

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

**WORKER'S COMPENSATION QUESTIONNAIRE**

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

Employer at time of injury \_\_\_\_\_ Job Title \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Has your employer been notified? Y / N

1. Date of injury \_\_\_\_\_ Time of day \_\_\_\_\_ AM / PM

2. Have you had **recent X-rays or MRI's**? Y / N Where? \_\_\_\_\_

3. Have you been off work? Y / N Dates \_\_\_\_\_ to \_\_\_\_\_

4. Are you off work now? Y / N Last date worked \_\_\_\_\_

5. Describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Where did you feel pain immediately after the accident? \_\_\_\_\_

7. What are your complaints / Symptoms since the accident? \_\_\_\_\_

8. Were you hospitalized for this injury? Y / N Date \_\_\_\_\_ Where \_\_\_\_\_

9. Any physical complaints / impairments / injuries **BEFORE** the accident? Y / N

Describe \_\_\_\_\_

10. Have you lost time from work **before**? Y / N Explain \_\_\_\_\_

11. Do any other diseases or accidents affect you employment? Y / N Explain \_\_\_\_\_

12. In your work do you favor any part of your body? Y / N Explain \_\_\_\_\_

13. Do you have a history of absenteeism caused from accidents on the job? Y / N

14. Have you ever had a Worker's Compensation claim before? Y / N

15. Are your work activities restricted as a result of this accident? Y / N

16. Before this injury were you capable of working on an equal basis with other employees your age? Y / N

17. Since this injury are your symptoms: improving \_\_\_ getting worse \_\_\_ same \_\_\_

To the best of my knowledge the information provided above is true and correct.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**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:

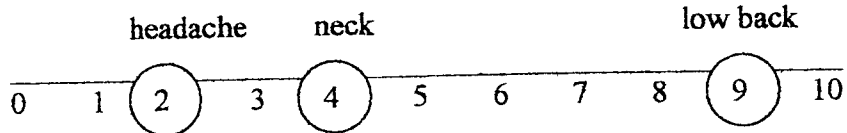
Date: \_\_\_\_\_

**VISUAL ANALOG SCALE**

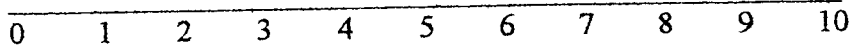
**INSTRUCTIONS:** Please circle the number (0 = no pain; 10 = unbearable pain) that best describes the question being asked.

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

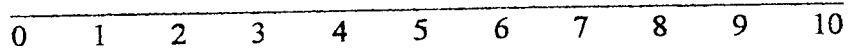
**EXAMPLE:**



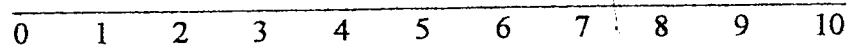
1. What is your pain **RIGHT NOW**?



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*



## Notice to Change Physician of Record

**The physician selected must be BWC certified or the injured worker will be responsible for payment.**

### INSTRUCTIONS TO THE INJURED WORKER:

• Please complete all of PART I of the form.

• Sign in the space provided and submit all copies to your MCO to record your change of physician.

### PART I

Injured worker's name		Date of injury	Claim number
Address		Phone number ( )	
City		State	9-digit ZIP Code
Please change my physician of record for the above listed claim as follows:			
From physician:		Provider number	
Address		Phone number ( )	
City		State	9-digit ZIP Code
To physician:		Provider number	
Address		Phone number ( )	
City		State	9-digit ZIP Code
Reason for change:			
<input type="checkbox"/> Physician moved <input type="checkbox"/> Physician no longer practicing <input type="checkbox"/> I moved <input type="checkbox"/> Physician is not a BWC certified provider			
<input type="checkbox"/> Physician terminated patient-provider relationship <input type="checkbox"/> Dissatisfied with physician's treatment <input type="checkbox"/> Other, please explain: _____			
Please explain: _____			
_____			
_____			
_____			
Have you been treated by the new physician for the condition(s) allowed in your claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes give date of first treatment _____			
Injured worker's signature			Date

### INSTRUCTIONS TO THE MCO:

• MCO to complete PART II.

• MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.

• Return signed copies per distribution listed below.

### PART II

Your request for change of physician has been received and recorded. Only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical management guidelines, may be billed to the MCO or the Self-Insured employer. The allowed conditions for this workers' compensation claim, with corresponding ICD-9-CM codes are as follows:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MCO name	Phone number ( )
MCO case manager	Date

Distribution: White-MCO Claim file • Yellow-Injured worker • Pink-Requested physician • Goldenrod-Former physician

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

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.

