Pittsburg Chiropractic Center

Dr. Jennifer M. Girth, D.C., B.S.

302 E 4th St Ste. E Pittsburg, KS 66762

(620) 232-6555

SAAT

PATIENT INFORMATION

Name (First, Middle, Last)_____

Guardian Name (If applicable) _____

Phone (H) _____ (W) _____ (C) _____

Home Address_____

Street City State Zip Code

Date of Birth: _____/_____/_____ Age: _____ Sex:_____ Weight:_____ Height:_____

Social Security #_____ Email Address (Optional) _____

In case of emergency contact:_____Phone: _____

Employer_____ Occupation _____

Name of Primary Care Physician _____

Name of Referring Physician (if applicable): _____

PATIENT FINANCIAL AGREEMENT

- Cancellation of appointments needs to be done at least 24 hours in advance, otherwise you will be billed a $50.00 no show fee.
- There is a $25.00 fee for all administrative/consultative letters requested on behalf of the patient for school, administrative, and legal services.
- A $40.00 fee will be charged to all patients for any returned checks.
- A minimum fee of $25 will be charged to the patient if this account should be sent out for collection.
- Should this account be referred to an attorney, a collection agency, or court, I agree to pay all collection/attorney fees that may be incurred by Dr. Girth in connection therewith or any other fees or expenses incurred by Dr. Jennifer Girth in relation to this account. If my account is delinquent, I agree to pay interest on the full outstanding balance at the maximum rate allowed by law.
- I understand that Jennifer Girth, D.C. *does not* accept any form of health coverage for SAAT treatments and that I am fully responsible for self-pay to Dr. Jennifer Girth or Pittsburg Chiropractic Center, LLC the full charges of all services rendered at the time of the appointment.
- A copy of this agreement may be used in place of the original.

Signature _____ Date _____

History Intake

Name:_____ Date_____

When did your Alpha-gal symptoms first start: _____

Date of Alpha-gal Diagnosis: _____ DX through: Blood Test Symptoms Not Sure

If diagnosed through blood work what was your original IgE levels of Alpha-gal in the blood: _____
Have you had any follow up labs since original Alpha-gal testing was done: **YES** **NO** If so results:_____

Which Alpha-gal containing Foods, by-products, Fumes, RX drugs, OTC drugs, Household products, Personal care products, Vitamins, etc. **trigger** an Alpha-gal reaction and what type of response do you have? (ex: hives, nausea, vomiting, runny nose, anaphylactic, fatigue, etc.) Please list the most severe to least severe.

	Current Triggers	**Response**
1.		
2.		
3.		
4.		
5.		

If your Alpha-gal gets triggered what do you use for treatment (Allergy Meds, EpiPen, Zantac, rest, etc.):_____
_____

Do you live on a farm: YES NO If YES, what kind of animals live there: _____

Have you ever been diagnosed with Lyme Disease? YES NO

Do you have an allergy to:

Stainless Steel: **YES NO** If yes what type of reaction do you have:_____

Glues/Adhesives: **YES NO** If yes what type of reaction do you have:_____

Alcohol (Isopropyl or Grain): **YES NO** If yes what type of reaction do you have:_____

Allergies: (excluding Alpha-gal allergens)
Environmental: _____
Drug/Food: _____

Any other information that you would like us to know about your condition: _____
_____
_____
_____
_____

Please circle any of the following that may cause a trigger, allergic reaction or sensitivity:

Avocado	Gelatin	Pork	Vinegar
Beef	Glycerin	Red Dye 40	Vitamin D
Bison	L-Cysteine	Rosemary Extract	Xanthan Gum
Cane Sugar	Lanolin	Sesame Oil	Toilet Paper
Bottled water	Lamb	Sesame Seed	Hand Soap
Carrageenan	Lemon	Soy	Pasta
Cowmilk (Milk)	Pudding	Stearic Acid	RX medicines
Deer	Magnesium Stearate	Sulfates/Sulfites	OTC meds
Di-Glycerides	Marshmallow	Toothpaste	Body wash
Eggs	Lime	Taurine	Cosmetics
Enriched Flour	Mono-Glycerides	Tomatoes	Shampoo/Conditioner
Garlic	MSG	Tri Calcium Phosphate	Laundry Detergent
Shaving Cream	Deodorant	Chapstick	Lactose
Tuna or Salmon	Cheese	Dogs	Lidocaine patch
Gummy Vitamins	Gummies (Candy)	Face cream	Facial Cleaners
Hair Spray	Styling Gel	Gel Nail Polish	Lotions
Leather	Teeth Whitener	Kleenex	Glue
Pop-Tarts	Toaster Strudels	Cats	Frosting
Wine	Fruit Juices	Gravies	Soups
Jelly	Syrup	Starburst	Altoids
Air Fresheners	Popsicles	Peanuts	Cashews
Walnuts	Perfumes	Protein Drinks	Protein Bars
Chewing Gum	Candles	Pecans	Jellybeans
Pie Filling	Beer	Bar Soap	Bath Salts
Face Serums	Dryer Sheets	Shrimp	Razors

