Shanna Kim, DDS
Diplomate, American Board of Orofacial Pain

PATIENT INFORMATION

(PLEASE USE BLACK PEN ONLY)

Today's Date: _____

Patient Name: _____ DOB: _____/_____/_____
Prefix First Middle Last Month Day Year

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Age: _____ Sex (F/M), Gender: _____

Preferred method of communication: ▪ Cell ▪ Home ▪ Work ▪ Email

Marital Status (S/M)_____ Occupation: _____

Person Responsible for Payment: _____ _____
First Middle Last Relationship

Emergency Contact: _____ _____ _____
Name Phone Relationship

I allow Nevada Orofacial Pain, TMJ and Sleep Clinic to give my clinical information to or answer questions from the following individuals (examples include spouse, parent, child, guardian, friend, partner, other)

1: _____ _____ _____
Name (First and Last) Phone Relationship

2: _____ _____ _____
Name (First and Last) Phone Relationship

3: _____ _____ _____
Name (First and Last) Phone Relationship

Preferred Pharmacy:

_____

Phone: _____

Pharmacy Name, Address: _____

_____

How did you hear about us (Google, referral, friend/relative)?

_____

Patient Name:_____

WE WOULD LIKE TO KEEP YOUR HEALTHCARE PROVIDERS UP TO DATE REGARDING YOUR TREATMENT,

PLEASE INCLUDE THEIR INFORMATION BELOW.

NOTE: By putting their info below, you are giving us a consent to disclose your protected health information, medical condition or test results with the providers listed below.

- Doctor's Name: _____
  Specialty: Primary Care Physician
  Address:_____
  Office No.:_____-_____-_____
  Fax No.:_____-_____-_____

- Doctor's Name: _____
  Specialty: General Dentist
  Address:_____
  Office No.:_____-_____-_____
  Fax No.:_____-_____-_____

- Doctor's Name: _____
  Specialty: _____
  Address:_____
  Office No.:_____-_____-_____
  Fax No.:_____-_____-_____

- Doctor's Name: _____
  Specialty: _____
  Address:_____
  Office No.:_____-_____-_____
  Fax No.:_____-_____-_____

MEDICAL HISTORY

Patient Name:_____

Sleep History

Current	Never	
□	□	Difficulty falling asleep
□	□	Difficulty staying asleep
□	□	Waking up gasping for air or choking
□	□	Told I stop breathing while asleep
□	□	Told that I snore frequently
□	□	Experience morning headaches
□	□	Excessively tired throughout the day
□	□	Wake up unrefreshed
□	□	Frequent mood swings
□	□	Difficulty breathing through my nose
□	□	Trouble with memory

Have you ever had a sleep study (Y/N)?_____

If yes, specify type (Home Sleep Test or In-lab Polysomnogram), ordering provider, date and results of sleep study:_____

If yes, have you ever tried CPAP (Y/N)? _____
If yes, have you ever tried an oral appliance for sleep apnea (Y/N)? _____

Patient Name:_____

Medical Conditions

Past	Current	Never	
☐	☐	☐	Acid reflux
☐	☐	☐	Anemia
☐	☐	☐	Anxiety
☐	☐	☐	Arthritis
☐	☐	☐	Artificial joints and/or valves
☐	☐	☐	Atherosclerosis
☐	☐	☐	Asthma
☐	☐	☐	Atrial fibrillation
☐	☐	☐	Autoimmune disorder (specify type _____)
☐	☐	☐	Bipolar disorder
			Bleeding ulcers
☐	☐	☐	Blood Clot
☐	☐	☐	Cancer or history of cancer (specify type _____
☐	☐	☐	Cerebral aneurysm
☐	☐	☐	Chronic fatigue
☐	☐	☐	Dementia/memory loss
☐	☐	☐	Depression
☐	☐	☐	Diabetes
☐	☐	☐	Dizziness or vertigo
☐	☐	☐	Eating disorder
☐	☐	☐	Epilepsy or seizures
☐	☐	☐	Fainting
☐	☐	☐	Fever blisters, herpes
☐	☐	☐	Fibromyalgia
☐	☐	☐	Glaucoma
☐	☐	☐	Gout
☐	☐	☐	Headache/Migraine
☐	☐	☐	Heart attack
☐	☐	☐	Heart pacemaker
☐	☐	☐	Hemophilia
☐	☐	☐	Hepatitis
☐	☐	☐	HIV/AIDS
☐	☐	☐	Hypertension
☐	☐	☐	Irritable bowel syndrome (IBS)
☐	☐	☐	Hypotension or Syncope
☐	☐	☐	Kidney disease
☐	☐	☐	Kidney stones
☐	☐	☐	Liver disease
☐	☐	☐	Meniere's Disease

