ChiroHealthUSA® The Network That Works for Chiropractic! ChiroHealthUSA Plus

DISCOUNT MEDICAL PLAN APPLICATION

THIS FORM SHOULD NOT BE GIVEN TO PATIENTS UNLESS THEY ARE JOINING CHIROHEALTHUSA OR CHIROHEALTH PLUS
You must read important disclosures and sign the reverse side

Date:

Patient Name:

Primary Card Holder Gender: ◯ **Male** ◯ **Female**

Primary Card Holder Date of Birth:

Dependents' Names:
(Spouse, Domestic Partner, Dependent Children up to age 26, Parents in the Household over age 60, and any other IRS Dependent)

Patient Address:

City:

State: **Zip:**

Phone:

Email:

I consent to receive communication via email from ChiroHealthUSA. You may opt-out of these communications at any time. ◯ Yes ◯ No
(Contact information will not be shared, sold or distributed)

FOR CLINIC USE ONLY

City:

Date entered in Online Membership Link:

By:

ChiroHealthUSA
250 Katherine Drive, Flowood, MS 39232
1-888-719-9990

◯ ***CHUSA PROCESSED***

PAYMENT INFORMATION

◯ **YES! I want ChiroHealthUSA PLUS for $89.00 for a ONE YEAR membership to include Chiropractic, Vision, Dental, Pharmacy, Lab and Imaging Discounts! NOTE: Not available in Alaska, California, Vermont and Washington.**

◯ **YES! I want ChiroHealthUSA for discounted Chiropractic Care Only for $49.00 for a ONE YEAR membership.**

You may renew your agreement by continuing annual payments as applicable for your plan. The brochure for your program contains a description of the benefits you will receive and is incorporated by reference and is a part of this document. PLEASE READ YOUR BROCHURE BEFORE SIGNING THIS DOCUMENT.

HSA and FSA accounts for payment of membership fees is not permissible.

Check and Credit card information will be destroyed once transaction is completed.

Check #:

Credit Card Type: ◯ **Visa** ◯ **MC** ◯ **Amex** ◯ **Disc.** **Card#:**

Card ID (CVV2/CID) Number: **Exp. Date:** **Billing Zip Code:**

Name on Card: **Signature:**

DISCLOSURES

These discount medical, health, and drug plans are NOT insurance, health insurance policies, Medicare Prescription Drug Plans or qualified health plans under the Affordable Care Act. These plans (The Plans) provide discounts for certain medical services, pharmaceutical supplies, prescription drugs or medical equipment and supplies offered by providers who have agreed to participate in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). The range of discounts for medical, pharmacy or ancillary services offered under The Plans will vary depending on the type of provider and products or services. The Plans do not make and are prohibited from making members' payments to providers for products or services received under The Plans. The member is required and obligated to pay for all discounted prescription drugs, medical and pharmaceutical supplies, services and equipment received under The Plans, but will receive a discount on certain identified medical, pharmaceutical supplies, prescription drugs, medical equipment and supplies from providers in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). Members will have free access to providers without restrictions such as waiting periods, notification periods, etc. except for hospital discounts. The Plans do not offer discounts on hospital services. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., 5005 LBJ Freeway, Suite 1500, Dallas, TX 75244. ChiroHealthUSA members may call 1-888-719-9990 for more information or visit www.chirohealthusa.com for a list of providers. ChiroHealthUSA Plus members may call 1-800-220-7752 for more information or visit www.chirohealthusaplus.com for a list of providers. The Plans will make available before purchase and upon request, a list of program providers and the provider's city, state and specialty, located in the member's service area. Alliance HealthCard of Florida, Inc. does not guarantee the quality of the services or products offered by individual providers. The fees for The Plans are specified in the membership agreement. You have the right to cancel your membership at anytime. If you cancel your membership within 30 days of the effective date, you will receive a full refund of your membership fees other than money paid by you to a provider. To cancel your ChiroHealthUSA Plan you must, verbally or in writing, notify ChiroHealthUSA at 1-888-719-9990, 250 Katherine Drive, Flowood, MS 39232. To cancel your ChiroHealthUSAPlus Plan you must, verbally or in writing, notify Alliance HealthCard of Florida, Inc. at 1-800-220-7752, 5005 LBJ Freeway, Suite 1500, Dallas, TX 75244. Any complaints should be directed to Alliance HealthCard of Florida, Inc. at the address or phone number above. Upon receipt of the complaint, member will receive confirmation of receipt within 5 business days. After investigation of the complaint, Alliance HealthCard of Florida, Inc. will provide member with the results and a proposed resolution no later than 30 days after receipt of the complaint.

Note to DE, IL, LA, NE, NH, OH, RI, SD, TX and WV consumers: If you remain dissatisfied after completing the complaint system, you may contact your state department of insurance. You may contact Alliance HealthCard of Florida, Inc. for department of insurance contact information.

Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00

Signature:

ChiroHealthUSA
250 Katherine Drive, Flowood, MS 39232
1-888-719-9990

SPACE INTENTIONALLY LEFT BLANK

ChiroHealthUSA
The Network That Works for Chiropractic!

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR ENROLLMENT AND MEMBERSHIP IN THE CHIROHEALTHUSA NETWORK

I,_____, authorize my provider,_____, to use and disclose my health information (including my name, phone number, address, email address, date of birth, gender, dependents name, name of my provider, and payment information) to ChiroHealthUSA for purposes of enrolling me in the ChiroHealthUSA network, and to send me marketing materials and other communications related to my ChiroHealthUSA network membership. I understand that my provider will not receive direct or indirect remuneration from ChiroHealthUSA in connection with this use and disclosure of my health information.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") and various state laws govern the terms of this Authorization. I understand this Authorization is limited to only the health information described above, and does not apply to sensitive categories of information (such as psychotherapy notes, genetic, mental health, substance abuse, or HIV/AIDS information).

I understand that I may revoke this Authorization at any time by contacting my provider and/or ChiroHealthUSA in writing at 250 Katherine Dr., Flowood, MS 39232, 888-719-9990. My revocation will be effective upon my provider and/or ChiroHealthUSA's receipt of such revocation, but will not be effective to the extent that they have already acted in reliance upon my prior Authorization.

I understand that my provider may not condition treatment or payment, or eligibility for benefits or enrollment in a health plan, on my signing of this Authorization. I understand that my health information disclosed pursuant to this Authorization may be further used and disclosed by ChiroHealthUSA to communicate with me regarding my ChiroHealthUSA membership, and no longer protected by HIPAA. I understand that I have a right to receive a copy of this Authorization.

This Authorization shall expire in accordance with the below, unless earlier revoked by me by notifying my provider and/or ChiroHealthUSA using the contact information and in the manner described above (check the applicable box):

- ☐ **Maryland**: One year from the date of signing this authorization
- ☐ **Maine**: 30 months from the date of signing this authorization
- ☐ **California**: On the_____day of_____, _____
- ☐ **All other states**: When my membership expires

_____ _____
Signature of Patient or Personal Representative Date of Signature

_____ _____
Relationship to Patient Patient Address