SEIBERT CHIROPRACTIC
SHARON M. SEIBERT, D.C.
12344 Oak Knoll, Suite A
Poway, California 92064
Telephone: (858) 679-3777

PAYMENT AND OFFICE POLICIES

It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time of service.

As a courtesy to our patients, our office will be happy to verify and bill your insurance.

You (the patient) are responsible for all charges incurred in our office. First day chares will be paid in full at the time of your visit. Subsequent visits will remain on a self-pay basis until insurance has been verified. This policy does not exclude the patient from their co-payments or deductible.

Our office makes every effort to provide prompt care to our patients. If it becomes necessary to re-schedule an appointment, please call the office 24 hours in advance. If we are not available to assist you please leave a message. Patients cancelling or rescheduling the day of an appointment, or failing to show up for an appointment, will generate a $45 fee for cranial, laser, and chiropractic services, $80 fee for new patient exams, and $60 fee for massages.

PATIENT INITIALS

_____

OFFICE INITIALS

_____

If you are delayed and cannot arrive for your appointment on time, please call to advise us of your delay. Any significant delay may require the visit be rescheduled.

We understand there may be issues beyond your control and want to be understanding. In the event you have a special circumstance (i.e. death in family, hospitalization, or auto accident), please contact our office manager.

Additionally, there will be a 1.5% service charge applied to all outstanding balances 6 months after release from care. Should we find it necessary to file with Small Claims Court to collect these fees, all costs incurred will be added to your balance, per California Code Section 1717.5.

If you have any questions regarding your account, we will be glad to answer them.

I give permission to Dr. Seibert to communicate with my primary care physician as needed for my care and treatment.

I have read and understand the above policy. I have also read and understand the fee policy.

_____ _____ _____

PATIENTS SIGNATURE PRINT NAME DATE

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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 Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", 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.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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 14, 2003 and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Seibert Chiropractic
12344 Oak Knoll Rd., Ste. A
Poway, CA 92064
(858) 679-3777

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practice* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Informed Consent

Patient Name: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use a mechanical instrument or my hands upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

_x_ Spinal Manipulative Therapy	_x_ Palpation	_x_ EMS (Electrical Muscle Stimulation)
_x_ Range of Motion Testing	_x_ Orthopedic Testing	_x_ Cold Laser Therapy
_x_ Muscle Strength Testing	_x_ Postural Analysis	
_x_ Ultrasound	_x_ Hot/Cold Therapy	
_x_ Radiographic Studies	_x_ Vital Signs	
__ Other (Please Explain)	_x_ Neurological Testing	

_____

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contribution to serious complications including stroke. However, the instances of stroke are rare (1 in 1 million or 1 in 10 million). Some patients will feel stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination and treatment to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of

tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in a million and one in ten million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:
-Self-administered, over-the-counter analgesics and rest
-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
-Hospitalization
-Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I HAVE READ OR HAVE HAD READ TO ME THE ABOVE EXPLANATION OF THE CHIROPRACTIC ADJUSTMENT AND RELATED TREATMENT. I HAVE DISCUSSED WITH DR. SHARON SEIBERT, D.C. AND HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION BY SIGNING. BY SIGNING BELOW I STATE THAT I HAVE WEIGHED THE RISKS INVOLVED IN UNDERGOING TREATMENT AND HAVE DECIDED THAT IT IS IN MY BEST INTEREST TO UNDERGO THE TREATMENT RECOMMENDED. HAVING BEEN INFORMED OF THE RISKS, I HERE BY GIVE MY CONSENT TO TREATMENT.

Dated:_____

_____
Patient's Name

_____
Signature

_____
Signature of Parent/Guardian
(If a minor)

Dated:_____

___Dr. Sharon M. Seibert___
Dr. Sharon M. Seibert, D.C.

_____
Doctor's Signature

Seibert Chiropractic
12344 Oak Knoll Rd. Ste A
Poway, CA 92064

Electronic Health Records Intake Form

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

For Office Use Only:

Alerts Input: Provider___ Front Desk:_____

Family Hx:_____

Meds Input:____

Allergies Input: ____

Vital Input: notes: ____ Dashboard:___

Office Manager Check: _____

Ok to Scan in:_____