□	□	□	Mitral valve prolapse
□	□	□	Multiple sclerosis
□	□	□	Neuropathy
□	□	□	Obesity
□	□	□	Osteoporosis
□	□	□	Parkinson's disease
□	□	□	Prolonged bleeding time (INR > 3.5)
□	□	□	Psychiatric care
□	□	□	Radiation treatment
□	□	□	Shingles
□	□	□	Stroke
□	□	□	Thyroid disorder (specify type: _____)
□	□	□	Tuberculosis
□	□	□	Urinary disorder

Are you currently pregnant? □ Yes □ No
Are you currently breastfeeding? □ Yes □ No

Allergies:

□ No known allergies	□ Iodine	□ Eggs, poultry	□ Antibiotics (penicillin, amoxicillin, etc.)
□ Metals (nickel, tin, etc.)	□ Latex	□ Local anesthetics	□ Sulfa drugs
□ Barbiturates	□ Codeine	□ Other: _____	

Patient Name:_____

Patient Name:_____

Surgical History:

Surgery	Date	Surgeon	Details
□ Wisdom tooth/teeth extraction			
□ Other dental surgeries			
□ Tonsils and/or adenoids			
□ Sinus surgery			
□ Head and/or neck surgeries			
□ Brain Surgery			

Please list any other surgeries and their dates:

_____

_____

List all your CURRENT medications, drugs, vitamins, and supplements

□ I take no medications, drugs, vitamins, or supplements

Name of medication	Dosage	Directions (ex: 1 per day)	Prescribing provider

Patient Name:_____

Medication and Medical Records History Authority Consent Form

____ (initials) I authorize Nevada Orofacial Pain, TMJ and Sleep Clinic to access and download my medication and medical history through their electronic health record system. I understand this helps ensure safe treatment and avoid drug interactions. This authorization will remain in effect until I revoke it in writing.

Have you ever taken bisphosphonates (e.g. alendronate or Fosamax, risedronate or Actonel, zoledronic acid or Reclast, ibandronate or Boniva, denosumab or Prolia, denosumab or Xgeva, rosozumab, etc.)?

□ Yes, I took _____ and my last dose was on: _____
□ No

Dental History:

1. Date of last dental visit: ___
2. Any history of trauma to the face, head, or neck? [ ] Yes [ ] No If yes, please explain:
   _____
3. Have you had any orthodontic treatment? [ ] Yes [ ] No
4. Do you wear a night guard or oral appliance? [ ] Yes [ ] No
5. Are you a mouth breather? [ ] Yes [ ] No
6. Do you clench or grind your teeth? [ ] Yes [ ] No
7. Have you ever had problems with your gums? [ ] Yes [ ] No
8. Are you planning on getting dental work done in the next 12 months, excluding cleanings? This includes fillings, crowns, root canals, extractions. [ ] Yes [ ] No

   If yes, please write the proposed or planned dental treatments:

   _____

9. Do you wear dentures and/or partial dentures? [ ] Yes [ ] No

Patient Name:_____

Social History:

Does the patient drink alcohol?	□ Yes □ No □ Past	If yes, on average, how many drinks per day: _____
Does the patient take sedatives/sleep aids to help fall or stay asleep?	□ Yes □ No	If yes, on average, how many times a week? _____
Does the patient consume caffeine daily?	□ Yes □ No	If yes, on average, how many drinks per day: _____
Does the patient smoke or use nicotine containing products?	□ Yes □ No □ Past	If yes, on average, how many packs per day: _____
Does the patient use recreational drugs?	□ Yes □ No □ Past	If yes, specify type: _____

I certify that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU ARE TAKING.

