Kyle Corbin, DC, PA DBA Merolla Chiropractic
664Taunton Ave
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PRIVACY NOTICE ACKNOWLEDGEMENT (HIPPA) We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the discloser of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of *Notices of Privacy Practices for Protection of Health Information* or have been offered a copy or declined to take it. **Initial here**: _______

Appointment Reminders and Health Care Information Authority
Your health care provider and members of the practice staff may need to use your name, address, phone numbers and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made *by phone, text or e-mail* and you are not home, a message will be left on your answering machine or inbox. By signing this form, you are giving us authorization to contact you with these reminders and information via *text, e-mail & phone*. **Initial here: ________**

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

Financial Responsibility I understand that I am financially responsible to Kyle Corbin, DC PA for any charges not covered by health care benefits. It is my responsibility to notify Kyle Corbin, DC PA of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Kyle Corbin, DC PA and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received. In certain circumstances, insurance companies may send a check for services provided by Kyle Corbin, DC PA directly to the patient. In such cases, the patient agrees to endorse and send such a check to Kyle Corbin, DC PA. If the patient deposits such a check into a personal account, the patient agrees to send a personal check for the equivalent amount to Kyle Corbin, DC PA within 10 days of having deposited the check from the insurance carrier.

Assignment of Benefits: I hereby assign all chiropractic/medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment directly to Kyle Corbin, DC PA.

Authorization to Release Information: I hereby authorize Kyle Corbin, DC PA to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature and this form to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Kyle Corbin, DC PA on behalf of myself and/or my dependents and understand by making this request that I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

This notice is effective as of ____/____/____. This authorization will expire seven years after the date on which you last received services from us.

________________________________	______/______/________	________________________________
Patient Name Printed	Date	Patient Signature
________________________________	____________________________	________________________________
Authorized Provider Rep.	Patient Representative Printed Relationship to Patient:	Patient Representative Signature