Hamilton Health Associates

6531 Winford Avenue
(513) 863-2273 (p) ~ (513) 863-6022(f)

Referred By:_____ Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Hamilton Health Associates** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

-Signature of Insured / Guardian - Date

*HHA – Hamilton Health Associates; PBH – Psynergy Behavioral Health; JBA – Jeffery Baker & Associates

INSURANCE

I authorize my insurance company to pay by check made out to **HHA, PBH or JBA** and mail directly to 6531 Winford Avenue, Hamilton, Ohio 45011. I also authorize the release of any information pertinent to my cause to any insurance company, adjuster, or attorney involved in this claim.

Policy Holder or Claimant Signature _____

Policy Holder Social Security Number _____

WORKERS' COMPENSATION

I authorize my MCO to pay by check made out to **HHA, PBH or JBA** and mail directly to 6531 Winford Avenue, Hamilton, Ohio 45011. I also authorize the release of any information pertinent to my cause 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 **HHA, PBH or JBA**, I agree to pay for all unpaid services rendered by **HHA, PBH or JBA**.

Patient Signature_____

PERSONAL INJURY

I authorize my attorney or car insurance company to pay by check made out to **HHA, PBH or JBA** and mail directly to 6531 Winford Avenue, Hamilton, Ohio 45011. I also authorize the release of any information pertinent to my cause to any insurance company, adjuster, or attorney involved in this claim. **HHA, PBH or JBA** will accept up to $5,000.00 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 **HHA, PBH or JBA**, I agree to pay for all unpaid services rendered by **HHA, PBH or JBA**.

Patient Signature_____

CONSENT TO TREAT A MINOR

I _____, give my permission for the physician and appointed staff to render services ant treatment to _____.

Patient/Guardian Signature_____

Relationship to Minor_____

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize the physician and appointed staff to render medical services and treatment to myself. I also agree that all providers that I am treating with at this office have my permission to share my medical information with each other if deemed medically necessary when I am receiving treatment from multiple providers at this office.

Patient Signature_____

FINANCIAL RESPONSIILITY

I understand and agree that I am responsible for all financial obligations for all services for the above account. I further understand that there is a fee of $25-$125 for missed appointments for all providers that I am treating with if a 24 hour notice is not given. I also agree that there will be a $25-$50 fee for any returned checks.

Patient/Guardian Signature_____

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 you 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 your entire 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 04/05/2003.

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 Name

_____
Date

Notice of Financial Policy

Matt Murdock, D.C., Tricia Giessler, Psy D, Physical Therapy,
Katie McGuire, LMT, David Schwartz, Ph D, Jeff Baker, Ph D.

Please carefully review the following policies regarding our financial practices pertaining to the collection of payment for the services provided at our office. Although we make every attempt to provide you with accurate information regarding your insurance benefits and coverage for all our services, we CAN NOT GUARANTEE your benefits will provide coverage for all of our services. **You insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize as health care providers, our relationship is with you and not your insurance company.** We ask that you also become familiar with your insurance policy by calling the Member Services phone number located on your insurance card or by logging in to your insurance company's website.

_____**MEDICARE:** Medicare provides chiropractic coverage for SPINAL ADJUSTMENTS ONLY. X-rays/Exam/therapies are not covered and will be a separate charge. Medicare patients will be required to sign an Advanced Beneficiary Notice (ABN). This form will explain which services Medicare may not cover and that you may be responsible for those charges.

ABN (Advanced Beneficiary Notice) Signed Yes □ No □

_____**MEDICAID**: We accept CARESOURCE. Caresource provides chiropractic coverage for SPINAL ADJUSTMENTS AND X-RAYS ONLY. Exam/therapies are not covered and will be a separate charge Caresource allows 15 chiropractic treatments per calendar year for ages 21 and over, for ages 0-20 they cover 30 visits. Payment for any additional treatment will be the patient's responsibility.

_____**WORKER'S COMPENSATION:** We are a certified Ohio Worker's Compensation provider. Only active, allowed claims are eligible for treatment authorization requests. ALL TREATMENT MUST BE PRE-APPROVED. If claim is inactive, payment is required at the time of service.

