PATIENT INFORMATION

Please complete the following forms to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient's Full Name: _____
Today's Date: _____

Address: _____ City: _____
State: _____ Zip: _____

Home Phone: _____ Work Phone: _____
Cell: _____

Birth Date: _____ Social Security #_____
Gender: ___Female ___Male

Are You: ____Minor ____Single ____Married ____Separated ____Divorced ____Widowed

May we contact you for appointment reminders via e-mail or text message? ☐ Yes ☐ No

If so mobile provider (ex: AT&T) _____

E-Mail Address: _____ (Monthly Newsletters, Updates, Schedule Changes)

Your Employer: _____

Occupation: _____

Emergency Contact: _____

Phone #:_____ Relationship _____

Whom may we thank for referring you to us:
_____

South Meadows Chiropractic

Lloyd Decker, D.C.

9437 Double Diamond Pkwy Ste. 18

775-683-9026

Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase of any kind of symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains, and/or increased pain and inflammation. I do not expect of or will not hold Lloyd Decker, D.C. at South Meadows Chiropractic or any other physician assigned to my case by Dr. Lloyd Decker to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesic and rest: Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had this read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of patient:_____

Signature of:_____

Printed Name of Parent/Guardian and Relationship to Patient:_____

Parent/Guardian Signature: _____

Date:_____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date _____

HIPAA Form

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor and/or Nurse Practitioner" refers to Dr. Lloyd Decker or Reno Regenerative Medicine LLC and/or Judy Thomas APRN.

I consent to the use or disclosure of my protected health information by the Chiropractor and/or Nurse Practitioner for analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor and/or Nurse Practitioner. I understand that analysis, diagnosis or treatment of me by the Chiropractor and /or Nurse Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor and/or Nurse Practitioner is not required to agree to the restrictions that I may request. However, if the Chiropractor and/or Nurse Practitioner agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor and/or Nurse Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have had a copy of the Notice of Privacy Practices of the Chiropractor and/or Nurse Practitioner made available to me and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor and/or Nurse Practitioner. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor and/or Nurse Practitioner with respect to my protected health information.

The Chiropractor and/or Nurse Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and/or Nurse Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority