**Pburg Hahn Medical Practices**
10 Valley St. Suite 101 - Petersburg, WV 268479543
Phone: (304) 257-9785 • Fax:

## Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

## Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

## Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

## Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

## Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

## Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

## Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

## How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

## Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Pburg Hahn Medical Practices all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insuranc

**I certify that I have read this form and understand its contents.**

Patient or Other Legally Authorized Person: _____ Date: _____

Hahn Medical Practices, Inc.
Hahn Orthopedics
Dr. Joseph M. Hahn

Patient's name:_____ Today's date:_____

Birth date:_____ Family physician:_____

Referring physician:_____ Please check if your visit was the result of any of the following:

___work accident
___auto accident
___home accident

Reason for your visit today:_____
Have you had x-rays or an MRI for the current injury or pain: YES NO
If yes, where:_____
Legal case: YES or NO
Date of injury:_____ Worker's Comp claim number:_____

Please list ALL medications:_____
_____
_____

Please list ALL surgeries:_____
_____
_____

Please list ALL medical problems:_____
_____
_____

Please list ALL drug allergies:_____
_____
_____

Are you allergic to latex: YES NO
Do you have any other allergies: YES NO
Are you pregnant or could you be pregnant: YES NO
Do you smoke: YES NO If yes _____ packs per day
Do you chew tobacco: YES NO
Do you drink alcohol: YES NO If yes, how much and how often_____
Do you work: YES NO If yes, what type of work_____
Are you married: YES NO

Ht:_____ BP:_____ R:_____
Wt:_____ P:_____

Hahn Medical Practices, Inc.
Hahn Orthopedics''
Joseph M. Hahn M.D.

Family History: Has anyone in your family had problems with: (check ALL that apply)

| | | | |
|---|---|---|---|
| __ eyes | __ears,nose,and throat | __lungs, breathing | __digestion or bowels |
| __ Bladder | __diabetes | __high blood pressure | __ bleeding problems |
| __ balance problems | __ blackouts/fainting | __AIDS | __ Cancer |
| __ Heart problems | __ epilepsy | | |

## Review of symptoms: Please answer Yes or No, if yes please elaborate

Any fever or night sweats? _____

Any visual problems? _____

Any hearing problems? _____

Any instances of chest pain? _____

Any shortness of breath? _____

Any digestive problems, such as heartburn, diarrhea or nausea? _____

Any urinary problems? _____

Any joint or muscle pain? _____

Any skin rashes? _____

Any problems with memory, attention span, numbness, tingling, balance? _____

Any changes in mood (e.g. depression, anxiety, agitation)? _____

Any enlarged lymph nodes? _____

Any unexplained bleeding? _____

Any hay fever or other allergies? _____

Patient's signature_____ Date_____

Witness _____ Date_____

AUTHORIZATION:

- I hereby authorize the providers, including physicians, physician assistants, nurse practitioners, and medical students, of Hahn Medical Practices, Inc. to provide medical treatment to myself/child.
- I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, including Medicare and Medicaid, for the purpose of filing and payment of medical claims.
- I authorize payment of medical benefits to the provider, Hahn Medical Practices, Inc.
- I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims and prescriptions.

INSURANCE:

- I understand that if my insurance coverage has expired or lapsed, I will be responsible for payment. If my insurance company denies payment or does not pay within 90 days, I am responsible for payment.
- I understand that my insurance is a contract between me and my insurance company, and that I am financially responsible for any services or deductibles not covered for payment under my insurance plan.
- I understand that it is my responsibility to inform the practice of any change of name, address, phone, insurance, or employment. I understand that my information changes left undisclosed or inaccuracies reported by me could lead to a reimbursement refusal from my insurance company, Medicaid, or Medicare, in which case, I will be held financially responsible for any unpaid balances.

REFERRALS:

- If referred by an insurance company, I have verified participation of the provider with the insurance company.
- I understand that if my insurance carrier lists the providers as participating physicians, I must follow the guidelines specified in my policies, particularly with regards to referrals. If a referral is required by my health insurance plan, I understand that the referral must be valid and completed with the provider's name. I understand that I will be held responsible for the cost of services provided if I do not present a valid referral.

