Office Policies

Dean C. Jacks, D.C.
1550 E John Sims Parkway
Niceville, Florida 32578

As a new patient, we feel it is important that you understand our policies regarding how patients are cared for. We believe it is in everyone's best interest to provide new patients with as much information as possible about how the doctor practices chiropractic so that an informed decision can be made as to whether they wish to start treatment.

Over time, individuals who are accepted as patients, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open concept area, patients have an opportunity to observe firsthand the positive results that are achieved from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health.

Patient Privacy- A majority of patient care takes place in an open concept area so it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room.

Your Care- When a patient seeks chiropractic health care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctor uses a variety of techniques, including diversified adjusting, instrument adjusting, drop table, SOT and Pettibon rehabilitation techniques. The doctor will outline a course of treatment that will take you beyond simple pain relief, thru two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health. Prior to receiving treatment, a health history, exam and x-rays will be completed to confirm the nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need.

Patient's Report of Findings- For further understanding the chiropractic approach, immediately following your first office visit, you will be scheduled for a "Dr.'s Report of Findings." The info you receive at this appointment will be informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays, exams, and Dr's recommendation for care will be discussed at the Dr.'s Report, we urge new patients to invite their spouse/significant other to attend. We know from experience when a patient's family understands the goals and objective of chiropractic care and how restoring /maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I acknowledge that I have read and understand this policy.

Patient Name: _____ Patient Signature : _____

Date: _____

Witness: _____

HIPAA Privacy Policy

core chiropractic

Dean C Jacks, D.C.
1550 E John Sims Parkway
Niceville, Fl 32578

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, please ask and one will be provided to you in a report folder labeled 'HIPAA'.

Permitted Disclosures:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes- to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For public health/safety- in to prevent or lessen a serious threat to the health or safety of a person or general public.
7. Government/law agencies- to identify/locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons- discussions with corners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders- we may call your home and leave messages regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

Your Rights:

1. To receive an accounting of disclosures and a paper copy of the comprehensive "Detail" Privacy Notice.
2. To request mailings to an address different than residence.
3. To request restrictions on certain uses/disclosures and with whom we release information to, though we are not required to comply. If we agree, the restriction will be in place until written notice of your intent to remove the restriction.
4. To inspect your records, with notice in advance.
5. To request amendments to information. However, like restrictions, we are not required to agree to them.
6. To obtain a copy of your records, when timely notice is provided (minimum 72 hours). X-rays are original records and you are therefore not entitled to them. If you would like to have a copy made on a CD, we will be happy to accommodate you with advance notice of one week. However you will be responsible for this cost.

Complaints:

If you wish to make a formal complaint about how we handle your health information, please call the Office Manager at (850) 678-8048. If unavailable, you may make an appointment with our receptionist to see her within 72 hours or 3 working days. If you are still not satisfied with the manner in which the office handles you complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building Washington DC 20201

I have received a copy of Core Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice' any time in the future and will make the provisions effective for all information that it maintains past and present.

Patient Signature: _____ Patient Name:_____

Date:_____ Witness: _____

Informed Consent

Dean C. Jacks, D.C.
1550 E John Sims Parkway
Niceville, Florida 32578
TID 47-2758195

(Females Only) X-Rays / Imaging Studies

Please ready and carefully check the boxes, include the appropriate date, then sign below if you understand and have no further questions. If you have questions, please see our front desk for further explanation.

☐ First date of my last menstrual cycle was on _____.

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____ Patient

Name Patient or Authorized Person Signature

(All Patients) Chiropractic Adjustments, Modalities, & Therapeutic Procedures:

I understand that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke which occurs at a rate between one instances per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Core Chiropractic have been explained to me to my satisfaction and I have conveyed my understating of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Patient Name Patient or Authorized Person Signature Date

_____

Witness

Insurance Benefits

Dean C. Jacks, D.C.
1550 E John Sims Parkway
Niceville, Florida 32578
TID 47-2758195

Patient Name: _____ ID # _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Core Chiropractic Center Inc., of all benefits that may be due and payable under insurance coverage for the patient named above. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Core Chiropractic Center Inc. Furthermore, I hereby IRREVOCABLY ASSIGN to Core Chiropractic Center Inc. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as identified in Florida Statutes for any service and/or charges provided by Core Chiropractic Center Inc.

Co Payments / Deductibles:

As a courtesy, Core Chiropractic will verify your insurance benefits and eligibility. It is your responsibility to ensure we have accurate information and an up-to-date insurance ID card on file. We will bill your insurance company on your behalf and collect the amount deemed your responsibility by your insurance plan. This will include payment of any co-payment and/or deductible/co-insurance or non-covered services determined by your policy with the insurance company. Co-payments and/or deductibles, which are established by your insurance policy, will be collected at time of service.

The verification we receive from your insurance plan is not a guarantee of benefits. We recommend that you also verify in-network /out-of-network benefits with your insurance company. Many times we are given incorrect information on your insurance coverage. Core Chiropractic will not be responsible for incorrect insurance information supplied by your insurance. In the event we are out of network with your insurance plan, full payment of services are due at time of visit.

Authorization to Release Medical Record Information:

Core Chiropractic Center Inc. is hereby authorized to disclose all or any part of the medical records on the above-named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Core Chiropractic Center Inc. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by Core Chiropractic Inc. The undersigned certifies that the patient has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

_____ _____

Patient Signature or Responsible Party Date

_____

Witness

AUTHORIZATION TO RELEASE MEDICAL INFORMATION /RECORDS

Dean C. Jacks, D.C.
1550 E John Sims Parkway
Niceville, Florida 32578

Date: _____

Patient Name: _____ Date of Birth: _____

_____ I authorize Core Chiropractic to release a complete copy of my patient records and/or x-ray images containing protected health information to _____.

_____ I authorize _____ to release a complete copy of my patient records and/or x-ray images containing protected health information to **Core Chiropractic**. Please send all the following documents in your possession concerning the above-named patient:

_____ Medical Information, notes, and records

_____ Diagnostic Reports or Emergency Medical Condition documents

_____ X-ray, MRI or CT films

My complete health record may include records relating to mental health, communicable diseases, HIV/AIDS, and treatment of alcohol/drug abuse. My medical information may be used by the personel authorize to receive this information for medical treatment, consultation, billing/claims payment, or other purposes as I direct. This authorization shall be in force and effective until I provide written notice to cancel such authorization. I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that a photo ID is required to retrieve my protected medical records. I understand that Core Chiropractic will not allow family or friends to retrieve my protected medical records in my absence. I authorize my protected health information to be electronically sent by email, fax and/or via US mail.

Patient name: _____ Signature of patient _____

Dean C. Jacks

Dean C. Jacks, D.C.

Fax: 855-333-8662
Email: mycorechiropractic@gmail.com
Phone: 850-678-8048
Mail: Core Chiropractic
Attn: Records
1550 E John Sims Parkway
Niceville, Florida 32578