Fitness Genome Tayebjee Chiropractic Neurology Center
1905 Calle Barcelona Suite, 234 Carlsbad, CA 92009
Phone: 858-208-0710
Email: infochiro@fitnessgenome.net

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic only has one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusions or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, results in a lessening of the body's innate ability to express its maximum health potential.

Chiropractic care like all forms of health care, while offering considerable benefit may also provide some level of risk. The level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition and rarely, fractures. One of the rarest complications associated with chiropractic care, occuring at a rate between one instance per one million to one per two million cervical spine (neck) adjustment may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care from Fitness Genome Tayebjee Chiropractic Neurology Center, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify you care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with your care plan prior to beginning care.

It is important to note, we do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxation or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, wed do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

_________________________________ _________________ ______/______/_____
Signature of patient Printed name Date

____ ___________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Agreements and Authorizations

Consent to Health Care Services
____ has been accepted as a patient to be seen at Fitness Genome Tayebjee Chiropractic Neurology Center. You, (the undersigned Patient, or undersigned person responsible for consenting on the Patient's behalf) hereby request and consent to Patient health care services (including any clinically appropriate examination and therapeutic procedures, as determined by the clinical staff) from Fitness Genome Tayebjee Chiropractic Neurology Center. The patient health care services will be provided by licensed health care practitioner. Health care services will also be provided by non-healthcare professionals employed, under contract, or otherwise retained by Fitness Genome Tayebjee Chiropractic Neurology Center. Medical, nursing, and other health care personnel who are in training may also participate in the patient's care as part of their education. These individuals will potentially observe all examination and treatment procedures.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Fitness Genome Tayebjee Chiropractic Neurology Center. The procedures ordered by the staff clinicians is recommended because the potential benefits are greater than the potential risks.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a prevention/cure or outcome for any illness, disease, or injury has been given. While the Fitness Genome Tayebjee Chiropractic Neurology Center's staff

will attempt to work with any patient we feel we can assist in optimizing or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that neither the patient or any assigns will hold Fitness Genome Tayebjee Chiropractic Neurology Center, its staff, or its volunteers liable for any actions, non-actions, or outcomes associated with diagnosis, treatment and/or recommendations of the staff

_____________ initial

Consent To Release of Information

Here at Fitness Genome Tayebjee Chiropractic Neurology Center we respect your privacy, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Fitness Genome Tayebjee Chiropractic Neurology Center to release to appropriate agencies or persons, any information acquired in the course of your or the above-named patient's examination and treatment. This information may be stored and transmitted electronically using appropriate safeguards and/or data encryption.

For more information, please see the HIPAA authorization form and privacy notice, or feel free to ask a member of staff should you need clarification.

_____________ initial

Cancellation/No Show Policy

We acknowledge there may be times when you miss an appointment due to emergencies or obligations to work or family; however, we urge you to call 24 hours prior to cancelling your appointment.

Our opportunities to treat patients are limited by our treatment regime, therefore the patient and/or his/her guardian(s), or legally responsible person(s) also acknowledge that if the patient No Shows for more than two appointments that they may be dismissed from care. The practice will notify you if you are discharged from care.

_____________ initial

Payment Guarantee

In consideration of the services provided by Fitness Genome Tayebjee Chiropractic Neurology Center provider to patient, you agree to: 1)guarantee payment of all charges incurred by patient in connection with such services "patient charges"; 2) irrevocable assign and transfer to Fitness Genome Tayebjee Chiropractic Neurology Center all right, title and interest to medical reimbursement benefits to which patient is entitled for the purpose of payment of patient charges; and 30 authorize payment of such benefits directly to Fitness Genome Tayebjee

Chiropractic Neurology Center You also agree to be fully responsible for the payment of any and all patient charges to the extent that these charges are not satisfied by the assigned benefits.

