

**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** \_\_\_\_\_

## PERSONAL INJURY QUESTIONNAIRE

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Name of attorney \_\_\_\_\_

1. Have you had **recent x-rays or MRI's**? Y / N Where \_\_\_\_\_
2. State Accident occurred \_\_\_\_\_ Date Of Accident \_\_\_\_\_ Time of Day \_\_\_\_\_
3. Road Conditions: DRY WET ICY GRAVEL ROAD PAVEMENT OTHER \_\_\_\_\_
4. Were you: Driver Passenger Front Seat Back Seat \_\_\_\_\_
5. What direction were you headed? North South East West ON Street \_\_\_\_\_
6. Were you struck from: Front Rear Left Side Right Side \_\_\_\_\_
7. Were you aware of the impending collision? Y / N \_\_\_\_\_
8. Did you lose consciousness? Y / N How long \_\_\_\_\_
9. Were you wearing a seatbelt? Y / N Lap Belt Shoulder Belt Lap and Shoulder Belt \_\_\_\_\_
10. Describe the position of your head rest or seat back relative to the position of your head or ears at impact: Above Below # inches \_\_\_\_\_
11. Was the vehicle you were in at the time of impact: Stopped Moving  
If stopped, was the driver's foot on the brake? Y / N \_\_\_\_\_  
If moving, estimate the approximate speed of the vehicle \_\_\_\_\_ MPH
12. Did your vehicle hit the other vehicle? Y / N Where? \_\_\_\_\_  
Did the other vehicle hit your vehicle? Y / N Where? \_\_\_\_\_
13. In your own words describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Were the police notified of the accident? Y / N \_\_\_\_\_
15. Were traffic citations issued? Y / N To whom? \_\_\_\_\_
16. Please describe what happened to you following the accident( I.E. transported by ambulance to hospital, taken to hospital by friend, etc)

17. Where did you feel pain immediately after accident?

18. Please describe bleeding cuts or bruises received as a result of your accident:

19. Please describe if any of your body parts struck any part of the vehicle. (I.E. head hit windshield, chest hit steering wheel, etc.)

20. Which direction was your head pointed at the time of the accident?

21. Which direction was your torso pointed at the time of the accident?

22. Which of the following vehicle parts broke during the accident? Windshield  
R / L Window Steering Wheel Other \_\_\_\_\_

23. Driver's name of the vehicle you were in \_\_\_\_\_

Auto insurance company \_\_\_\_\_ Med Pay Amount \_\_\_\_\_

Phone number \_\_\_\_\_ Policy Number \_\_\_\_\_ Agent \_\_\_\_\_

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  
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

**Hamilton Health Associates**

Patient Name: \_\_\_\_\_

Case:

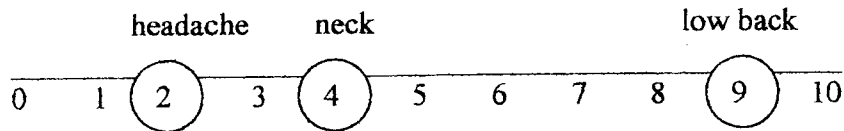
Date: \_\_\_\_\_

**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**?

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

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

0 1 2 3 4 5 6 7 8 9 10

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

*see other side*

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.