Please list the Brand/Brand Names of the following that you currently use:

Laundry Detergent:_____

Fabric Softener/Dryer Sheets: _____

Hand Washing Soap: _____

Body Wash/Bar Soap: _____

Body Lotion: _____

Shampoo: _____

Conditioner: _____

Deodorant: _____

Toothpaste: _____

Mouthwash: _____

Shaving Cream: _____

Toilet Paper: _____

Dish Soap: _____

Dish Washer Soap: _____

Makeup: _____

Facial Cleansers/Moisturizers: _____

Perfume/Cologne: _____

Cleaning Supplies: _____

FOOD/MEDS:

White Sugar: _____

Bottled Water:

_____

Coffee Creamer: _____

Multi Vitamin: _____

Vitamin D: _____

Pain Reliever: _____

Ketchup: _____

Mayo: _____

Milk/DF Milk: _____

Dog Food/Cat Food main ingredient: BEEF CHICKEN SALMON LAMB VENISON BISON

List all current medications:

Habits:

___**Smokes**: Packs Daily_____How Long:_____ When Stopped_____
___**Alcohol:**_____ ____**Coffee:** Cups Daily_____ ___**Caffeine**: _____

General: Mark any applicable problems:

___ Vertigo/Dizziness Explain:_____

___	Forgetfulness	___	Glaucoma	___	Cataracts
___	Numbness	___	Tinnitus	___	Excessive Tearing
___	Photophobia	___	Earache	___	Nosebleed
___	Migraines	___	Deafness	___	Sinusitis
___	Hair Problems	___	Eye Dryness	___	Excess Mucous
___	Skin Problems	___	Eye Twitching	___	Increased Salivation
___	Headaches	___	Weak Vision		

___ Teeth and Gums Problems: Describe:_____

___	Recurrent Sore Throats	___	Mouth Inflammation	___	Teeth Grinding
___	Tongue and Lip Sores	___	Mouth Pain	___	TMJ problems

CARIOVASCULAR:

___	Hypertension	___	Varicose Veins	___	Congenital heart disease
___	Hypotension	___	Murmur	___	High Cholesterol
___	Fainting	___	Swelling of Hands/Feet	___	Congestive heart failure
___	Palpitation	___	Heart attack/Stroke	___	Blood Clots
___	Chest Pain	___	Angina	___	Arrhythmias

RESPIRATORY:

___	Shortness of Breath	___	Asthma	___	Recurrent Respiratory Tract Infection
___	Chronic Bronchitis	___	Tuberculosis	___	COPD

GASTRO-INTESTINAL:

___	Gastric Ulcers	___	Nausea and Vomiting	___	Colitis	___	Esophageal Reflux
___	Diarrhea/Constipation	___	Belching	___	Hemorrhoids	___	Hepatitis
___	Gall Bladder Disease	___	Hepatitis	___	Gas	___	Duodenal Ulcers

ENDOCRINES:

___	Hypothyroidism	___ Hyperthyroidism	___ Diabetes Mellitus

___ Others:_____

URINARY:

___	Pain on Urination	___	Excessive Urination at night	___	Frequency
___	Bladder Disease	___	Kidney or Bladder Stones	___	Kidney Disease

CONSENT FOR COMPLEMENTARY AND ALTERNATIVE EVALUATION & THERAPY

I, the undersigned below request and agree to holistic evaluation and treatment. Through alternative medicine approaches which may include Homeopathic/Dietary Supplements/Herbal/Acupuncture and other complementary and alternative approaches. I understand that there is a lack of sufficient scientific data to support the efficacy of these approaches. I understand that a traditional consultation is needed prior to the alternative medicine evaluation. I understand that the fees for Traditional Medical Consultation are separate from the fee for Holistic Evaluation. I also understand that the fees do not include the cost of any alternative medicine treatment, which includes alternative medicine remedies or approaches. I understand that I will be financially responsible for all services rendered and products received and/or ordered at the time of the visit.

