Pittsburg Chiropractic Center

SAAT

Dr. Jennifer M. Girth, D.C., B.S.
302 E 4th St Ste. E Pittsburg, KS 66762
(620) 232-6555

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_____ Social Security #_____

Email Address (Optional) _____In case of emergency contact_____

Employer_____ Occupation _____

Name of Referring Physician _____

Name of Primary Care Physician_____

PATIENT FINANCIAL AGREEMENT

- Cancellation of appointments needs to be done at least 24 hours in advance, otherwise you will be billed a $100.00 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 2-week turn around for completing requested forms or copies of charts is kindly requested. If you require copies of any portion of or your entire chart Maryland's medical record law was amended in 1994 to allow a patient or "person in interest" access to his/her chart when requested in writing. Health General Article 4-304 also sets forth a maximum fee for copying the record and permits an annual adjustment for inflation based on the CPI. Preparation fee is $22.88 & copy fee is $.76 per page.
- 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 to pay Dr. Jennifer Girth 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_____

Age:_____ Sex: ____Male ____Female Weight:_____ Height:_____

Allergies: Environmental:_____
Drug/Food Allergy:_____
Alcohol Allergy: Yes or No Metal Allergy: Yes or No Adhesive Allergy: Yes or No

Current Health Problems (List in order of importance, most important first) Date Problem Started
1.
2.
3.
4.
5.
6.

M**AIN COMPLAINT (please describe in some details):**
Alpha-Gal Patients what foods will trigger your alpha-gal & what foods do you avoid?

Treatment received up-to-date for your current problem:

List all current medications:

Check all treatment received in the past or being currently received:

___ Bed Rest ___Hypnosis ___Acupuncture
___Traction ___Chiropractor ___Epidural blocks
___Nerve blocks ___Electrical stimulation ___Heat treatment
___Exercise ___Surgery

Habits:

___Smokes: Packs Daily_____ How Long:_____ When Stopped_____
___Alcohol_____ ____Coffee: Cups Daily_____
___Recreational Drugs_____ ___Drug Abuse History_____

FAMILY HISTORY:

___ Heart Disease ____ Glaucoma ____ Thyroid Condition
___ Hypertension ____ Diabetes ____ Mental Illness
___ Stroke ____ Kidney Disease ____ Bleeding tendencies
___ Cancer ____ Epilepsy

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 ___ Rheumatic fever
___ Chest Pain ___ Angina
___ Blood Clots ___ 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
___ Gall Bladder Disease ___ Hepatitis ___ Gas
___ Hemorrhoids ___ 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

Genital:

Female:

___ Pregnancies #: _____ Normal or Abnormal
Age Periods Started: _____ Length of Cycle: _____ Duration of Flow: _____
___ Regular ___ Irregular ___ Infections
___ Pain Durning Periods ___ Age at Menopause _____
Flow: ___ Light ___ Medium ___ Heavy

Male:

___ Premature Ejaculation ___ Prostatitis ___ Impotence ___Other:_____

MUSCULO-SKELETAL:

___ Muscle Pain ___ Gout ___ Back Pain ___ Others
___ Osteoporosisi ___ Neck Pain ___ Arthritis

NEUROLOGICAL:

___ Seizures ___ Neuropathies ___ Stroke ___ Other:_____

LIST OF ALL SURGICAL OPERATIONS:	**YEAR:**
1.	
2.	
3.	
4.	
5.	
6.	

CONSENT FOR COMPLEMENTARY AND ALTERNATIVE EVALUATION AND 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. Soliman 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-Chism and my family physician.
I consent that I have been advised by Dr. Jennifer Girth-Chism 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-Chism 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. Soliman and take full responsibility for this decision. I verify that neither Dr. Soliman nor any of his staff have given me any guarantees or promises with respect to the outcome of the Complementary and Alternative treatment. I also understand that some Acupuncture treatment devices are considered investigative devices.

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 Notice of Privacy Procedures
Patient Name
for the office of Dr. Jennifer Girth-Chism.

_____ _____
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

REQUEST FOR MEDICAL RECORDS

I hereby request from:

Physician's Last Name:_____

First Name: _____

Physician's Phone#:_____

Fax Number: _____

Address:_____

To release my medical records as requested below to Dr. Nader Soliman at the above mentioned center. Most recent history and physical Most recent lab tests Most recent X-rays and MRI result if applicable

Patient's name:_____ Date:_____

Signature:_____

Witness_____

NOTICE OF NON-COVERAGE

ATTENTION: Dr. Jennifer Girth-Chism does not participate with any health coverage provider 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 (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	$50 + $25/needle
Homeopathic/Dietary Supplements	Can range from $100-$2,000
Acupuncture Treatment	$40

*Prices effective June 16, 2023

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 _____

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Appointment Deposit Policy

We do our best with reminder texts or calls, but it is ultimately your responsibility to show up for your scheduled appointment. If you can not make your appointment you must call us at 620-232-6555 and talk with the receptionist or leave a voicemail at least 48 hours prior to your scheduled appointment. Social media contact to cancel will not be accepted.

Scheduling Deposit Fee

To confirm your desired appointment, a $100.00 deposit fee is required at the time of booking all SAAT & Auricular Medicine appointments to guarantee your reservation. If the appointment is kept, the deposit is applied as a credit for future appointments/procedures. If the appointment is missed, the $100.00 deposit is non-refundable and will be applied to the cancellation fee (unless 48-hour notice is given).

Cancellation

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill the appointment time and clients on our waiting list miss the opportunity to receive services they need. We ask all new and established client's supply a credit card to have on file. All cards on file are added to the system via a secure electronic process that ensures the information is encrypted and remains secure. In the event we do not receive the required notice for adjustments and cancellations, the following fees will occur on your card or billed to you in the event the card is declined:

- Your first no-show or notification given less than 48 hours prior to your appointment will result in Pittsburg Chiropractic Center keeping your deposit. You will not be able to apply that money to future appointments.

- Your second no-show or notification given less than 48 hours prior to your appointment will result in you being charged for 50% of the scheduled service, regardless if the service is pre-paid.

- Your third or any following no-show or notification given less than 48 hours prior to your appointment will result in you being charged for 100% of the scheduled service.

Payment

Payment for all individual treatments are at the time of treatment. You may choose to prepay for your individual treatment. We do not offer financing or payment plans. All services are final sale; there are no refunds issued for any services. We accept cash, Visa, MasterCard, and Discover; we do accept checks but if the check is returned there will be a returned fee of $35.

- Your first no-show or notification given less than 48 hours prior to your appointment will result in Pittsburg Chiropractic Center deducting the $50.00 deposit.

● Your second no-show or notification given less than 48 hours prior to your appointment will result in you being charged 50% of the scheduled service before you can book your next appointment, or we can take the amount off of your package.

● Your third or any following no-show or notification given less than 48 hours prior to your appointment will result in you being charged for 100% of the scheduled service.

Late Arrival

We suggest arriving 5-10 minutes prior to your appointment time to allow time to complete paperwork or answer questions about your service that you may have. We understand that issues may arise that may cause you to be late for your appointment. However, we ask that you call to inform us if that ever occurs, so we can do our best to accommodate you. Appointment times are reserved for each client, so oftentimes we cannot exceed that reserved time in order to be timely for the next patient. If you arrive more than 10 minutes late, your appointment may be shortened or canceled if there is not enough time to complete the procedure.

Please ask us any questions that you may have!

Signing below means that you have received this notice and that you understand the policy and agree to the policies listed above.

Patient Name: _____

Patient/Guardian Signature _____

Date _____