

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 _____

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: _____

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.

Attention all Worker's Compensation patients!!!

In an effort to provide you with the best care possible there are a few things you should know regarding your BWC injury.

BWC will only pay for an office visit that is focused around your injury and the allowed body parts. Any other claims that you may have may not be discussed during your office visit. Those will have to be scheduled at a separate time. The visit must focus on the specific body part allowed. If the BWC denies your bill for any reason you will be financially responsible for that bill before your next office visit.

Any letters that you or your attorney may request are subject to a fee. BWC does not pay for these fees. These fees are based on the length of the letter and how much research went into the letter. These fees will need to be paid for by you before you can pick up your letter. If you agree to have the letter dictated and do not pick it up you will still be charged and the fee will need to be paid before your next office visit.

Any C-84's (paperwork for compensation while you are off work) that you or your attorney request to have filled out must be done during your office visit and you must take the original with you to turn it in. A copy will be placed in your file but we are not responsible for turning them in. You must bring the C-84 with you we do not keep any in the office.

Once Dr. Goldman feels that you are at MMI (Maximum Medical Improvement) he will refer you to another physician who may specialize in chronic pain. We will forward all of your medical records with your authorization.

If at anytime during your care here at Hamilton Health Associates you have any questions please feel free to ask us. If you feel that your questions are not being answered please talk to Brhea (Insurance Manager) or Debbie (Office Manager).



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

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 AUTHORITIES 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

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), I 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 _____.

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 _____