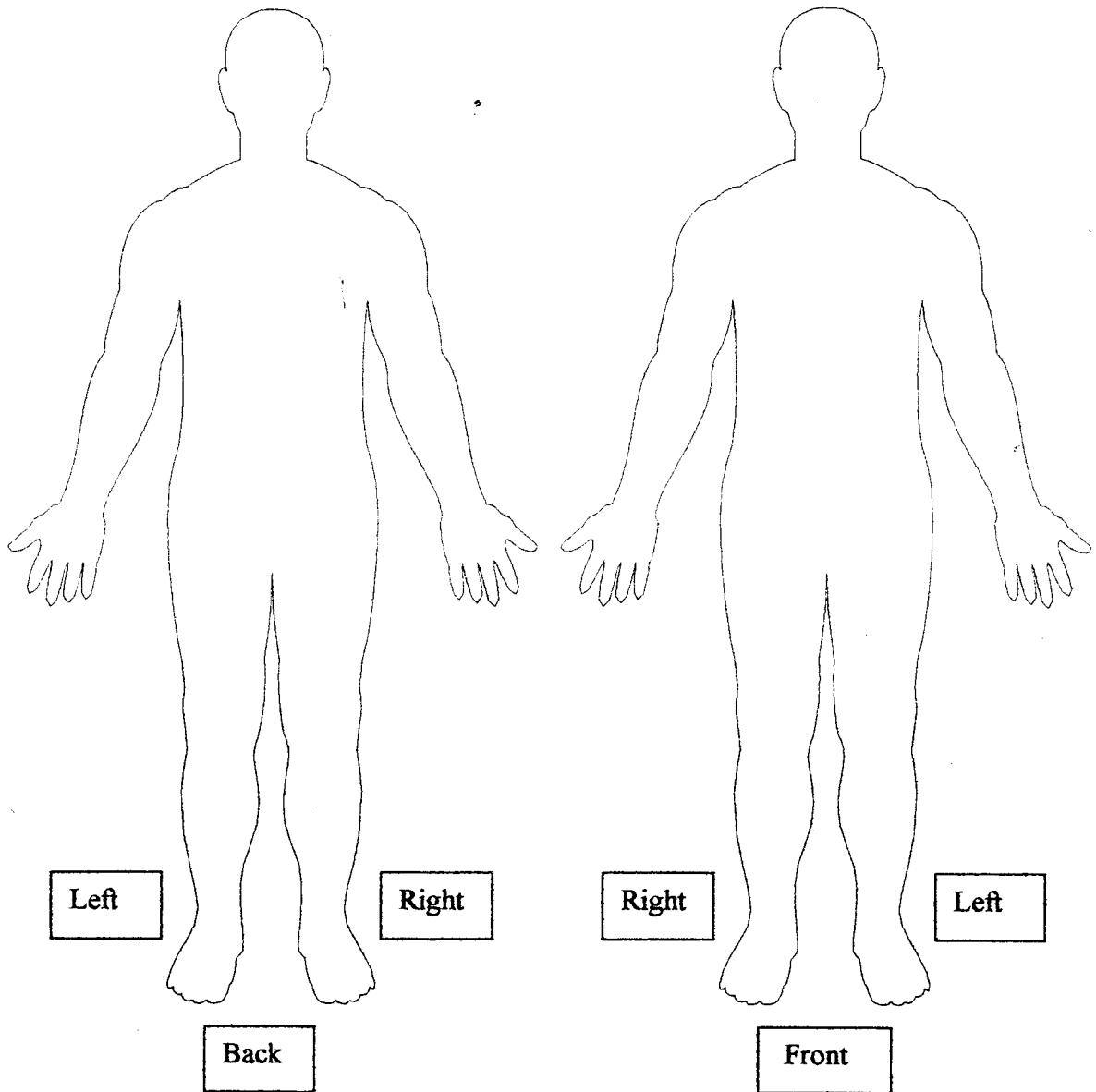
EFFECTIVE DATE

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: \_\_\_\_\_



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: \_\_\_\_\_

# HAMILTON HEALTH ASSOCIATES

1199 Main Street, P.O. Box 13346

Hamilton, Ohio 45013

(513) 863-2273 – Telephone

(513) 863-6022 – Facsimile

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## DOCTOR'S LIEN

Patient: \_\_\_\_\_

I do hereby authorize the above doctor to furnish you, my (attorney/insurance carrier), with a full report of his/her case history, examination, diagnosis, treatment and prognosis of (myself/my child) in regard to my (accident/illness) which occurred/began \_\_\_\_\_.

I hereby give a lien to said doctor on any settlement, claim judgment, or verdict as a result of said accident/illness, and authorized and direct you, my attorney/insurance carrier to pay directly to said doctor such sums as may be due and owing him/her for services rendered to me, and without such sums from such settlement, claim judgment, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am fully responsible to said doctor for all bills submitted by him/her for services rendered to me, and that this agreement is made solely for said doctor's additional protection and in contingent upon settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Date: \_\_\_\_\_ Patient/Guardian \_\_\_\_\_

The undersigned, being attorney of record or authorized representative of the above patient, does hereby acknowledge receipt of the above signed lien, and does agree to honor same to protect said doctor.

Date: \_\_\_\_\_ Authorized Person: \_\_\_\_\_

**Notice: Please date, execute and return a copy of this form to the doctor's office at P.O. Box 13346, Hamilton, Ohio 45013, or you may fax this executed document to the fax number listed above. Keep a copy for your records.**

**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** \_\_\_\_\_