The services you have elected to participate in implies complete financial responsibility on your part. The financial responsibility obligates you to ensure payment in full of our fees and the costs of all testing, including laboratory and other outside tests. We expect these payments at the time of service.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that at no time will Fitness Genome Tayebjee Chiropractic Neurology Center be obligated to communicate or bill any insurance company. We will provide you with a detailed statement of services should you wish to seek reimbursement independently.

While your specific treatment plan is determined by the clinical staff. The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that all costs specific to transportation, lodging, and travel expenses are to be borne by the patient and/or his/her guardian(s), or legally responsible person(s).

I have read the above policy regarding my financial responsibility to Fitness Genome Tayebjee Chiropractic Neurology Center for providing services to myself or the above-named patient. I certify the information is, to the best of my knowledge, true and accurate. Payment in full and the entire amount of bill incurred by me or the above-named patient is due prior to service rendered.

_____________ initial

Communication:

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree to communicate with Fitness Genome Tayebjee Chiropractic Neurology Center and its staff regarding health information utilizing the following methods:

❑ Email; please provide the address: ____

❑ Voicemail; please provide number: ____

❑ Standard mail; please provide the address: __________________________________

❑ Fax; please provide number: ____

Name of any person(s) allowed to communicate with Fitness Genome Tayebjee Chiropractic Neurology Center: ______________________ Relationship to patient: ________________________

______________ initial

Experimental Therapy Statement

Some of the devices and therapies used at Fitness Genome Tayebjee Chiropractic Neurology Center are proprietary and/or are in the process of gaining regulatory approval. While they are thought by our clinical staff to have a positive effect, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

- Compounded infusion formulas for the treatment of specific conditions.
- Various compounded nutritional and dietary and supplemental usage combined with conventional medical care.

Additionally, the nutraceuticals and supplements offered may contain elements that have not been assessed by the Food and Drug Administration. While none of these, in the opinion of the clinical staff, pose an unbalanced risk or are Inherently unsafe, we as healthcare providers feel you should be made aware that they may not have been proven effective in treating your specific condition.

_____________ initial

I have read and acknowledge all above statements; all of my questions have been answered to my full satisfaction in a way that I can understand, and by initially beside each section agree to the terms listed above. By signing below, I am authorizing that the information in this form has been read and filled out completely and accurately to the best of my understanding and I agree to comply to the terms listed above.

_________________________________ ______________________ _____/______/_____
Signature of patient Printed name Date

____ ___________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Video and Photography Consent

Occasionally Fitness Genome Tayebjee Chiropractic Neurology Center will conduct filming and/or photography for promotional materials as well as for training purposes. The patient and/or their legal guardian is responsible for ensuring they are not incidentally recorded should they refuse this consent. The staff at this facility will never attempt to employ hidden or covert means to record any patient without their knowledge.

Educational Usage

In consideration that Fitness Genome Tayebjee Chiropractic Neurology Center partners with educational organizations, we request your consent to film or record various aspects of your treatment. We also request your consent to use information related to your condition or care in

the training of staff and/or students. Any protected health information (PHI) will be removed or redacted from any documents used in this manner.

Promotional Usage
While relatively uncommon, we will ask to record patients for testimonials or photograph for promotional materials. General information may be shared such as a brief description of your condition, your first name and/or initials and statements you may wish to make. Should you be asked and agree to provide a testimonial, there will be no reimbursement and the product, including the rights to use your likeness, will become the sole property of FGTCNC.

You are free to refuse your consent to be recorded or photographed with **NO EFFECT** on your care.

I have read the above policies and wish to give my consent to:
__ Both educational and promotional usage.
__ Only educational usage.
__ None of the above.