Your chief complaint/concern – your reason for contacting our office.

1. Chief complaint

_____

_____

_____

Other complaints or concerns you have.

_____

_____

Descriptors of Chief Complaint

Note: If sleep is your chief complaint, please only answer what is relevant to your situation.

A. **Quality**: What words would you use to describe how the pain feels (circle all that apply)?

Aching	Throbbing	Stabbing	Burning	Pounding	Sharp	Radiating	Exhausting
Tight	Nauseating	Electric	Itchy	Numbness	Sore	Tender	Cramping

B. **Aggravating Factors**: What makes it worse?
C. **Alleviating Factors**: What makes it better?
D. **Time**: Is there a time when it is usually worse?

□ On awaking □ Mornings □ Afternoons □ Evenings □ Work/school days □ Weekends

E. **Location:** Where do you feel the pain?

_____

_____

F. **Severity**: If your complaint involves "pain," please rate the intensity of the pain. Use a '0' to '10' scale (0 is no pain, 10 is the worst pain)

How intense is the pain right now?	
How intense has the pain been in the past 30 days?	

G. **Duration**: When it occurs, how long does it last (check all that apply)

□ Continuously (Never ending from the time I awake until I fall asleep)
□ Episodic
On average, how long do you experience each pain episode? Examples: Less than 1 second, seconds, minutes, hours, days, months, years?

H. **Frequency**: On average, how often does it happen?

□ Continuously (Never ending from the time I wake until I fall asleep)
□ Episodic
On average, how often does your pain recur? Examples: Every few minutes, every hour, daily, weekly, monthly, etc?

I. **Autonomic involvement:** When the pain comes, do any of the following always occur with the pain or headache?

Eye redness or tearing on 1 side only	□ Yes	□ No	□ Don't know
Nose runs or gets congested on 1 side only	□ Yes	□ No	□ Don't know
Face flushes and/or sweats on 1 side only	□ Yes	□ No	□ Don't know

Other: _____

History:

A. **Onset**: When did this start?
B. What do you think caused it?

□ Spontaneous	□ Stressful situation	□ Accident at home or work	□ Medical treatment
□ Following an illness	□ Following surgery	□ Auto accident	□ Dental treatment

Please explain: _____

C. How quickly did it take to come on or develop (instantly, minutes, days, weeks, months)? _____
D. Has it changed since it began? If so, how?

□ Increased/worse □ Decreased/better □ Same □ Varies

Past Consultation and/or Treatment
Since this began, which of the following providers have you seen for this condition?

Category (ex: dentist, ENT, chiropractor, etc.)	Provider's Name	Year Seen	Treatments Performed	Any improvement? Yes/No/Unsure

Do you or have you ever experienced any of the following:

	Current	Past	Never
Jaw popping, clicking, rubbing, crunching, grinding	□	□	□
Headaches	□	□	□
Facial Pain	□	□	□
Ear Pain	□	□	□
Neck or shoulder stiffness or pain	□	□	□
Can not open mouth wide	□	□	□
Jaw locking open and/or closed	□	□	□
Feeling like your bite is off	□	□	□
Pain/discomfort with chewing	□	□	□
Clenching/grinding your teeth	□	□	□
Ringing, hissing or buzzing in ear(s)	□	□	□
Hearing loss or fullness in the ear(s)	□	□	□
Dizziness or balance problems	□	□	□
Pain in, around, or behind the eyes	□	□	□
Painful or burning tongue	□	□	□
Teeth or gum pain	□	□	□

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY and INITIAL/SIGN BELOW
In consideration of receiving services from "Nevada Orofacial Pain, TMJ and Sleep Clinic" you agree that:

Mission: Time is very valuable to us. It is our mission and goal to focus as much time on addressing the pain and suffering of our patients. Failed appointments and unpaid services run contrary to this mission. We require patients to present on time, complete their forms in advance of their appointment and pay in-full at the time of service.

Fees: Patients are required to pay all charges or copays at the time of service. The practice accepts credit card as payment. We can also accept personal checks. However, all returned checks and credit card denials will incur an additional service fee of $100.00. We are not a provider with any dental insurance plans.

