Hahn Family Chiropractic

NOTICE OF PRIVACY POLICIES AND PROCEDURES
And
CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Hahn Family Chiropractic treats all personal health information as confidential and privileged. We are very concerned with protecting your privacy, and your health care information will only be used for treatment, payment and health care operations. Our staff is trained to protect the privacy of your medical records and financial information. If you have any concerns or questions regarding your personal health information you may contact Dr. Eric Hahn.

There are several circumstances in which we may have to use or disclose your health care information and billing records, including the following:

- We may have to share your health information with another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your condition.
- We may share your health and billing information with another party who is potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may need to disclose your health and billing information to the North Carolina Chiropractic Association (NCCA) should we need the association's assistance to receive reimbursement for your services, or because the insurance company has processed your claim improperly.
- We may need to call or leave a message on your answering service regarding future or missed appointments.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

By signing below I attest that I have read the Privacy Practices notice posted in the patient waiting area and I consent to Hahn Family Chiropractic using my health care records and billing information as described above.

Signed _____ Date: _____

Printed Name: _____

Hahn Family Chiropractic

FINANCIAL POLICIES

Payment and Insurance

As part of our sincere desire to offer excellent health care to you, we would like to present our financial policies to minimize misunderstandings about fees. **The patient is responsible for all charges whether or not covered by insurance or a personal injury settlement**. See the separate fee schedule.

As a courtesy to our patients we will file insurance with most insurance carriers. Insurance patients are usually responsible for paying co-pay at the end of each visit. Insurance patients must pay all charges at the time of visit if your deductible has not yet been met. Charges are accrued for personal-injury patients and filed periodically or at the end of treatment.

We are in-network with the following insurance companies: Blue Cross/Blue Shield plans, NC State Employees' plan; we are out-of-network for Atena, Alliance PPO Guardian, Medicare, PHCS.

Many insurance companies provide up to 80% coverage for out-of-network providers, and we will be happy to file insurance with such companies. Hahn Family Chiropractic is not required to accept contracted rates if we are not in their network; therefore, the patient is responsible for paying the remainder of the unpaid charges at our full rates.

We are not guaranteed payment from any insurance company until the claim is filed. If the patient owes any balance after we receive an explanation of benefits, we will invoice the patient. If the patient has not paid the balance within 60 days, we reserve the right to put any remaining charges on the patient's credit card. Patients are welcome to pay by cash, check, or credit card. We only accept MasterCard and Visa.

Canceled or Missed Appointments

Please provide us the courtesy of 24 hours notice if you need to cancel your appointment. If you cancel or fail to show on the day of your appointment, the time that has been reserved for you will stand open. In such cases, a fee of $25 will be charged. If you arrive more than five minutes past your scheduled time, priority will be given to the next person waiting.

I _____, agree that I have read and understood the information as stated above, and I agree to abide by these policies.

_____ _____

Patient Signature Date

Hahn Family Chiropractic

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments, and/or acupuncture, meridian therapy, nutritional therapy and any other chiropractic procedures, including examination tests, diagnostic X-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) that are recommended by Dr. Eric Hahn and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed, by, working for or associated with or serving as back-up for Dr. Hahn.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separation. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications related to chiropractic treatment, acupuncture and nutritional therapy, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) that the doctor feels at the time, based upon the facts then known, are in my best interest. I have had an opportunity to discuss with Dr. Hahn and/or other doctor(s) or office personnel the nature, purpose and risks of chiropractic adjustments, acupuncture, nutritional therapy and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic, acupuncture, or nutritional therapy treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE

_____ _____

Printed Name of Patient Date

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Representative (if minor or physically incapacitated Date

_____ _____

Witness to Patient's Signature Date

_____ _____

Translated By Date

Hahn Family Chiropractic

Patient Information

Assignment and instruction for direct payment to Doctor

Patient name	
Date of Birth	Address
Home phone	Work phone
Cell phone or pager	Email address
Employer	Occupation
Insurance Company	Claim #

I hereby instruct the above-named insurance company to pay by check made out to and mailed directly to:

Hahn Family Chiropractic Inc.
4330 Bland Road
Raleigh, NC 27609

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O Hahn Family Chiropractic
4330 Bland Road
Raleigh, NC 27609

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment of Benefits shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

_____ _____

Signature of Policyholder
Dated

Hahn Family Chiropractic

Patient ADL Information and History Complaint Attestation

Patient Name: _____

Primary Complaint(s) _____

Daily Activities: Effects of Current Condition on Performance

	No Effect	**Mild** Painful but Can Do	**Moderate** Painful Limited function	**Severe** Unable to Perform
Bending:	☐	☐	☐	☐
Care –Infirm Family	☐	☐	☐	☐
Carrying Groceries:	☐	☐	☐	☐
Change position–Sit-Stand:	☐	☐	☐	☐
Climb Stairs:	☐	☐	☐	☐
Driving:	☐	☐	☐	☐
Extended Computer Use	☐	☐	☐	☐
Feeding:	☐	☐	☐	☐
Household Chores:	☐	☐	☐	☐
Kneeling:	☐	☐	☐	☐
Lift Children:	☐	☐	☐	☐
Lifting:	☐	☐	☐	☐
Pet Care:	☐	☐	☐	☐
Reading (Concentration):	☐	☐	☐	☐
Self Care–Bathing:	☐	☐	☐	☐
Self Care–Dressing:	☐	☐	☐	☐
Self Care–Shaving:	☐	☐	☐	☐
Sexual Activities:	☐	☐	☐	☐
Sleep:	☐	☐	☐	☐
Static Sitting:	☐	☐	☐	☐
Static Standing:	☐	☐	☐	☐
Walking:	☐	☐	☐	☐
Yard Work:	☐	☐	☐	☐
Other Activities:				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

I the undersigned patient do hereby attest that the history information and complaints presented by me today have been recorded directly into a computer system electronically in consultation with Dr. Eric A. Hahn DC. I have had the opportunity to review them and attest that they are complete, accurate and truthful to the best of my understanding and knowledge.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date