_________________________________ ______________________ _____/______/_____
Signature of patient Printed name Date

____ ___________________
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Patient Acknowledgement
For use and/or disclosure of Protected Health Information (PHI) to carry out Treatment, payment and Health Care Operations.
I ________________________________, hereby state that by signing this consent I acknowledge and agree as follows:

1) The practice's privacy notice has been provided to me prior to my signing this consent. The privacy notices include a complete description of the uses and/or disclosure of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the privacy notice would be available to me in the future at my request. The practice has further explained my right to obtain a copy of the privacy notice prior to signing this consent, and has encouraged me to read the privacy notice carefully prior to my signing this consent.
2) The practice reserves the right to change its privacy practice that are described in its privacy notice, in accordance with applicable law.
3) The practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the practice's website. I may also request a copy from this office at any time via US Mail.

4) This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information

I authorize Fitness Genome Tayebjee Chiropractic Neurology Center to access, use or disclose my protected health information in the manner described below.

1) Fitness Genome Tayebjee Chiropractic Neurology Center may request and be provided with a copy of prior health records, including protect health information from your current or previous healthcare provider(s)
2) Fitness Genome Tayebjee Chiropractic Neurology Center may communicate with your current or previous health care provider(s) in reference to your care.
3) Fitness Genome Tayebjee Chiropractic Neurology Center may communicate internally regarding your case.
4) You have the right to authorize or disallow communication with outside non-clinical personnel (such as a family member) regarding your care at Fitness Genome Tayebjee Chiropractic Neurology Center.

The following information may be disclosed to, from or between outside medical personnel and Fitness Genome Tayebjee Chiropractic Neurology Center as it is relevant to your care. Medical records, Records regarding communicable diseases, Alcohol/drug abuse treatment records, Mental Health Records, all treatment records, chiropractic records, any other information relating to your condition.

The purpose of the use or disclosure of this information is to facilitate effective and accurate care and to comply with state and federal laws.

I acknowledge that the information used or disclosed under this authorization may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations.
I have the right to refuse to sign this authorization form; however, if I refuse to sign the staff of Fitness Genome Tayebjee Chiropractic Neurology Center may refuse service if they are unable to gain access to previous medical records. If signed, I have the right to revoke this authorization, in writing, at any time. I acknowledge that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Please see the HIPAA privacy notice for a more detailed outline of our privacy policy.

In the event I cannot be reached, FGTCNC may use the following methods to communicate important health information:
___ e-mail provide the email address: ______________________________
___ voicemail at the following number (be aware work voicemails may not be secure): _______
___ standard mail at the following address: ____

Name of any person(s) allowed to communicate with FGTCNC and relation to patient:
____
____

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. No revisions or changes to this form, by you, will be accepted by Fitness Genome Tayebjee Chiropractic Neurology Center. I certify the information is, to the best of my knowledge, true and accurate.

___________________________	________________________	_______________
Printed Patient (Guardian) Name	Patient (Guardian) Signature	Date

<u>Disclosure(s) and Informed Consent</u>

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical, chiropractic or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to undergo the procedure or after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but recommended to you by us, as your providers.

Details of the diagnostic tests that we run at Fitness Genome Tayebjee Chiropractic Neurology Center are contained in the list at the end of this Disclosure and Informed Consent.
I understand that medical, chiropractic or diagnostic tests or procedure(s) may be necessary or advisable and I voluntarily consent and authorize such tests or procedure(s) as deemed necessary or advisable upon examination. The list of tests and procedure(s) to be performed, and their risk, benefits, is included below, and I have been informed that the risks/hazards of such test or procedure(s).

Just as there may be risks and hazards in continuing my present condition, with or without treatment or procedure(s), there are also risks and hazards related to the performance of medical, chiropractic, or diagnostic procedure(s) planned for me. I realize that common to medical, chiropractic and/or diagnostic procedure(s), is the potential for infection, allergic reaction(s) and, in very rare cases, even death due to severe systemic reaction.