FINANCIAL RESPONSIBILITIES: (We accept payment in the form of check, cash, Visa, and MasterCard.)

- All charges are due at time of service. This includes co-payments and deductibles. If self-paying, payment is due at the time of the visit.
- Some services may not be covered under your contract. Please check with your insurance company if you have any questions regarding which services are covered. You are responsible for these services if the insurance company does not pay.
- If an overpayment is made by you on your account, a refund will only be issued if there are no other outstanding debts on other accounts containing the same guarantor or financial responsibility party. Patient charges unforeseen at the time of service will be billed to the address you have provided for billing purposes. All balances are due in full within 14 days of the billing date.
- I understand that in the case of returned checks, the fee charged by the bank will be added to my account. In the case of nonpayment for services performed, 10% interest will be added to my account from the date of service. All collection costs incurred by Hahn Medical Practices, Inc. for outstanding balances will be added to my account. Interest and/or collection fees may be charged on all balances owing to the provider that are past due.
- I understand that I am financially responsible for cosmetic, non covered, or medically non indicated services.

DIAGNOSTICS:

- Sunrise Diagnostic provides laboratory, pathology, and radiology services for Hahn Medical Practices, Inc. If you receive these services, you will incur separate charges for these services. I understand that I am responsible for all charges including any balance remaining after payment of insurance benefits for these services. If my insurance requires a designated diagnostics facility other than Sunrise Diagnostic, it is my responsibility to request such facility before the necessary tests are performed. If I neglect to inform the practice in a timely manner, I will be responsible for any testing expenses incurred on my behalf.

INFORMED CONSENT:

- I understand that during my course of treatment, unforeseen conditions may occur that necessitates a skin biopsy(s) to be taken by shave, punch, and/or excision. In addition, I also give permission to have minor surgical procedures and any subsequent treatments as deemed necessary as long as the risks and complications are discussed with me prior to the said procedure. These risks include, but are not limited to, scarring, bleeding, swelling, pain, deformity, infection, and/or ulceration. I will also inform the dermatologic practitioner of any possible contraindications to the planned procedure, including medications, such as anticoagulant, aspirin, cardiac, infectious, or psychotropic medications.
- I recognize that every surgical procedure involves uncertainty and no result can be guaranteed. I also recognize that the practitioner is not responsible for natural complications that may occur. If any postoperative complications occur, it is my responsibility to contact the practitioner as soon as possible.
- I consent to the disposal of any tissue that is removed in accordance with accustomed practice and procedure. I further give my permission to have any tissue that is removed during a procedure sent for histologic examination.
- I understand that any controversy or claim arising out of medical care provided will be resolved through arbitration.
- I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

I permit a copy of this release to be used in place of the original.
My signature below certifies that I have read, understood, and agree with the terms set forth in these Policy Statements.

_____ _____

Signature of Patient / Responsible Party Date

_____ _____

Chart:_____

## HIPPA SIGNATURES

Please initial and check the following items that you give the office of Hahn Medical Practices, Inc. permission to communicate Personal Health Information to (Please check all that apply):

◊ I give permission for the office to leave a message on my answering machine regarding:
( ) test results ( ) appointments, and/or ( ) account information
( ) I DO NOT have and answering machine

_____
Initial

◊ I give permission for the office to speak with a family member regarding:
( ) test results ( ) appointments, and/or ( ) account information
( ) I DO NOT give permission to speak to a family member

_____
Initial

◊ ( ) I give permission, or
( ) I DO NOT give permission for the office to phone my place of employment to reschedule an appointment (ONLY IF NECESSARY)
( ) I DO NOT have a place of employment

_____
Initial

◊ I specifically DO NOT give permission for:

_____
_____
_____
_____

Signature:_____ Date:_____

Witness/Staff Signature:_____ Date:_____

*Expiration date is seven years from the date of original signatures unless otherwise noted*