Jacoby Chiropractic LLC

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HIPAA Privacy Policy

I understand that I have certain rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Jacoby Chiropractic LLC to use and disclose my protected health information to carry out treatment, including direct or indirect treatment by other healthcare providers involved in my treatment, obtaining payment from third party payers and day to day healthcare operations of Jacoby Chiropractic LLC. I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Jacoby Chiropractic LLC reserves the right to change the terms of this notice and that I may contact Jacoby Chiropractic LLC at any time to obtain an up-to-date copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, however, Jacoby Chiropractic LLC is under no obligation to comply with these requested restrictions. In the case that restrictions are mutually agreed upon Jacoby Chiropractic LLC is bound to comply with these new restrictions. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Informed Consent For Chiropractic Treatment and Payment

I certify that I am the patient or legal guardian listed below. I have read and understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to Jacoby Chiropractic LLC and/or Total Health Associates. I authorize this office and its staff to examine and treat my condition. I do hereby give my consent to move forward with the recommended chiropractic care plan and I acknowledge that no guarantee has been made regarding the outcome of the procedures. I am aware there are alternatives to treatment including medication and/or surgery or even no treatment at all.

Due to the nature of Chiropractic treatment, the Doctor will use his hands or a mechanical device in order to move your joints. You may feel a “click” or a “pop”, such as the noise when a knuckle is “cracked” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, laster therapy or traction may also be used. As with any healthcare procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of the bone, muscular strain, ligament sprain, dislocation of joints or injury to intervertebral discs and nerves, however, these complications are rare. A small percentage of patients may notice stiffness or soreness after the first few days of treatment.

I hereby authorize the doctors and licensed providers of Jacoby Chiropractic LLC and Total Health Associates to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and an individual. I understand that fees for professional services are due at the time of service.

Request for Payment of Benefits

I hereby irrevocably authorize my insurance company / insurance administrator to pay by check made out and mailed directly to: Total Health Associates, the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by the above named Doctor of Chiropractic to be released to any representative of their offices. I have agreed to pay, in a current manner, any balance of said applicable charges I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill. I authorize the office to act in my behalf and report any suspected violations of proper claims practices by my insurance company to the proper regulatory authorities.

Name of Patient or Legal Guardian _____ Date _____

Signature of Patient or Legal Guardian _____ Date _____

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