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
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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)