A charge of $100.00 will be assessed for cancelled visits (and no-show visits) if the office is not notified at least 24 hours prior to appointment date. These charges are not billable to insurance and are patient's responsibility. Also, if you arrive more than 15 minutes late to your appointment and fail to communicate this with the office, your appointment may be rescheduled and you will be charged $100 for a broken appointment fee. **Cancelled, no-show or late visits must be paid in advance before scheduling another appointment. After a total of three (3) no-shows and/or late appointment arrivals, patients may be encouraged to seek care from another provider.**

You will be emailed a link to our secure patient portal. Please fill out the forms as thoroughly as possible to prevent any delays in your treatment**. We ask that you submit all documents within 24 hours of your scheduled appointment. If we do not receive all new patient forms within 24 hours of your appointment, you may be rescheduled.** If you have any difficulty filling out forms, please call us immediately.

If you have any relevant medical records (reports, imaging, lab-work), please allow at least 3 business days for the doctor to review. You can arrange a time to drop the records at our office if you would like the documents to be reviewed prior to your appointment. Any imaging that requires a radiology interpretation may be subject to a fee that is not covered by insurance. To avoid these costs, we ask all patients to request any relevant imaging and ask for the "radiology report" to be sent to our office.

We do not take workers compensation or accident/injury cases at this time.

Our office has a no tolerance policy for any disrespectful behavior causing distress, fear or intimidation directed at our staff or patients. These individuals will be immediately directed to find another provider for their care.

The use of artificial intelligence (AI) may be used during your appointment to record and analyze your appointments. The purpose of AI is to ensure we address all your concerns thoroughly and

improve the quality and consistency of your care. Your appointment will be audio-recorded and a AI system will analyze the recording. All recordings and AI generated data are encrypted and securely stored. Access is strictly limited to authorized healthcare providers involved in your care. You have the right to decline the use of AI without affecting your care. You can revoke this consent at any time by notifying us in writing.

For contracted insurances: I authorize "Nevada Orofacial Pain, TMJ and Sleep Clinic" to submit claims on my behalf for payment of services rendered to the named insurance company in these form. Furthermore, I authorize "Nevada Orofacial Pain, TMJ and Sleep Clinic" to release information relative to my medical history, diagnosis and treatment to the named insurance company if asked to process the claim.

By typing your legal name, you are signing this agreement electronically and will serve as the legal equivalent of your manual signature. By inserting your legal name, you consent to be bound by this agreement's terms and conditions.

_____	_____	_____
PRINT LEGAL NAME	SIGNATURE	DATE

If patient is a minor, please sign as Parent or Legal Guardian

Signature:_____Date: _____

Parent or Legal Guardian

Print Name: _____

PATIENT FINANCIAL AGREEMENT

PLEASE READ THOROUGHLY and INITIAL/SIGN BELOW
In consideration of receiving services from "Nevada Orofacial Pain, TMJ and Sleep Clinic" you agree that:

1. _____ **Initial** All services are provided with the understanding that the patient is ultimately responsible for the treatment costs regardless of the insurance coverage, as not all services are a covered benefit.

2. _____ **Initial** Patients must notify this office if they have become a Medicare recipient.

3. _____ **Initial** Patients are responsible for full-payment of services rendered at each visit unless other financial arrangements are made. Patient is

responsible for submitting their own claims for reimbursement. Reimbursement amounts vary by insurance plan. The practice will not negotiate with insurance companies regarding claims or payments. The practice will provide a detailed receipt for potential reimbursement.

4. _____**Initial** Charges for attorney cases, workers compensation, accident and/or injury cases must be paid in full and in advance. This will be taken on a case by case basis as determined by the provider.

5. _____**Initial** If the patient does not take delivery of appliance, patient will be billed for costs. Patients are required to show up for follow-up visits to ensure that the appliance is properly adjusted or titrated and to check for any adverse effects related to the use of the appliance. The cost of the office visit can vary depending on the length of the visit and procedures performed. **Appliance fees are non-refundable**

6. _____**Initial** There is a fee for all paper record copies ($1 per page) and imaging ($15 per memory stick or CD).

