

Hamilton Health Associates

Date _____

Patient

First _____ M _____ Last _____

Home# () _____ - _____ Address _____

City _____ State _____ Zip _____ Sex _____ Birthdate _____

Social Security# _____ Single/Married/Other _____

Number of Children _____ Occupation _____ Employer _____

Work# () _____ - _____

Spouse/Legal Guardian

Name of Legal Guardian, Wife or Husband _____

Social Security# _____ Birthdate _____

Occupation _____ Employer _____ Work#() _____ - _____

Emergency Contact _____ Phone# () _____ - _____

Medical Doctor Consulted within the past year:

Name _____ Condition: _____

Name _____ Condition: _____

Please list all medical conditions that you have had in the past or have now:

Reason for appointment

Date started _____ Have you had this before? Y/N Injury Related? Y/N

List all Previous Surgeries:

_____ Date _____

_____ Date _____

Are you allergic to any medications? Y/N What Kind? _____

Are you taking any medications? Y/N What Kind? _____

Are you Pregnant? Y/N Date of last menstrual period? _____

As a patient at Hamilton Health Associates you are not required to see any additional physician at this location if you do not deem necessary. All physicians at Hamilton Health Associates are available to participate in your healthcare if you desire.

Patient Signature _____

FORM OF CONSENT

Doctors of chiropractic, medical doctors, and the physical therapists using manual therapy treatments for patients with neck problems such as yours are required to explain that there have been rare cases of injury to the vertebral artery as a result of treatment. Such an injury has rarely caused stroke, sometimes with serious neurological injury. The chance of this happening are extremely remote, approximately 1 per 1 million treatments. Appropriate tests will be performed on you to help identify if you are susceptible to that kind of injury. If you have any questions about this please do not hesitate to speak with one of doctors. I have read and understood the above statement, accept the risk mentioned, and hereby consent to treatment.

Patient Signature _____ Date _____

**DIAGNOSTIC IMAGING CONSULTANTS, INC.
11123 MONTGOMERY ROAD SUITE 201
CINCINNATI, OH 45249
(513) 489-0055
FAX: (513) 489-4587**

**ASSIGNMENT OF BENEFITS
FOR RADIOGRAPHIC INTERPRETATION**

I understand that to insure the highest quality of interpretation of my x-rays, the services of a certified chiropractic radiologist are being utilized. This fee is separate from that of the chiropractic clinic. I also understand that the fees for this service will be submitted to my insurance carrier, Worker's Compensation, or attorney in the case of personal injury.

I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible, or the balance due stated by my insurance company as my responsibility.

In the event that I receive payment for the services I agree to promptly remit payment to Diagnostic Imaging Consultants.

I acknowledge and give my consent to have my x-rays interpreted by Dr. Bryan Hosler, DACBR. I understand that any balance due is my responsibility.

Signature: _____ Date: _____

The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

**DIAGNOSTIC IMAGING CONSULTANTS, INC.
11123 MONTGOMERY ROAD SUITE 201
CINCINNATI, OHIO 45249**

Signature: _____ Date: _____

Witness: _____

Hamilton Health Associates

Patient Name: _____

Case:

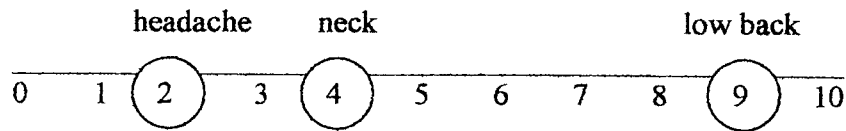
Date: _____

VISUAL ANALOG SCALE

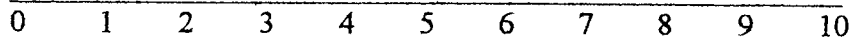
INSTRUCTIONS: Please circle the number (0 = no pain; 10 = unbearable pain) that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

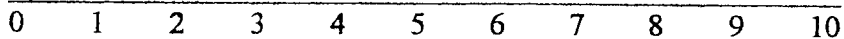
EXAMPLE:



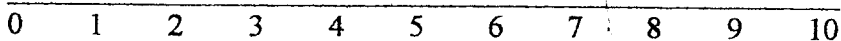
1. What is your pain RIGHT NOW?



2. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



3. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



4. What percentage of your awake hours is your pain at its worst? _____ %

see other side

HAMILTON HEALTH ASSOCIATES
AUTHORIZATION FORM

Patient Name _____ DOB _____ SS# _____

I hereby authorize the use or disclosures of the following protected health information as described below
to: Hamilton Health Associates 513-863-2273
1199 Main St, P.O. Box 13346 513-863-6022 fax
Hamilton, Oh 45013

I hereby request the release of the following:

- () Office Notes
() Diagnostic Results
() Medication List
() Other: _____

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing. This may be accomplished by contacting the practice's Privacy Officer at 863-2273 and requesting a Revocation of Authorization form.

I understand that such a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by federal or state law.