_____**AUTO ACCIDENTS/PERSONAL INJURY:** If you have been involved in an auto accident we will bill treatment for your injuries to YOUR AUTO INSURANCE. If you have comprehensive coverage (not just liability) you have "medpay" coverage. We will need to verify how much medpay coverage is available. If you were not the at-fault party your insurance company will recover any money paid from the at-fault party's insurance company. We will honor a LETTER OF PROTECTION from your attorney; this is required prior to treatment. Any reports required will be the patient's responsibility.

_____**GENERAL HEALTH INSURANCE:** We are IN networks with the following major health insurance providers: Anthem BC/BS. Medical Mutual of Ohio, Aetna, Cigna, United Health Care. Also, please be aware of any deductibles and co-insurance that you may owe. Chiropractic services are typically reimbursed as a SPECIALIST or PHYSICAL THERAPY. Therefore, your co-pay may only apply to the initial office visit. Co-insurance and deductibles are calculated by your insurance company and reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement, payable upon receipt. Some benefits are not covered by insurance and will be patients responsibility.

_____**NO COVERAGE/SELF PAY**: We do not have alternative payment options if you do not have insurance that provides chiropractic benefits or if you have no insurance at all. We will customize a cash payment plan based on your individual treatment plans. Pre-pay, Monthly, or Pay as you Go are available based on your needs and frequency of care.

Massage Therapy Services, Orthotics, Spinal Supports, Pillows, Retail Goods, and all other non-physician provided services are NOT BILLED TO YOUR INSURANCE and payment is required at the time of service/purchase

Please remember your overall health needs are our NUMBER ONE priority here. We will not turn you away because you are underinsured or uninsured. We understand financial strains and will be respectful of your decisions to alter your recommended treatment plans to accommodate your payment responsibilities.

By signing below I acknowledge that I have read and understand the Financial Policies of this office and that I am responsible for arranging payment of all services provided to me at this office.

Patient Signature (or Parent of Minor) _____ Date _____

Patient Name: _____

MEDICAL/SURGICAL HISTORY

Please circle Y/ N if you have ever had:

Y	N	Allergies	Y	N	Gallbladder Problems
Y	N	Anemia	Y	N	Hepatitis
Y	N	Anxiety	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	Incontinence
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Cancer	Y	N	Metal Implants
Y	N	Cardiac Conditions	Y	N	Multiple Sclerosis
Y	N	Cardiac Pacemaker	Y	N	Osteoporosis
Y	N	Chemical Dependency	Y	N	Parkinsons
			Y	N	Rheumatoid Arthritis
Y	N	Circulation Problems	Y	N	Seizures
Y	N	Currently Pregnant	Y	N	Speech Problems
Y	N	Depression	Y	N	Strokes
Y	N	Diabetes	Y	N	Thyroid Disease
Y	N	Dizzy Spells	Y	N	Tuberculosis
Y	N	Emphysema/Bronchitis	Y	N	Vision Problems
Y	N	Fractures	Y	N	Other: _____

Within the past year, have you had any of the following symptoms? (Circle all that apply)

Y	N	Chest pain	Y	N	Difficulty sleeping
Y	N	Heart palpitations	Y	N	Loss of appetite
Y	N	Cough	Y	N	Nausea/vomiting
Y	N	Hoarseness	Y	N	Difficulty swallowing
Y	N	Shortness of breath	Y	N	Bowel problems
Y	N	Dizziness or blackouts	Y	N	Weight loss/gain
Y	N	Coordination problems	Y	N	Urinary problems
Y	N	Weakness in arms / legs	Y	N	Fever/chills/sweats
Y	N	Loss of balance	Y	N	Headaches
Y	N	Difficulty walking	Y	N	Hearing problems
Y	N	Joint pain or swelling	Y	N	Vision problems
Y	N	Pain at night	Y	N	Other: _____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe including dates: _____

Are you currently under the care of the following? (Check all that ap

☐ Acupuncturist	☐ Occupational Therapist
☐ Cardiologist	☐ Orthopedist
☐ Chiropractor	☐ Osteopath
☐ Dentist	☐ Physical Therapist
☐ Family practitioner	☐ Podiatrist
☐ Medical Doctor (MD)	☐ Psychiatrist / Psychologist
☐ Massage Therapist	
☐ Neurologist	Other:

Within the past year, have you had any of the following tests? Check all that apply.