For patients with contracted insurances:

I authorize "Nevada Orofacial Pain, TMJ and Sleep Clinic" to submit claims on my behalf for payment of services rendered to the named insurance company on this form. Furthermore, I authorize "Nevada Orofacial Pain, TMJ and Sleep Clinic" and to release information relative to my medical history, diagnosis and treatment to the named insurance company if asked to process the claim.

By typing your legal name, you are signing this agreement electronically and will serve as the legal equivalent of your manual signature. By inserting your legal name, you consent to be bound by this agreement's terms and conditions.

_____	_____	_____
PRINT NAME	SIGNATURE	DATE
_____	_____	_____

If patient is a minor, please sign as Parent or Legal Guardian

Signature:_____Date: _____

Parent or Legal Guardian

Print Name: _____

NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Date of Birth:_____

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this office may use your personal health information for the purpose of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing the consent form. You may request restrictions on the "restriction request" form, which we will provide if needed. You may revoke this consent at any time by signing and dating the revocation form, which we will provide if needed.

ACKNOWLEDGEMENT / CONSENT OF NOTICE OF PRIVACY PRACTICES

*I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also acknowledge that I am informed of "*Nevada Orofacial Pain, TMJ and Sleep Clinic*" Practice Privacy Policy and have been offered a copy.*

_____ _____

Signature of patient or patient representative Date

AUTHORIZATION FOR RELEASE OF PHI

I_____, hereby give Nevada Orofacial Pain, TMJ and Sleep Clinic authorization to discuss my medical condition and test results with:

Please list all the names and phone numbers as appropriate.

☐ No one but patient

☐ Spouse _____ Cell _____

☐ Mother _____ Cell _____

☐ Father _____ Cell _____

☐ Son(s) _____ Cell _____

☐ Daughter(s) _____ Cell _____

☐ Caregiver _____ Cell _____

☐ Other _____ Cell _____

_____ _____

Signature of patient or patient representative Date

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.

The Health and Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individual ally identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your heath care records for the purpose of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialist's involved n the continuation of your care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a medical and/or dental plan for your medical and/or dental services.

- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The rights to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.

- The right to request an amendment to your protected health information. We may deny your request in certain situations.

- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations or based on your previous authorizations.

- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 1, 2022 as we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal 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.

Privacy Officer: Dr. Shanna Kim
Office Name: Nevada Orofacial Pain, TMJ and Sleep Clinic
4840 Vista Blvd, Suite 108
Reno, NV 89436
Phone: (775) 362-9374

For more information or to file complaint:
Office of Civil Rights
200 Independence Ave., S.W.
Washington D.C. 20201
877-696-6775 (toll free)

(PATIENT'S COPY)

Patient Name:_____

COMMUNICATION CONSENT

Voicemails

□ I give NOPTSC permission to leave a detailed message with medically sensitive information on my voicemail at the phone number provided at check-in.

□ Please do not leave any detailed messages on my voicemail

Consent for Email Communication

I give permission to NOPTSC to communicate with me via email. I understand that this may include, but is not limited to, appointment reminders, treatment follow-ups, and general health information.

By signing this consent:

1. I understand that email is not a confidential method of communication. There is a risk that emails may be intercepted and read by unauthorized third parties.
2. I acknowledge that email should not be used for emergency communications or time-sensitive matters. For emergencies, I will call 911 or go to the nearest emergency room.
3. I agree to inform the clinic of any changes to my email address.
4. I understand that all emails to and from me may become part of my medical record.
5. I am aware that I can revoke this consent at any time by notifying the clinic in writing.
6. I agree not to use email for discussion of sensitive medical information.
7. I understand that the clinic will make every effort to respond to my emails in a timely manner, but immediate response is not guaranteed.
8. I release Dr. Shanna K. Kim and Nevada Orofacial Pain, TMJ and Sleep Clinic from any and all liability that may occur due to email miscommunication.

□ I give NOPTSC permission to send emails with medically sensitive information.

□ I do not wish to communicate via email. Please contact me via phone or mail only.