My physician will not condition my treatment, payment, Enrollment in a health plan, or eligibility for benefits (if applicable), on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I have the right to:

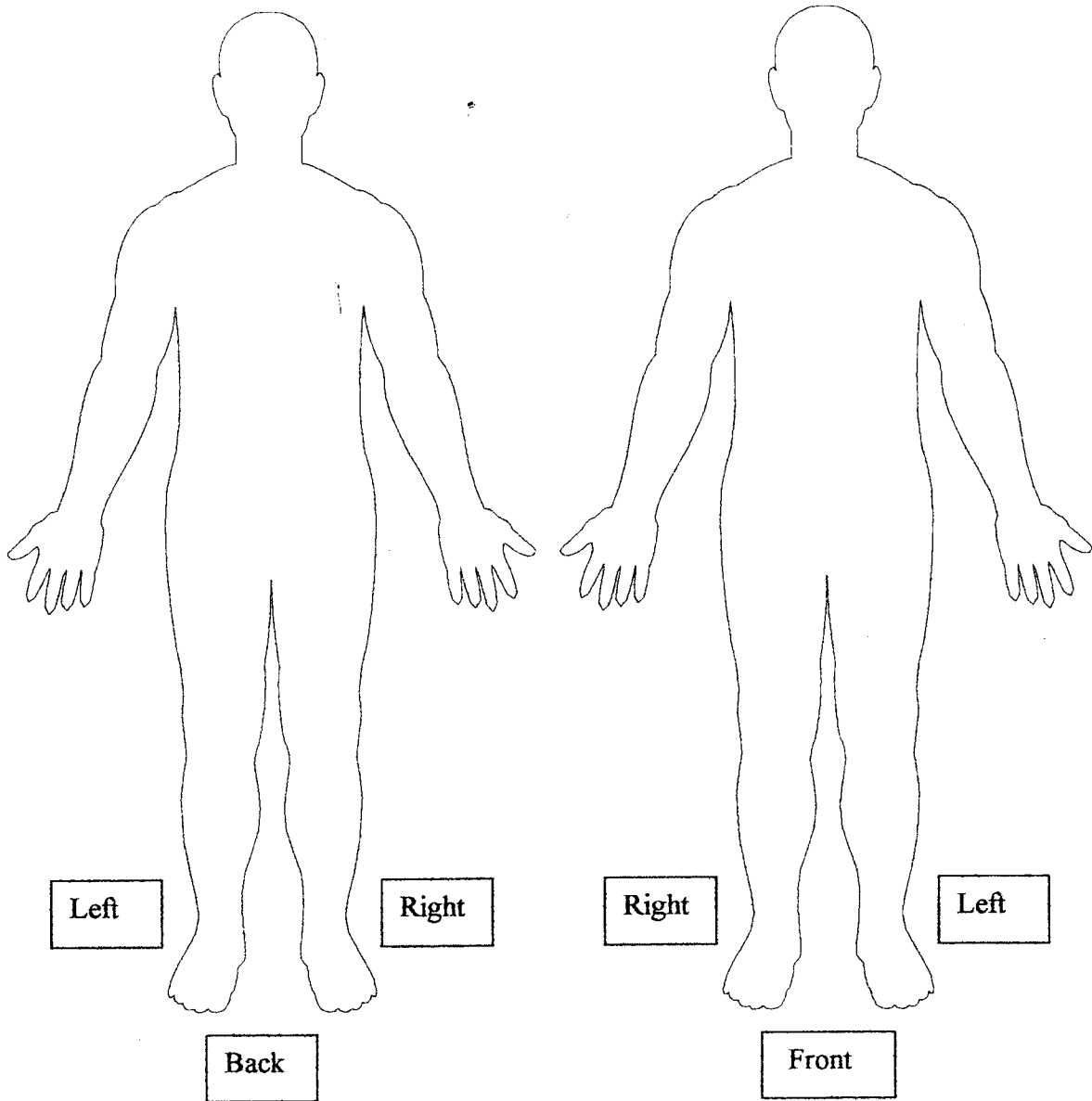
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

Signature of Patient or Patient's Representative

Date

Print Name of Patient's Representative

Description of Patient's Representative Authority



Using the symbols listed below, mark on the two drawings above the areas on your body where you feel the described sensations:

- | | | | |
|------------------|-----|----------------|-------|
| Numbness | === | Hot Burning | xxx |
| Dull Ache | ooo | Sharp Stabbing | /// |
| Pins and Needles | +++ | Other | _____ |

Patient Signature: _____ Date: _____

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient

Date: _____

Assignment of Benefits: INSURANCE

I authorize my insurance company to pay by check made out to Hamilton Health Associates and mail directly to P.O. Box 13346, Hamilton, Oh 45013. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Policy Holder or Claimant Signature _____

Policy Holder Social Security Number _____

Assignment of Benefits: WORKER'S COMPENSATION

I authorize my Managed Care Organization to pay by check made out to Hamilton Health Associates and mail it directly to P.O. Box 13346, Hamilton, Oh 45013. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim. Should I elect to settle my claim either fully or in part and the settlement does not include Hamilton Health Associates I agree to pay for all unpaid services rendered by Hamilton Health Associates.

Patient Signature _____

Assignment of Benefits: PERSONAL INJURY

I authorize my Attorney and or Car Insurance Company to pay by check to Hamilton Health Associates and mail directly to P.O. Box 13346, Hamilton, Oh 45013. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim. Hamilton Health Associates will accept up to \$5000.00 of liability on my personal injury case any amount beyond that will need to be paid for by my medical insurance or cash at the time of service. Should I elect to settle my claim either fully or in part and the settlement does not include Hamilton Health Associates I agree to pay for all unpaid services rendered by Hamilton Health Associates.

Patient Signature _____

CONSENT TO TREAT A MINOR

I _____, give my permission for Hamilton Health Associates and appointed staff to render medical services and treatment to _____.

GuardianSignature _____ **Relationship** _____

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Hamilton Health Associates and appointed staff to render medical services and treatment to myself. I also agree that all providers of Hamilton Health Associates have my permission to share my medical information with each other if deemed necessary when I m receiving treatment from multiple providers of Hamilton Health Associates.

PatientSignature _____

FINANCIAL RESPONSIBILITY

I understand and agree that I am responsible for all financial obligations for all services for the above patient account. I further understand that there is a \$15.00 missed appointment fee for Chiropractic, Physical Therapy and Medical appointments not cancelled with a 24 hour notice. I also agree that there will be a \$25.00 fee for any returned checks.

Patient Signature _____