☐ Angiogram	☐ Mammogram
☐ Arthroscopy	☐ MRI
☐ Biopsy	☐ Myelogram
☐ Blood Tests	☐ Nerve Conduction Velocity
☐ Bone Scan	☐ Pulmonary Function
☐ Bronchoscopy	☐ Spinal Tap
☐ CT Scan	☐ Stress Test
☐ Doppler Ultrasound	
☐ Echocardiogram	
☐ EEG	
☐ EMG	
☐ EKG	

MEDICATIONS

Please list any physician-prescribed medications you currently take, the reason, dosage, and frequency (include pills, injections, topical, skin patches)

_____

_____

_____

_____

_____

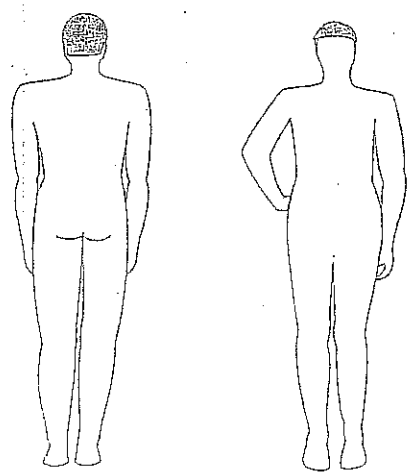
_____

_____

Do you take any nonprescription medications? (Check all that apply)

☐ Advil/Aleve/Ibuprofen	☐ Decongestants
☐ Antacids	☐ Herbal supplements
☐ Tylenol	☐ Antihistamines
☐ Aspirin	☐ Other _____

On the diagram, please indicate the location of your symptoms:



Primary Physician: _____

Referring Physician: _____

Patient Signature: _____

Therapist Signature: _____

PERSONAL INJURY QUESTIONNAIRE

Date: _____ Name of Attorney: _____

Name _____ DOB: _____

1. Date of injury _____ State accident occurred _____ Time of day _____ **AM/PM**
2. Have you had **recent X-ray's or MRI's? Y/N** Where? _____
3. Road conditions: DRY, WET, ICY on GRAVEL ROAD, PAVEMENT, OTHER _____
4. Were you: DRIVER or PASSENGER in the FRONT SEAT or BACK SEAT
5. What direction were you headed: NORTH, SOUTH, EAST, WEST on what 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 were you out? _____
9. Were you wearing a seatbelt? **Y/N** LAP BELT, SHOULDER BELT or BOTH
10. Describe the position of your headrest or seat back relative to the position of your head or ears at impact: ABOVE or BELOW #INCHES _____
11. Was the vehicle you were in at the time of impact: MOVING or STOPPED
    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? _____
13. Did the other vehicle hit your vehicle? **Y/N** Where? _____
14. Please describe the accident: _____

    _____

    _____
15. Were the police notified of the accident? **Y/N**
16. Were traffic citations issued? **Y/N** To whom? _____
17. What happened immediately following the accident? (I.E. transported by ambulance to hospital, taken to hospital by friend, etc.) _____

    _____

    _____
18. Where did you feel pain immediately after the accident? _____

    _____
19. Please describe bleeding cuts or bruises received as a result of the accident: _____

    _____
20. Please describe if any of your body parts struck any part of the vehicle: _____

    _____
21. What direction was your head and torso pointed at the time of the accident? _____/_____
22. Did any parts on the car break? If so, list them: _____
23. Driver's name of the vehicle you were in? _____

Auto Insurance Company _____ **Med Pay Amount $**_____

Adjuster's Name & Number _____; ( )_____-_____

Med Pay Claim # _____

Patient Signature: _____ **Date:** _____

HAMILTON HEALTH ASSOCIATES

6531 Winford Avenue, Hamilton, Ohio 45011
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 6531 Winford Avenue, Hamilton, Ohio 45011, or you may fax this executed document to the fax number listed above. Keep a copy for your records.