Patient Name:_____

Nevada Orofacial Pain, TMJ and Sleep Clinic's
SMS Text Messaging Terms of Service

These SMS Text Messaging Terms of Service (these "SMS Terms") are incorporated into all agreements between you and NOPTSC, *including any agreements that are preexisting and any agreements that might be enacted contemporaneously with these SMS Terms.*

NOPTSC *might use SMS text messaging, from time to time, for certain types of communication with you, including potentially for administrative issues, such as billing, or for health-related issues, such as care reminders.*

You agree to receive (you "opt in" to receiving) SMS text messages from Nevada Orofacial Pain, TMJ and Sleep Clinic, related to services that we are providing to you. Message and data rates may apply, and message frequency varies. You may text us STOP at any time to opt out of receiving SMS text messages from us. You may text us HELP at any time to receive help.

SMS text messages from Nevada Orofacial Pain, TMJ and Sleep Clinic may originate from our organizational phone numbers, including: (775) 362-9374. There may be terms in other agreements between you and us that also apply to our organization's use of SMS text messaging, such as general terms related to privacy and data handling for our organization that are not specific to SMS text messaging. You agree that you have reviewed all agreements that we have provided you.

□ I give Nevada Orofacial Pain permission to text detailed message with medically sensitive information at phone number provided at check-in.

□ Please do not leave any detailed text messages.

Signature: _____ Date: _____

If patient is a minor, please sign as Parent or Legal Guardian

Signature:_____Date: _____

Parent or Legal Guardian

Print Name: _____

Patient Name:_____

INFORMED CONSENT FOR TELEHEALTH SERVICES

Your appointment(s) with Dr. Shanna Kim will be using telehealth services.

As part of your treatment, remote patient visits may take place over certain platforms that allow for video chats, video, audio and/or photo recordings to be taken of you during the procedures or services.

Please protect your own privacy by being in a private location for this appointment. As always, our office will take your privacy very seriously and will do our best to protect the information you send us.

Some expected **benefits** of this telehealth visit could include:

- The ability to communicate with and be evaluated by your provider without needing to physically travel to the provider's office.
- The convenience of being able to communicate with your provider from a wide variety of locations.

Some possible **risks** of this telehealth visit might include:

- While we believe the risk of privacy breaches are not high, it may be greater than it would be if these services were provided in person. In certain instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In certain instances, lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- While telehealth visits are entirely sufficient in most cases, your provider may not be able to discover certain underlying conditions that they would be able to during a face-to-face office visit. In rare cases, problems such as poor resolution of images may not allow them to provide appropriate care.
- Delays in evaluation and treatment could occur due to lack of face-to-face visits, records or equipment. Equipment failures, such as dropping of calls, could occur during the session. In case of technology or equipment failures during the telehealth visit, all reasonable efforts will be made to resolve these failures.

Patient obligations and acknowledgements:

- I understand that my provider wishes me to participate in a telehealth visit and that the same standard of care applies to a telehealth visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my provider. I will be notified of and hereby give my consent if anyone is in the room with the provider.
- I understand that I have the right to withhold or withdraw my consent to use this platform during my care at any time, without affecting my right to future care or treatment.
- I understand my health care information obtained during the telehealth visit may be shared with other individuals for billing and scheduling purposes and to keep referring providers informed.

- I understand that the laws that protect privacy and confidentiality of health care information apply to telehealth services.
- I understand that while certain benefits of this telehealth visit may occur, health results cannot be guaranteed, and it may be necessary to conduct future telehealth visits or in-person visits for treatment.
- I understand that my insurance will not cover telehealth visits. I will be responsible for payment at the time services are rendered.
- I agree that any dispute arising from the telehealth consult will be resolved in Nevada and that that state law shall apply to all disputes.
- I have read this document in its entirety and have had an opportunity to ask questions. Each of my questions has been answered to my satisfaction. If I do not understand this document, I have been offered this document in a different language or have been offered a language interpreter. My family alone is not acceptable to be my interpreter.

Please sign and date below to confirm your agreement with the above statements and to provide your informed consent for the use of telehealth. You will receive a copy of this document for your records, and it will be included in your patient records.

Patient Signature:_____Date: _____

Print Name: _____

If patient is a minor, please sign as Parent or Legal Guardian

Signature:_____Date: _____

Parent or Legal Guardian

Print Name: _____