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____

HAMILTON HEALTH ASSOCIATES

1199 Main Street, P.O. Box 13346
Hamilton, Ohio 45013
(513) 863-2273 – Telephone
(513) 863-6022 – Facsimile

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.

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

Philip M. Goldman, M.D.
HAMILTON HEALTH ASSOCIATES
1199 Main Street
PO BOX 13346
Hamilton, OH 45013
(513) 863-2273
FAX (513) 863-6022

PAIN MANAGEMENT AGREEMENT

PATIENTS ARE RESPONSIBLE FOR KEEPING TRACK OF THE MEDICATION THEY TAKE FOR PAIN. THE GOAL OF TREATMENT IS TO REDUCE PAIN AND INCREASE YOUR ABILITY TO SELF-MANAGE PAIN. YOU WILL BE ON A PROGRAM FOR PAIN MANAGEMENT FOR WHICH OPIOIDS (**NARCOTIC MEDICATION**) ARE USED AND WILL LAST FOR A RECOMMENDED AMOUNT OF TIME. IF YOU RUN OUT OF PAIN MEDICATION BEFORE IT IS TIME TO REFILL YOUR PRESCRIPTION, YOU WILL NOT BE GIVEN A REFILL UNTIL THE SCHEDULED TIME.

THE **OHIO REVISED CODE** LISTS DECEPTION TO OBTAIN DANGEROUS DRUGS SUCH AS OPIOIDS (**NARCOTIC MEDICATION**) AS A FELONY OFFENSE AND ARE PUNISHABLE BY IMPRISONMENT.

CONDITIONS OF TREATMENT

1. YOU ARE **NOT ALLOWED TO CHANGE** THE WAY MEDICATION IS TAKEN OR CHANGE THE DOSE OF YOUR MEDICATION WITHOUT PRIOR APPROVAL FROM YOUR PHYSICIAN.
2. **PRESCRIPTION RENEWALS REQUIRE AN OFFICE VISIT.** ONLY THE PAIN PHYSICIAN WILL PRESCRIBE YOUR PAIN MEDICATION, IN ACCORDANCE WITH HIS OR HER MEDICAL JUDGEMENT AS APPROPRIATE FOR YOU.
3. **YOU MUST SCHEDULE YOUR RETURN APPOINTMENTS TO THE OFFICE IN SUCH A MANNER THAT YOU DO NOT RUN OUT OF MEDICATIONS.**
4. NO REPLACEMENTS WILL BE PROVIDED FOR LOST OR STOLEN MEDICATIONS OR PRESCRIPTIONS.
5. ONLY THE PERSON WHO THE PRESCRIPTION IS WRITTEN FOR CAN PICK UP THE PRESCRIPTION AT THE PHARMACY. A **PHOTO ID** AND SIGNATURE ARE REQUIRED TO PICK UP PRESCRIPTIONS AT THE PHARMACY.
6. REFILLS ARE NOT MADE AT NIGHT, ON HOLIDAYS, OR WEEKENDS. PRESCRIPTIONS FOR PAIN MEDICATIONS ARE NOT CALLED IN TO THE PHARMACY.
7. YOU ARE REQUIRED TO BRING ALL CURRENT MEDICATIONS WITH YOU FOR YOUR OFFICE VISITS.
8. YOU ARE SUBJECT TO RANDOM URINE OR BLOOD DRUG SCREENS AND MEDICATION COUNTS. YOU WILL BE GIVEN A TWO-HOUR NOTICE.
9. **CHOOSE ONLY ONE PHARMACY**. YOU ARE REQUIRED TO GIVE NOTICE OF ANY CHANGE OF PHARMACY.
10. **A PSYCHOLOGICAL EVALUATION MAY BE REQUIRED IF DEEMED NECESSARY BY THE PHYSICIAN.**
11. ONLY ONE PHYSICIAN IS PRESCRIBING YOUR PAIN MEDICATIONS (THIS OFFICE). YOU MUST INFORM ALL HEALTH CARE PROVIDERS THAT YOU ARE UNDER A PAIN AGREEMENT.

YOU ARE NOT ALLOWED TO USE SUBSTANCES OF ABUSE WHILE UNDER TREATMENT FOR PAIN. THIS INCLUDES BUT ARE NOT LIMITED TO ALCOHOL, MARIJUANA, COCAINE, AMPHETAMINES, PCP, RAVE, CRYSTAL METH-AMPHETAMINE, ETC.

DISMISSAL

1. ANY QUESTIONABLE BEHAVIOR OR CIRCUMSTANCES IN THE USE OF MEDICATIONS (PRESCRIBED OR OTHERWISE).
2. INFRACTION OF ANY OF THE GUIDELINES IN THIS AGREEMENT.

PRECAUTION

OPIOID MEDICATION IN SOME INSTANCES MAY IMPAIR REACTION TIME OR COGNITIVE FUNCTION. THEREFORE, IT IS NOT RECOMMENDED THAT YOU OPERATE DANGEROUS EQUIPMENT OR OPERATE A MOTOR VEHICLE WHILE TAKING THESE MEDICATIONS.

I UNDERSTAND THAT THIS AGREEMENT DOES NOT ENTITLE ME TO TREATMENT. **I** RELEASE **DR. PHILIP M. GOLDMAN, REPRESENTATIVES** AND ANY **INDIVIDUALS** OR **ENTITIES** FROM LIABILITY FOR ANY ACT OR OUTCOME RELATED TO THE USE OF MEDICATIONS OR ANY MODALITIES USED TO TREAT PAIN.

I CONFIRM THAT I HAVE READ AND **FULLY UNDERSTAND** THE ABOVE AND THAT ALL BLANK SPACES HAVE BEEN COMPLETED PRIOR TO **MY SIGNING. I** AUTHORIZE A COPY OF **THIS AGREEMENT** TO BE SENT TO MY PHARMACIST IF REQUESTED.

I HEREBY CONSENT TO THE PROPOSED TREATMENT.

I AUTHORIZE **DR. PHILIP M. GOLDMAN** TO **INVESTIGATE** AND **EVALUATE,** AND CONSULT WITH ANY PERSON, ORGANIZATION, OR ENTITY THAT HAS, OR COULD HAVE ANY INFORMATION, DATE, OR DOCUMENTS REGARDING MY BACKGROUND AND HISTORY. I ALSO UNDERSTAND THAT ANY TEST RESULTS THAT INDICATE I AM INVOLVED IN ANY ILLEGAL DRUG ACTIVITY MAY BE TURNED OVER TO THE PROPER AUTORITIES FOR THEIR INVESTIGATION.

____
PATIENT SIGNATURE

____
PRINT NAME DATE

____
NAME OF PHARMACY PHONE EXPIRATION DATE

MEDICAL CERTIFICATION:
I HEREBY CERTIFY THAT I HAVE EXPLAINED THE NATURE, PURPOSE, BENEFITS, RISKS OF, AND ALTERNATIVES (INCLUDING NO TREATMENT AND ATTENDANT RISKS), TO PAIN MANAGEMENT. I HAVE OFFERED ANSWERS TO ANY QUESTIONS AND HAVE FULLY ANSWERED ALL SUCH QUESTIONS. I BELIEVE THAT THE PATIENT/PARENT/GUARDIAN FULLY UNDERSTANDS WHAT I HAVE EXPLAINED AND ANSWERED.

____
PHYSICIANS SIGNATURE DATE

____
WITNESS SIGNATURE PRINT NAME 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____________________________________