _____
MM/DD/YYYY

Witness Name: _____

Date: _____ **Witness Signature:** _____
MM/DD/YYYY

Chiropractic Informed Consent

The nature of the chiropractic manipulation: I will use either my hands, an instrument, or both to move the joints of your body; this may result in an audible "pop" or "click".

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatment recommended: Ice, Moist Heat Peaks, Electrical Muscle Stimulation, Stretching/Strengthening Exercises, Massage Therapy, Neuromuscular Re-education and Passive/Regainer Traction.

Risks involved with the recommended ancillary treatments: Ice and Electrical Muscle Stimulation (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching/Strengthening Exercises and Mechanical Traction can cause temporary post treatment soreness or reflex muscle spasms. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self-management with over-the-counter medication, rest, and/or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self-dosages and surgical risks including complications from either the procedure and/or the anesthesia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it was my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Minor Patient's Name (if applicable):_____

Printed Name: _____

Signature:_____ **Date:** _____
MM/DD/YYYY

Patient Financial Agreement

Patient Name: Enter First and Last Name Date of Birth: Click or tap to enter a date.

BENEFIT ASSIGNMENT CONTRACT/EQUITABLE LIEN AND INDEMNIFICATION AGREEMENT

I the undersigned Patient hereby agree to establish a lien/assignment of benefits or claim in favor of Pain Stop Clinics by this contract and pursuant to any state statues that apply. I give my permission for Pain Stop Clinics and/or their agent, to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from this accident and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so I have entered into a contract with the above named health care or service provider. I direct that a photocopy of this lien be considered valid as the original.

Date of Accident: Click or tap to enter a date.

This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy, settlement, disability benefits, medical payments benefits, no-fault benefits, health and/or accident benefits, workers' compensation benefits, compromise, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary to fully compensate the health care or service provider from whom I have received care.

I hereby authorize and direct my attorney to pay directly to Pain Stop Clinics such sums as may be due and owing for medical services rendered to me by reason of this accident and to withhold such sums from any settlement or judgment or verdict as may be necessary to adequately protect said medical provider. I understand that no settlement, verdict, or judgment proceeds can be disbursed to me without first satisfying this lien. I agree to fully to protect Pain Stop Clinics by disallowing the use of the common/general fund dispersal and/or a reduction based upon LaBombard v. Samaritan Health System (195 AZ 543,991 P.2d App. 1998) or Andrews v. Samaritan Health System (201 AZ 379, 36 P.3d 57 app. 2001).

I fully understand that I am directly and fully responsible to Pain Stop Clinics for all bills submitted for services rendered to me and on my behalf in preparing my case for trial or settlement and that this agreement is made solely for Pain Stop Clinics additional protection and in consideration of Pain Stop Clinics awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may recover said fees. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or serving notice of this lien/assignment upon any liable parties and their insurance companies.

Date: Click or tap to enter a date. Signature: _____

The undersigned, being attorney of record for the above patient does hereby acknowledge receipt of the above lien, and agrees to observe all the terms of the above agreement and agrees to abide by his/her ethical obligations and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Pain Stop Clinics. This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office.

Date: Click or tap to enter a date. Signature: _____

MEDICAL RECORDS REQUEST

Pain Stop Mesa 4540 E Baseline Rd, Suite 105, Mesa, AZ 85206 Phone: 480.272.8944 Fax: 480.237.5682

Patient Name:_____ **Date of Birth:**_____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Above listed patient authorizes the following healthcare facilities to release/receive record disclosure:

☐ Release ☐ Receive

Facility Name: _____

Facility Address: _____

City, ST, Zip: _____

Facility Fax: _____

Dates and Type of information to disclose:

☐ 1 year prior from last date seen

☐ Dates Other: _____

☐ Specific Information Requested:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____

Printed name of Authorized Representative Relationship / Capacity to patient