CA LICENSE: 28999
TAX ID: 20-3241393
CLINIC NPI: 1114107901
DR NPI: 1023297322

SAHARA CLINIC
Dr. Darrick E. Sahara
Chiropractic Kinesiologist

221 E. Walnut St., Ste. 125
Pasadena, California 91101
Tel: (626) 796-6830
FAX: (626) 796-6950
Web: www.saharaclinic.com
E-mail: saharaclinicdc@gmail.com

Patient Information

Welcome to our office. Please take a moment to tell us about yourself.

Personal Information

Last Name _____ First Name _____ M.I. _____

D.O.B _____ Social Security # _____ Driver's License # _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell / Message # _____

Age _____ Sex _____ Height _____ Weight _____ E-mail _____

If Minor, Parent or Legal Guardian _____

Employer Information

Employer _____ Business Phone # _____

Employer Street Address _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Who May We Thank for Referring You? _____

Health History (Please continue any part of this section on the back if you need more space to explain your health issues.)

Primary Reason for coming to Sahara Clinic _____

Is complaint due to an accident? ☐ Yes ☐ No Date of accident _____

List all allergies _____

List all medications / supplements you are currently taking _____

_____

_____

List any injuries, surgeries, or treatments you have had _____

_____

_____

Medical Physician's Name _____ Contact Phone # _____

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment. ***I understand it is my responsibility to update this information as needed. This includes changes in medical conditions, diagnosis, medications and personal & physician contact information***. I agree to be responsible for payment of all services rendered on me or my dependent's behalf.

Signature _____ **Date** _____
(patient / parent or guardian for minor)

DARRICK E. SAHARA, D.C., INC.
SAHARA CLINIC
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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY & COMPLETELY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (09/23/13), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose protected health information about you for treatment, payment, and healthcare operations. For example:

Treatment: You give permission for our doctor & clinical staff to perform any necessary procedures to properly complete diagnosis & treatment. We may disclose your medical and health information to our employees and others who are involved in providing the care you need. We may also share your health information with a third party such as another physician or another healthcare provider who does services that we do not provide.

Payment: We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. Therefore, if you decline to give us the necessary authorization(s), we may decline to treat you or to continue treatment if you revoke any authorization you have given us.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. However, you have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. We may receive payment for communications to you in relation to our provision, coordination, or management of your health care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your

health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership: If this practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another health practice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health: We may and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

PATIENT RIGHTS

Below are your rights with respect to your protected health information.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for each page, per hour for staff time to locate and copy your health information and postage will be added if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Breach Notification: In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

We reserve the right to change the terms of this notice at any time and we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You then have the right to object or withdraw as provided in this notice.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at Sahara Clinic and ask for the Office Manager.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office. Upon request, we will provide you with an address for the U.S. Department of Health and Human Services to file your complaint.

We support your right to the privacy of your health information. It is our policy not to retaliate in any way for anyone filing a complaint.

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Informed Consent for Sahara Clinic

All patients have the opportunity to discuss with Dr. Darrick E. Sahara and/or any other office personnel, the purpose and benefits of chiropractic kinesiology and other related treatments. Your questions should have been adequately answered and you are hereby requesting and consenting to chiropractic adjustments and other procedures to be performed on you by the doctor.

Chiropractic Kinesiology is not an exact science, and therefore, reputable practitioners cannot fully guarantee results. You acknowledge that no guarantee or assurance has been made by anyone regarding the treatments that you have requested and have authorized. You have had the opportunity to read this form and ask questions. Signing this form assumes that questions have been answered to your satisfaction and that you fully consent to the proposed treatment.

I affirm that the information I have been given above is correct to the best of my knowledge. **I hereby am giving my full consent for chiropractic treatment and other procedures by Darrick E. Sahara, D.C. of Sahara Clinic.** I hereby authorize the release of any information necessary for evaluating my condition and administering claims.

I hereby authorize payment to the Sahara Clinic for any treatment that has been given to me. I understand that I am responsible for payment in full for all my accounts. I have the right to revoke my consent at any time by giving written notice of my revocation. Please understand that revocation of my consent will not affect any action or treatment Sahara Clinic took before they received my revocation. If I revoke my consent, Sahara Clinic will decline to treat or to continue to treat me and I will be responsible for any outstanding bills.

Payment for your service is considered an integral part of your health benefits. To ensure uninterrupted care we appreciate your cooperation with the following:

1) Expect to pay your portion at the time service is rendered. An immediate change in your financial arrangement with this office may occur due to changes you make in your treatment plan.

2) Changes to any appointment should be made at least 48 hours in advance to avoid a service fee. Re-schedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule. Please be sure to read and understand our Cancellation Policy.

3) When you pay by check and your check is dishonored or returned for any reason, you expressly authorize this office to electronically debit your account for the amount of the check, plus a processing fee of $50 and any applicable sales tax. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms.