While some of the devices and therapies used Fitness Genome Tayebjee Chiropractic Neurology Center are thought by our clinical staff to have a positive effect on your condition, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

<u>Risks Associated with Diagnostic and Therapeutic Modalities</u>

As with any healthcare procedure, there are certain complications that may arise during diagnostic procedure(s) and therapeutic intervention(s). The following procedure(s) and

intervention(s) may or may not be used in your specific case. The complications are outlined below and include but are not limited to:

Electrical Therapy
Risks include pain, skin irritation, muscle spasms or minor electrical burn at the end point of contact

Gaze Stability
Risks for gaze stability exercises include temporary discomfort in the neck, changes to vision, dizziness, nausea, light-headedness, fatigue and headaches

Vibracussor, balance testing, NSI and other Neuromuscular Re-Education
Risks include local soreness, increase in symptoms, fatigue, headache, light-headedness and dizziness; rarely therapy may result in loss of balance with subsequent fall with injury.

OVARD:
Benefits: The patented Off Vertical Axis Rotational Device (OVARD) provides neurological rehabilitation to patients whose lives have been affected by concussions, physiological and neurological disorders, and other conditions that may benefit from brain-based therapy. It targets the vestibular system, which affects balance, spatial orientation and movement. This rotation stimulates the vestibular system to encourage neural activity in parts of the brain that have been affected by illness or injury.
Risks: Include temporary light-headedness, dizziness, nausea, anxiety, headache and malaise. Risks that are uncommonly encountered include fainting, changes to blood pressure and heart rate and death.

Chiropractic Manipulation and Manual Myofascial Therapy:
Reactions that are most commonly reported are local soreness/discomfort and bruising, headaches, fatigue, radiating discomfort, dizziness. The vast majority of the aforementioned conditions will resolved within 48 hours. Rare side effects include: fracture or joint injuries isolated cases with underlying physical defect, deformities or pathologists, muscle and ligament sprain, disc herniations, cauda equina syndrome, compromise of vertebrobasilar artery (i.e stroke).

Cold Laser Therapy:
Benefits: Cold Laser Therapy is a pure from of light energy of a specific color and wavelength that does no increase thermal temperature of what it is contacting. The laser light interacts with tissue causing the occurrence of certain photochemical reactions and stimulating the neural biological process. It is a non-invasive procedure, meaning that it does not require a surgical incision. This means that there is no prolonged recovery time. Laser therapy also does not involve taking any medications, and many patients prefer to avoid taking medications.

Risks: Patients do no typically get full relief or resolution from their pain symptoms after the first treatment. It takes a series of days after treatments, but for most patient this sensation is short term, lasting for a couple of days.

Blood Draw:
The risks of taking blood include discomfort, local bruising, redness and swelling of the vein and the rare risks of fainting and infection.

IV Therapy:
The risks of taking blood and/or IV therapy include discomfort, local bruising, redness and swelling of the vein and the rare risks of fainting and infection. Severe reactions include allergic reaction, anaphylaxis, infection, cardiac arrest and death.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedure, including those used at Fitness Genome Tayebjee Chiropractic Neurology Center. The procedures order the staff clinicians are recommended because the potential benefits are greater than the potential risks. The patient and/or his her/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Fitness Genome Tayebjee Chiropractic Neurology Center staff will attempt to work with any patient, we feel we can assist in the recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

I have been given the opportunity to discuss with my medical provider, and to ask questions about my condition and treatment, risks of non-treatment and the medical, chiropractic or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such treatment and procedure(s), and I believe that I have sufficient information to give this informed consent. I acknowledge that this DISCLOSURE AND INFORMED CONSENT have been fully explained to me, that I have read it or have had it read to me and that I understand its contents. The patient and or his/her guardian(s), or legally responsible person(s) desire to be examined by Fitness Genome Tayebjee Chiropractic Neurology Center. They give permission/consent to any clinically appropriate examination and therapeutic procedures as determined by the clinical staff.

__________________________________ ________________________ _____/______/_____
Signature of patient *Printed name* *Date*

____ ____________________
Signature of Guardian, if patient is a minor or dependent *Relationship to patient*