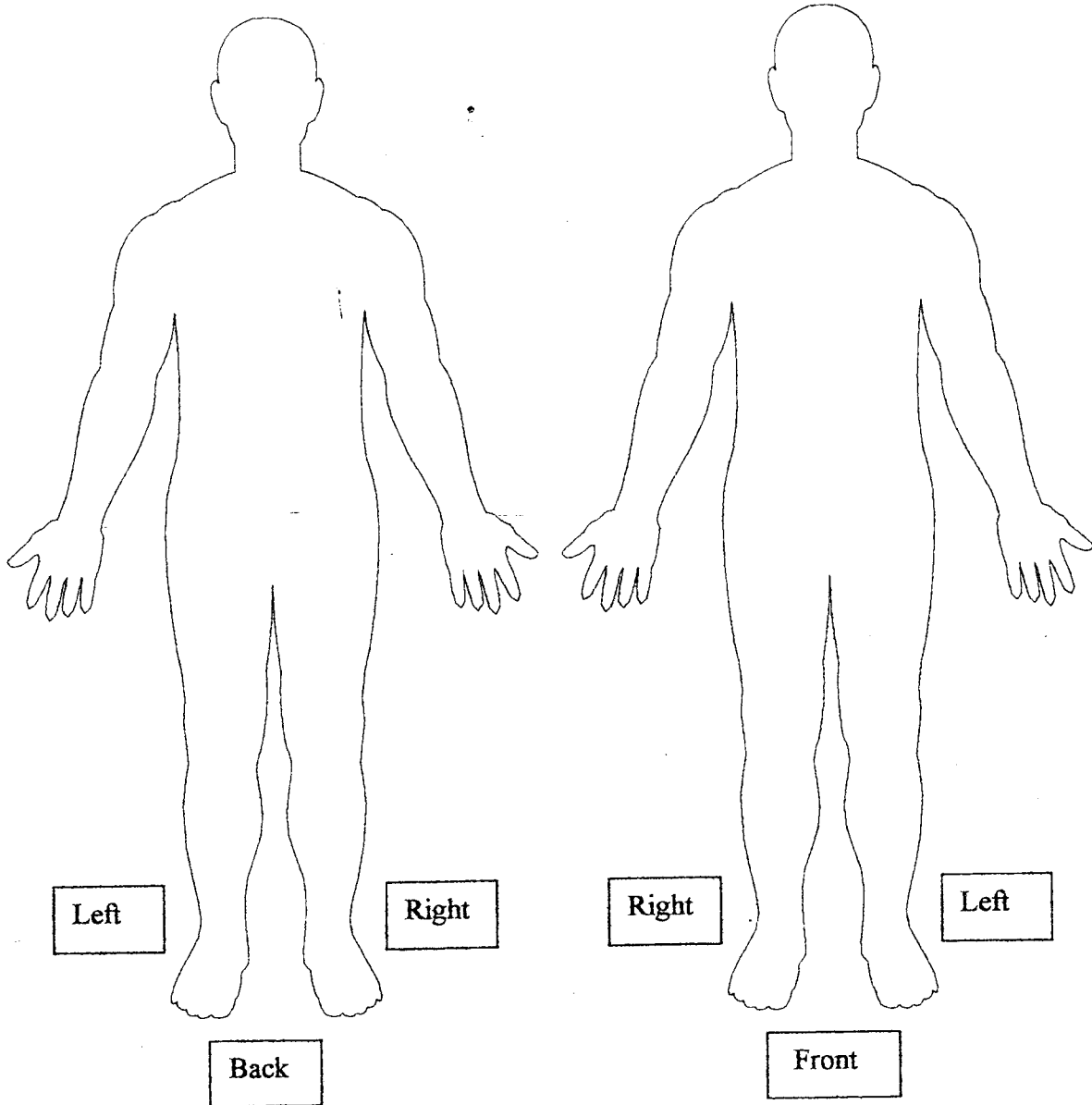
EFFECTIVE DATE

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: \_\_\_\_\_

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO  
HAMILTON HEALTH ASSOCIATES FOR  
WORKER'S COMPENSATION AND ATTORNEY

Patient Name \_\_\_\_\_  
Employer \_\_\_\_\_  
Claim# \_\_\_\_\_  
SS# \_\_\_\_\_

Should I elect to settle my Worker's Compensation claim(s), either fully or in part, and basis of the settlement includes consideration of the services provided by Hamilton Health Associates, and the settlement does not specifically provide for direct payment to Hamilton Health Associates for all of the services and treatment it has rendered on my behalf on my claim(s), the agree that the cost of all unpaid services and treatment rendered by Hamilton Health Associates on my behalf relative to my claim(s) shall be paid directly to me, or my attorney if I am represented, from my portion of the settlement proceeds directly to Hamilton Health Associates. In addition, I hereby authorize my attorney (if represented), to withhold those monies which I have agreed to accept as payment in full for any treatment or services provided by Hamilton Health Associates on my behalf. Finally, I hereby authorize my legal representative to discuss those portions of my case that are relevant to assisting my attorney in obtaining payment of all treatment and services provided by Hamilton Health Associates on my behalf.

Forward payments onto: Hamilton Health Associates  
P. O. Box 13346, Hamilton, Ohio 45013.

A photocopy of the Assignment shall be considered as effective and valid as original.

Dated at \_\_\_\_\_ County, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature Claimant

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature Attorney

\_\_\_\_\_  
Witness

**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 \_\_\_\_\_.

**Guardian Signature** \_\_\_\_\_ **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.

**Patient Signature** \_\_\_\_\_

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