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

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)_____