Increase Patient Access to Chiropractic

Patients could soon have access to chiropractic services through Medicare because of a bill recently introduced in the U.S. House of Representatives.

The Chiropractic Medicare Coverage Modernization Act (H.R. 2654) would allow Medicare beneficiaries access to the chiropractic profession's broad-based, non-drug approach to pain management, which includes manual manipulation of the spine and extremities, evaluation and management services, diagnostic imaging and utilization of other non-drug approaches that have become an important strategy in national efforts to stem the epidemic of prescription opioid overuse and abuse.

By contacting your representative in Washington, you are advocating for chiropractic to be a vital part of healthcare policy.

Please complete the form below to give your authorization to send an electronic letter to your Representative stating your support for H.R. 2654. You will receive a confirmation email once this message is sent.

All information you provide will remain private: It will not be sold or distributed to unaffiliated third parties.

First Name*____________________ Last Name*____________________

Address* ____

City* ____________________State* ________ Zip* ______________

E-mail*____

I do hereby give my authorization for an electronic letter in support of H.R. 2654 be sent on my behalf.

I authorize (Doctor's name) ________________ to use and disclose the protected health information described above for the purpose described above subject to the following:

1. This authorization shall be in force and effect until ________________ (date or event), at which time this authorization expires.
2. I understand that 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.
3. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
   (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Signature* ____________________________ Date* ________________
*Required fields.

ONCE AUTHORIZATION FORM IS COMPLETED, PLEASE COPY AND GIVE TO PATIENT

Thank you for letting your voice be heard!

For more information, visit www.HR2654.org.