_____
Please initial

I consent that I knowingly, intelligently, and voluntarily accept the risk of the treatment provided with due care. I also understand that it is best to combine these approaches with Conventional Medical Treatment. If I choose to abandon Traditional Medical Treatment exclusively in favor of Complementary and Alternative Therapy approaches, I consent that I do so against the advice of Dr. Jennifer Girth and take full responsibility for this decision.
I understand that I will continue to monitor my condition through Conventional Medical treatment as well as Complementary and Alternative Medicine; I will do so by consulting with both Dr. Jennifer Girth and my family physician.

I consent that I have been advised by Dr. Jennifer Girth not to eliminate or delay my Conventional Medical treatment without consulting with my family doctor.

I understand that it is necessary for me to have a Traditional Medical Consultation and history intake prior to any alternative medicine evaluations or therapies. I understand that this is a separate charge from any alternative medicine evaluations or therapies and that I will be responsible for payment of this service. The cost of these services has been fully discussed with me and I agree to be financially responsible for this cost. I consent that the charges have been fully discussed with me in advance of the evaluation and treatment. I also understand that payment for such services is due at the time of service.

_____ Date: _____
Signature

_____
Witness

CONSENT FOR COMPLEMENTARY AND ALTERNATIVE THERAPY APPROACH PART II

My physician Dr. Jennifer Girth has clearly discussed in detail the nature and purpose of the treatment, the expected benefits, potential side effects, and risks of Complementary and Alternative Medicine. All the risks and benefits of Complementary and Alternative Medicine versus Conventional Medical Care have been discussed. I consent that I knowingly, intelligently, and voluntarily accept the risk of treatment provided with due care. I also understand that it is best to combine these approaches with Conventional Medical Treatment. If I choose to abandon Traditional Medical Treatment exclusively in favor of Complementary and Alternative Therapy approaches, I consent that I do so against the advice of Dr. Girth and take full responsibility for this decision. I verify that neither Dr. Jennifer Girth nor any of her staff have given me any guarantees or promises with respect to the outcome of the Complementary and Alternative treatment of SAAT (Soiman Auricular Allergy Treatment). I also understand that some Acupuncture treatment devices are considered investigative devices.

Signature _____ Date: _____

Witness _____

Consent to SAAT (Soliman's Auricular Allergy Treatment)

Treatment Description

SAAT (Soliman's Auricular Allergy Treatment) is a specialized form of allergy treatment through the ear micro system whereby Pittsburg Chiropractic Center uses auricular medicine to determine a point in the ear that corresponds to a specific allergen. A sterile, single-use Spinex needle is then inserted transdermally in the allergen point to the right ear by a state licensed healthcare professional. The needle should be left in place for approximately 3-4 weeks depending on what allergens are being treated.

Voluntary

I hereby voluntarily consent to be treated in the SAAT protocol. I understand I will be treated with a small semi-permanent needle/needle (taped in my ears) that should be left in the ear for approximately three weeks. I have not been guaranteed any success concerning the uses and effects of SAAT. I understand I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reaction

I understand that SAAT may result in certain side effects including: local bruising, slight bleeding, fainting, temporary pain and discomfort, and/or temporary aggravation of symptoms existing prior to treatment. Be aware that it may become necessary to seek conventional medical treatment if the site were to become infected. It is the client's responsibility to keep their ears dry and free from contaminants.

Medical Referral

I understand if there is a worsening of my ailment or condition or if a new ailment or condition arises, that I should consult a licensed physician and/or seek immediate medical attention. Pittsburg Chiropractic Center does not recommend the discontinuation of any ongoing current medications or medical treatments without speaking to your licensed physician or provider.

Infections Disease/Clean Needle Procedures

I understand that infectious diseases may be carried through the air, through physical contact, and through body fluids. I understand that SAAT practitioners follow the prescribed national standards of Universal precautions to guard against the spread of infection through the use of sterilized/prepacked disposable single-use needles.

Signature _____ Date: _____

Witness _____

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 Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law 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.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes 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.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your medical plan for your medical services.
- 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 include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state, or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you for the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary facilitates organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the President, other officials, or foreign heads of state, or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an Inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers compensation and similar programs.

