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: _____Carrier_____

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

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

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Hamilton Health Associates**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any appointment that is not canceled 24 hours prior to scheduled appointment will be charged $35.00 - $125.00

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]
May we contact you via email/text? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ 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 _____

Hamilton Health Associates
6531 Winford Avenue, Hamilton, Ohio

CASE HISTORY

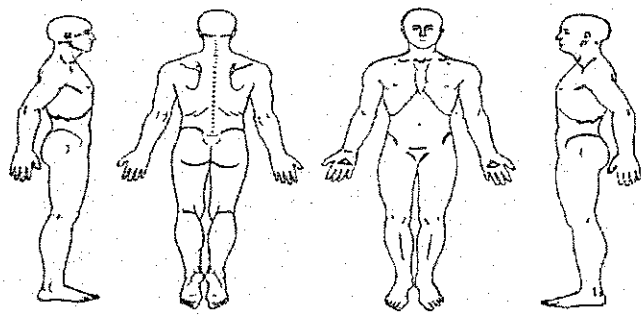
_____ Height
_____ Weight
_____ BP
_____ Temp

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain)

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____