4) **We do NOT bill any insurance company, including Medicare**. Insurance Policies are not a guarantee or authorization of payment. They are the sole contracts between the subscriber and the subscriber's insurance company. Ultimate financial responsibility lies with you, the patient. Carefully review your "Explanation of Benefits" from your insurance company. Call your insurance carrier directly to resolve any discrepancies on your claims, to avoid unnecessary out of pocket expenses.

5) Financial arrangements are valid under your present condition. They are subject to renewal at the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office immediately prior to your care. Should you discontinue care or be released from further service at this office, all outstanding balances are due upon notification.

I have read and understand the above explanation of chiropractic kinesiology and related procedures. I also understand my financial responsibility for treatments. My questions have been discussed and answered. I hereby give my consent to treatments and release Darrick E. Sahara, D.C. and all other employees working or associated with the Sahara Clinic from all liabilities associated with the above procedures.

Print Name _____ Signature _____ Date _____

Print Repr. Name_____ Signature _____ Date _____
(For Minor or Handicapped)

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Explanation of Fees and Billing

Dr. Sahara is a non-participating provider with insurance companies. If you have an insurance plan (PPO, EOP, or Flex plan) that usually reimburses a patient for our services, we will provide you with a bill that includes procedural and diagnostic codes to submit to your insurance company. The insurance company may or may not reimburse you. We do not provide bills for HMO or "pre-authorization needed" type insurances (eg. Workman's Compensation). Our experience has been that these insurance plans do not cover our services or supplements. Most insurance companies do not cover the first exam/consultation, but will often cover a certain number of treatments. The doctor has been given permission to opt out of Medicare. Therefore, we do not bill Medicare. Dr. Sahara is not a provider because he does not want the insurance companies dictating the treatment for his patients. Please be aware that prices are subject to change at any time and treatment times vary according to the patient's needs.

For tax purposes, please save all paid bills and receipts of re-imbursements from your insurance company (if you are sending in claims). Please consult your accountant for further information about itemizing your medical expenditures and how you should pay for your medical expenses.

CONSULTATION		
Comprehensive	5 – 10 min	NO CHARGE (N/C)
DYNAMIC KINESIOLOGY (upon request)		To Be Determined (TBD)
TOTAL KINESIOLOGY		
Total Initial Exam	30 min	Pay Before Appointment $100.00
Total Initial Exam & Treatment First Visit/Comprehensive	90 min (1 1/2 hrs)	520.00
Deposit for Initial Exam & Treatment		50% Deposit 260.00
Chiropractic Adjustment Only	5 min	100.00
Chiropractic Initial Exam & Adjustment	20 min	150.00
AK Basic Treatment (1-2 Regions)	15 min	120.00
AK Detailed Treatment (3-4 Regions)	30 min	200.00
AK Extended Treatment (5 Regions)	45 min	240.00
AK Comprehensive Treatment (Extra Regions)	60 min (1 hr)	330.00
AK IntensiveTreatment	90 min (1 1/2 hrs)	420.00
AD Additional Time	120 min (2 hrs)	480.00
	150 min (2 1/2 hrs)	520.00
	180 min (3 hrs)	560.00
ADDITIONAL THERAPY		
Ortho Molecular Support – Supplements		TBD
Herbal Essences		Per Dose 10.00
Flower Essences		Each 50.00
Element Vials		50.00
OTHER SERVICES		
Cold Laser Treatment		Each Treatment 70.00
Detox – Biocleanse	1-5 sessions	50.00 – 150.00
Hyperbaric Oxygen Treatment (HBOT)	1-5 sessions 60 min (1 hr) each session	85.00 – 299.00
Counseling – Nutrition, Exercise, etc.	15 min	100.00
Testing – Muscle, Range of Motion, etc.	15 min	100.00
Copies of Past Bills		Each Bill 35.00
Letters		Minimum 350.00
Symptom Survey		70.00
Shipping and Handling		10.00 – 15.00

The billing practices have been explained to me and I understand that payment is due when service is rendered. All exam and consultation times are approximate since treatment and diagnosis depends on the patient's condition.

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Insurance Policy

How We Handle Insurance

Dr. Sahara is a non-participating provider with insurance companies. Our office has discontinued courtesy billing and we only provide PPO, EOP or Flex plan patients, with a bill that has the procedural and diagnostic codes necessary to submit a claim. The insurance company may or may not reimburse the patient. We do not give this type of bill to patients with HMO or "pre-authorization needed" type insurances (eg. Workman's Compensation) because you will not get reimbursement. Many PPO, EOP and Flex plan insurance companies do not cover the first exam, consultation or supplements, but will often cover a certain number of treatments. It is our policy to provide the patient with as much information and help necessary to receive payment. Please contact your insurance company's customer service for help in filing a claim.

Attention Medicare Patients: The doctor has been allowed to opt out of billing Medicare. We do not provide superbills or letters. Please see a staff member if more information is needed.

Dr. Sahara is not a provider of any insurance because his treatments are according to the patient's needs and not what the insurance companies dictate as the correct treatment. For tax purposes, please save all paid bills and receipts of reimbursements from your insurance company. Consult your accountant for further information about itemizing your medical expenditures and how you should pay for your medical expenses.