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 certain rights with regard to your protected health information, which you can exercise by presenting a written request to our privacy office at the practice address listed above.

- 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 request 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 right to access, inspect and copy your protected health information
● The right to request an amendment to your protected health information
● The right to receive an accounting of disclosures of protected health information outside of treatment, payment, and health care operations.
● 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. 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, written complaint with us at the address above, 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.

For more information about HIPAA or to file a complaint
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
877/696-6775 (toll-free)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____ have been given the opportunity to review a copy of the
Patient Name
Notice Privacy Procedures for the office of Pittsburg Chiropractic Center, LLC and Dr. Jennifer M. Girth.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness Date

PERMISSION TO DISCUSS

I, _____, give Dr. Jennifer Girth-Chism, DC., permission to discuss the following information:

_____ Test Results
_____ Billing Information
_____ Diagnosis, prognosis, and/or treatment information
_____ Prescription information
_____ All of the above
_____ Other (please specify): _____

With the following people:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Signature of Individual or Guardian or Personal Representative of Patient's Estate

_____
Date

***Note: THIS FORM MUST BE FILLED OUT IN ORDER TO ENSURE THE CONFIDENTIALITY OF OUR PATIENT'S MEDICAL RECORDS

NOTICE OF NON-COVERAGE

ATTENTION: Dr. Jennifer Girth-Chism does **not** participate with any health provider coverage for acupuncture/SAAT treatments.

SERIVCES:	*Estimated Cost:
Traditional Medicine Consultation	$250.00
Holistic Evaluation	$250.00 Holistic eval $50 follow-up each visit for one year. $50 for additional evaluation time $250.00 biannual re-evaluation fee
Dietary Product Evaluation (up to 8 items)	$100.00
FULL Allergy Evaluation: Food or environmental	$250-$350 (does not include holistic eval)
Auricular Allergy Needle Treatment **Auricular Needle Treatment** (other)	$25 per needle $25 per needle
SAAT Intake + 4 allergies	$250
SAAT Follow-Up Appointment *(does not include needles)*	$100
Acupuncture treatment	$40
Homeopathic/Dietary Supplements	Can range from $100-$2,000
Electrical Stimulation	$25.00

*Prices effective 10/16/2024

Please ask us any questions that you may have!

Signing below means that you have received this notice and that you understand the fees listed above.

Patient Name: _____

Patient/Guardian Signature _____

Date _____

Pittsburg Chiropractic Center

Office Policy for late arrivals, missed appointments, and cancellations.

At Pittsburg Chiropractic Center, we pride ourselves in offering you personalized care and reserved appointment times to accommodate your needs. Late arrivals, missed appointments, or cancelled appointments without sufficient notice create a gap in our providers' schedule. These are appointments that could have been utilized to offer care to another patient.

Late Arrivals: If a patient arrives **more than 5 minutes late** for an appointment, without proper notification the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day, if one is available; otherwise, you may have to reschedule.

New Patients: Need to arrive a minimum of **15 minutes** prior to their scheduled appointment time, this is to complete your new patient paperwork and the registration process. If you arrive late, you may be asked to reschedule.

If you are a **New Patient** and you arrive at the scheduled appointment time **without** the completed new patient paperwork, you may also be asked to reschedule.

Last Minute Cancellations and Missed Appointments: We do require 24-hour notice on all cancellations. As a courtesy to our patients, we attempt to confirm all appointments. We do recognize that situations arise that are out of your control; however, it is imperative that you contact our office immediately to notify us of your cancellation in a timely manner. Appointments cancelled with less than a 24-hour notice or missed appointments will be subject to a $50.00 fee.

If it is your first time cancelling with less than 24 hours' notice or missing an appointment with our office, there will be no charge. Any future last-minute cancellations or missed appointments will be assessed with a fee of $50.00.

If you are a **New Patient** and you No-Show to your initial appointment, you will not be allowed to reschedule.

We will try to accommodate late-comers in the best manner possible but cannot compromise on the quality and timely care provided to our other patients. If a patient presents to the office 10 minutes late for a scheduled appointment with our provider, the patient will be asked to reschedule their appointment.

I, _____ have been given the opportunity to review a copy of the office policy for late arrivals, missed appointments, ,and cancellations and I fully understand and agree to this policy.

_____ _____

Signature of Patient/Guardian Date