

MEININGER*clinic*

MARK J. MEININGER BS DC CCSP CPT CME

Whiplash Case Management, Sports Injury and Spinal Care

550 HAMPTON RD.

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03/24/2021

RE: EFFECTIVE IMMEDIATELY FOR ALL NEW PATIENTS

To Whom It May Concern:

As you may have heard, in light of stricter federal guidelines, healthcare providers are now required to implement "Compliance Programs" which include review of billing policies and assure that improper discounts are not being offered to patients. Compliance Programs are designed to eliminate potential fraud and abuse.

Although we may not always agree with the stricter rules and limitations, we must comply with them in order to protect our practice. As part of our commitment to providing affordable care, we have chosen to participate in a program that allows us to provide discounted fees to our patients who become members and still remain compliant with federal law.

ChiroHealthUSA is a network that works in conjunction with a Discount Medical Plan Organization giving patients access to the same discounts that are typically only negotiated by the insurance companies. **ChiroHealthUSA** is NOT insurance, however, and should not replace your insurance. It simply allows us to lower the cost for your noncovered services at our clinic.

Becoming a member of **ChiroHealthUSA** is easy.

- Join right here in our clinic in just minutes
- Pay just \$49 per year
- Membership covers you and your legal dependents
- Receive discounts with any **ChiroHealthUSA** provider nationwide

We hope that you and your family will take advantage of this program to help lower your health care expenses. Be sure to ask about **ChiroHealthUSA** at your next appointment. If you have any questions, please do not hesitate to call.

With regards,



Dr. Mark J. Meininger

As a member of ChiroHealthUSA,
MEININGER CLINIC
MARK MEININGER, DC

offers a **20 %** minimum discount off all clinic professional services

The following rates listed are the ChiroHealthUSA rates for each service. Any service not listed will default to the minimum of **20 % off.**

CODE	CODE DESCRIPTION	RETAIL FEE	CHUSA FEE	DISCOUNT
98940	Spinal CMT 1-2 Regions	\$45.00	\$30.00	33%
98943	Extraspinal CMT	\$42.00	\$15.00	64%
99202	NP Exam, Expanded	\$125.00	\$60.00	52%
99203	NP Exam, Detailed	\$185.00	\$75.00	59%
99212	EP Exam, Focused	\$65.00	\$50.00	23%
99213	EP Exam, Expanded	\$110.00	\$60.00	45%
97012	Traction	\$38.00	\$10.00	74%
97014	E Stim, Unattended	\$38.00	\$10.00	74%
72100	X-Ray, Lumbar Spine <4 views	\$70.00	\$49.00	30%
72040	X-ray, Cervical Spine <4 views	\$70.00	\$49.00	30%
72050	X-ray, Cervical Spine 4-5 views	\$140.00	\$98.00	30%
72070	X-ray, Thoracic Spine 2 views	\$70.00	\$49.00	30%

338.00 164.00

***DISCOUNTS AND CAPPED FEES EXCLUDE:**

- Axial Decompression (S9090),
- Sports Physical, Preemployment Physicals, Drug Screens, Alcohol Tests,
- Any Services Related to DOT Physicals

4/fee 49.00
213.00

KID ADJ \$ 20

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 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 understand email is an unsecured method of communication and I give my consent to email communications from ChiroHealthUSA.

You may opt-out of these communications at any time.

(Contact information will not be shared, sold or distributed)

Yes No

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**

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