



CHARLOTTE CHIROPRACTIC CLINIC, P.A.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had chiropractic care before?

Yes: \_\_\_\_\_

No: \_\_\_\_\_

If Yes, did you receive treatment at our office? \_\_\_\_\_

If not out office, where? \_\_\_\_\_

How did you here about our practice? (Please be specific)

Relative \_\_\_\_\_

Friend \_\_\_\_\_

Doctor \_\_\_\_\_

Sign \_\_\_\_\_

Billboard \_\_\_\_\_

Yellow Pages \_\_\_\_\_

Other \_\_\_\_\_



In reference to your health insurance: (please choose one and initial on the line)

\_\_\_\_\_ I have health insurance and wish to have it filed if it includes chiropractic coverage.

\_\_\_\_\_ I do not have health insurance.

\_\_\_\_\_ I have health insurance but choose not to have it filed for this injury/illness. You will need to pay for each visit at time of service.

Charlotte Chiropractic Clinic, P.A.  
537 West Sugar Creek Road  
Charlotte, North Carolina 28213  
Phone: (704) 598-8040 FAX: (704) 509-0915

ASSIGNMENT OF BENEFITS, LIEN AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illness, past, present, or future ("condition") to pay directly and exclusively to Charlotte Chiropractic Clinic (CCC) or Office such sums as may be owing to CCC for charges incurred by me at the Office relating to my condition ("charges"), and with such payment to be made exclusively in the name of Charlotte Chiropractic Clinic. I further grant a lien to CCC with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purposes of this document (herein "Assignment and Lien"), "benefits" shall include, but not be limited to, proceeds medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distribution, disability benefits, workers' compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

I authorize this Office CCC to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to CCC any information regarding any coverage or benefits I may have including, but not limited to, the amount of coverage, the amount paid for thus far, and the amount of any outstanding claims. I hereby direct this Office, CCC to file a copy of this Assignment and Lien, together with any applicable charges, with any and all payers, regardless or whether a claim has been establish with said payers. I hereby grant CCC power of attorney to endorse / sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any dependents.

I further authorize CCC to apply and credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or any of my dependents, regardless if these are related to my condition.

I understand that I remain personally responsible for the total amount due CCC for their services. This Assignment and Lien does not constitute any consideration for this Office to await payments and it may demand from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse CCC for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of CCC and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

PATIENT NAME (please print): \_\_\_\_\_ Chart #: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

CUSTODIAL PARENT/ LEGAL GUARDIAN (please print): \_\_\_\_\_

CUSTODIAL PARENT/ LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_

# HIPAA Notice of Privacy Practices (page one)

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Charlotte Chiropractic Clinic  
537 West Sugar Creek Road  
Charlotte, North Carolina 28213  
(704) 598-8040

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## 1. Uses and Disclosures of Protected Health Information

### Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

# HIPAA Notice of Privacy Practices (page two)

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## Your Rights

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have and objections to this form, please ask to speak with our HIPAA Compliances Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Chart #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_