matlock chiro
healthy living

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(print name)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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

- Conduct, plan, and direct my treatment and follow-up amount 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 acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose treatment plan, payment, or healthcare operation. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I specifically authorize disclosure of my protected health care information to the following:

☐ **Spouse Only** ☐ **Any Immediate Family Member**

☐ **Other** (please specify): ______________________ Relationship: ____________

INSURANCE BENEFITS DISCLAIMER

Many insurance companies cover some chiropractic care. We will be happy to file your insurance claim for you and do all we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will no cover. It is the policy of Matlock Chiropractic to not enter dispute with your insurance company.

I understand that the service Matlock Chiropractic provides for verification for insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to Matlock Chiropractic, the balance of my account will be billed to me and due to Matlock Chiropractic.

I understand that if I choose to use my insurance coverage I will be responsible for any co-pays, deductibles and uncovered fees based on my insurance Explanation of Benefits.

ASSIGNMENT OF BENEFITS

I understand that my signature below indicates my acceptance of all the information presented on this page. I also understand that my signature below serves as a "signature on file" to bill the insurance company I have provided information for and allows Matlock Chiropractic to accept assignment of insurance benefits.

✘ _______________________________ (signature) ____________________ (date)