Payment is due when service is rendered.

We only accept cash or credit cards.

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Cancellation Policy

Dr. Sahara gives each patient undivided attention in his treatment. He does not double book appointments. When a patient misses an appointment at the last minute (less than 48 hour notice), a huge block of time could have been given to other patients who need his services. Therefore, we have found it necessary to have a cancellation policy.

NEW PATIENTS:
All new patients must give credit card information to be kept on file before making their first appointment. A deposit of $100 will be charged to the credit card provided. If the appointment is cancelled without at least a 48 hour notice, the deposit of $100 is applied as a missed appointment and is non-refundable. If the appointment is for an Initial Exam and Treatment, a full deposit to secure the appointment will be required. Deposits will be applied to your actual bill if the appointment is kept.

ALL PATIENTS:
First Missed Appointment:
A fee will be applied to appointments cancelled without at least a 48 hour notice. $100 is charged for a missed 1 hour appointment and $200 for a missed $1^1/_2$ hour or more appointment. This fee is a missed appointment fee and is non-refundable. Therefore, all patients must have a credit card on file or may make a deposit in person before the appointment. If a deposit has been made ahead of time, the deposit will be applied to the actual bill if the appointment is kept.

Second+ Missed Appointment:
After the first missed appointment, a full deposit to secure your appointment will be necessary. You may make the deposit in person or we can charge your credit card on file. Deposits are applied to your actual bill if the appointment is kept. If the appointment is missed or cancelled without 48 hours notice, the deposit will become a missed appointment fee and is non-refundable.

Tardiness to an Appointment:
If you are extremely late (15 minutes or more) to an appointment, please do not expect your full treatment time and you will be charged for the scheduled appointment. The doctor may have to reschedule your appointment if he does not have enough time to do your treatment and will charge your credit card on file a $100 missed appointment fee if the appointment needs to be rescheduled.

Please be aware that the patient is ultimately responsible for his/her appointment even though courtesy reminder calls are usually provided.

Sahara Clinic understands that dire emergencies do occur. If such an emergency happens, please discuss the situation with our office staff.

Credit Card Information on file with the Sahara Clinic by my permission.

Patient Signature _____ ***Date*** _____

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Supplements Policy

Supplements are recommended as an integral part of your treatment.

Unfortunately, we are unable to refund or exchange any supplements because they are temperature sensitive. Therefore, please keep them in a cool place and remember to take them out of your car. California and local health laws restrict the reuse of any opened container of food supplements or additives for consumption by the public.

Only a limited inventory of supplements are provided at our clinic because we want you to receive a fresh and potent supply. Supplements may need to be ordered and there will be a waiting period.

All supplements picked up at the Sahara Clinic are discounted. This means that we do not charge for tax or shipping and handling. You will be charged a shipping fee only if supplements are delivered to you at another address.

If you have any questions regarding supplements, please ask the doctor or the receptionist.

Thank you!

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of Sahara Clinic's:

1) HIPAA Notice of Privacy Practices _____**Initial**

I have received the "Notice of Privacy Practices" for Sahara Clinic and give my consent to the use & disclosure of my protected health information to carry out treatment, payment activities & healthcare operations.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

2) Informed Consent Policy _____**Initial**

I have received a copy of the "Informed Consent Policy" and acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized by Dr. Darrick E. Sahara, D.C.

3) Explanation of Fees and Billing _____**Initial**

I have received the "Explanation of Fees and Billing" for Sahara Clinic and understand that I am ultimately responsible for all charges on the date services are rendered. I consent to be financially responsible for rendered services. This consent is valid unless Darrick E. Sahara, D.C., Inc. (Sahara Clinic) is notified.

4) Insurance and Medicare Policy _____**Initial**

I have received a copy of the "Insurance or Medicare Policy" for Sahara Clinic and understand insurance billing is ultimately my responsibility and my insurance may or may not reimburse me.

5) Cancellation Policy _____**Initial**

I have received a copy of the "Cancellation Policy" for Sahara Clinic and understand that I will be responsible for any fees that are incurred from missing an appointment.

6) Supplements Policy _____**Initial**

I have received a copy of the "Supplements Policy" for Sahara Clinic and understand that supplements cannot be reimbursed, exchanged or returned, once they leave our office.

I agree to the above policies. I have the right to revoke my consent at any time by giving written notice of my revocation. Please understand that revocation of my consent will not affect any action Sahara Clinic took in reliance on this consent before they received my revocation. If I revoke my consent to these policies, Sahara Clinic may decline to treat or to continue to treat me. Also, please be aware that prices and policies of the Sahara Clinic may change.

_____

Print Name of Patient or Representative | Relationship to Patient

_____

Signature | Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, Informed Consent, Explanation of Fees & Billing, Insurance & Medicare Policies, Cancellation and Supplements Policies, but acknowledgement could not be obtained because:

- ❒ Individual refused to sign
- ❒ Communication barriers prohibited obtaining the acknowledgement
- ❒ An emergency situation prevented us from obtaining acknowledgement
- ❒ Other (Please Specify)_____