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: _____ (May we send your health information to this provider? Y / N)

Person to contact in case of emergency: Name_____ 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 Yes, Where? _____

What operations have you had? _____ When? _____

Serious Illness/Infectious Diseases: _____ When? _____

Have you received the COVID 19 Vaccination (you are not required to provide this information) Y / N Have you had boosters? Y / N

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? _____

_____

Known drug allergies? _____

Preferred Pharmacy? _____

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.

X_____ _____

Signature of Insured / Guardian Date

INSURANCE

I authorize my insurance company to pay by check made out to Hamilton Health Associates and mail directly to 6531 Winford Avenue, Hamilton, Ohio 45011. 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 _____

WORKER'S COMPENSATION

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

Patient Signature _____

PERSONAL INJURY

I authorize my Attorney or Car Insurance Company to pay by check made out to Hamilton Health Associates and mail directly to 6531 Winford Avenue, Hamilton, Ohio 45011. 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.

Patient Signature _____

CONSENT TO TREAT A MINOR

I_____, give my permission for the physician and appointed staff to render services and treatment to_____.

Parent/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 RESPONSIBILITY

I understand and agree that I am responsible for all financial obligations for all services for the above patient account. I agree to pay for all services rendered by Hamilton Health Associates. The fees vary depending on provider and range from $50.00-$300.00/visit which reflects a good faith reduction. 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 _____

Notice of Financial Policy

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. Your 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.

_____**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.

_____**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. 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. or if my claim doesn't pay for treatment rendered, I agree to pay for all unpaid services rendered by Hamilton Health Associates. The fees vary depending on provider and range from $50.00-$300.00/visit which reflects a good faith reduction.

_____**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 consider honoring a LETTER OF PROTECTION from your attorney; this is required prior to treatment. Any reports required will be the patient's responsibility. 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. or if my claim doesn't pay for treatment rendered, I agree to pay for all unpaid services rendered by Hamilton Health Associates. The fees vary depending on provider and range from $50.00-$300.00/visit which reflects a good faith reduction

_____**GENERAL HEALTH INSURANCE:** We are IN networks with many major health insurance providers: 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. 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. Should my insurance not pay for my services, I agree to pay for all unpaid services rendered by Hamilton Health Associates. The fees vary depending on provider and range from $50.00-$300.00/visit which reflects a good faith reduction.

_____**NO COVERAGE/SELF PAY**: We do have alternative payment options if you do not have insurance that provides chiropractic benefits or if you have no insurance at all. Time of Service discounts with a 30-50% reduction as payment made without billing insurance.

Injections, 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. Custom orthotics are $250/pair and due up front in order for them to be ordered.

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

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 key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you.

Please read below and if you have any questions, please ask a member of our office staff.

Informed Consent for Chiropractic:

A patient, in coming to the chiropractic doctor, gives 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 the special practice and is available to work with other types of providers in your healthcare regimen. I understand that if I am accepted as a patient 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. *Please circle what applies to you.*

Consent to Evaluate and Treat a Minor:

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

Communication:

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

Spouse: _____; Children: _____; Other: _____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machine or voice mails Yes ( ) No ( )
May we contact you via email and/or text? Yes ( ) No ( )

Practice Requirements, Effective 04/05/2003

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 terms of the 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.

Acknowledgment

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

Print Name: _____ Signature: _____

Date: _____

Hamilton Health Associates

6531 Winford Avenue

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Informed Consent for Pain Procedures

You have a pain problem that has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatment of your pain. There is NO guarantee that a procedure will cure your pain, and in rare cases, it could become WORSE, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, then determine if further treatment is necessary. Your physician will explain the details of the procedure listed below. Tell the physicians if you are taking any blood thinners, as these can cause excessive bleeding and a procedure should NOT be performed. Alternatives to the procedure include medications, physical therapy, acupuncture, surgery, etc. Benefits include increased likelihood of correct diagnosis and /or of decrease or elimination of pain.

Risks are

- Increased pain and allergic reaction from local anesthetics, iodine, contrast (X-Ray dye), materials containing latex, IV anesthetics and/or other medications
- Allergic reaction from steroid; facial flushing, elevation in blood glucose, headache, increased appetite, weight gain, swelling, menstrual irregularities, hoarseness, numbness, infection, abnormal heartbeats, increased blood pressure, stroke, heart attack, insomnia, ect.
- Infection on skin, tissue, bones, joints, discs, nerves, ligaments, possibly blood stream (Sepsis), brain and spinal cord (Meningitis) may require hospitalization
- Bleeding into epidural space (Epidural Hematoma) and into spinal canal (Spinal Hematoma) may require surgical interventions such as an evacuation of blood from epidural space or spinal canal and decompression surgery
- Nerve damage, nerve injury, tissue injury, tissue damage, temporary and permanent numbness and/or weakness, paralysis, spinal cord injury, urinary and/or fecal incontinence
- Headache ("Spinal headache") may require blood patch (Injecting your own blood into epidural space) and hospitalization
- Death
- Trigger Point Injection, Peripheral Nerve block, Occipital Nerve Block: In addition to the above complications, air in lung (Pneumothorax) requiring chest tube in hospital, local pain from tissue and/or nerve irritation, dimpling of/depression in skin.
- Joint injection: In addition to the above complications, injection and fluid collection in the joint(s) may require antibiotic treatment, fluid aspiration and surgical interventions.

Procedure: _____

The incidence of serious complications listed above requiring treatment is low, but it may still occur. Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done. I have read or had read to me the above information. I **UNDERSTAND** there are risks involved with any spinal procedure, to include rare complications, which may not have been specifically mentioned above.

The risks have been explained to my satisfaction and I accept them and consent to any procedure which is performed by Dr. J.L. Mattson Murdock I herein authorize physicians, nurse practitioners and their associates in Hamilton Health Associates to perform this procedure.

I also understand that one of the greatest risks involved with pain management procedures involves various medications taken, allergies and my general medical condition. I will inform the doctor of any blood thinning medication taken or any changes in other medications, allergies, or medical condition prior to any procedure.

_____ _____

Patient or his/her legal guardian Date

Pharmacy _____ Allergies _____

Medical Provider Declaration: I and/or my associate have explained the procedure and the pertinent contents of this document to the patient and have answered all the patient's questions. To the best of my knowledge, the patient has been adequately informed and the patient has consented to the above-described procedure.

_____ _____

J.L. Mattson Murdock, DC APRN-CNP, DACBSP Date

Hamilton Health Associates
6531 Winford Avenue, Hamilton, Ohio

CASE HISTORY

_____ Height
_____ Weight
_____ Blood Pressure
_____ Temperature

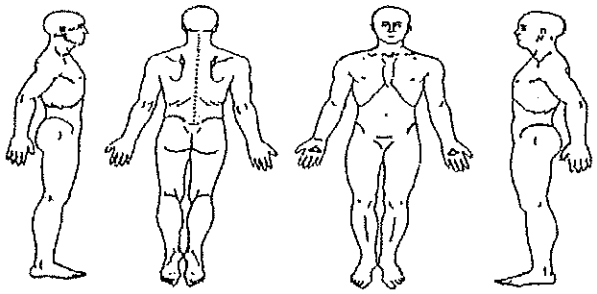
Name: _____

Age: _____

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

(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 didn't help? _____

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
19. List current medications, past surgeries and diagnostic tests _____

_____

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

Patient/Guardian Signature _____ Date: _____

Additional information can be written on back side of sheet.

Pain Disability Index

Name _____ Date_____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the seven categories of live activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family / Home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (eg, yard work) and errands of favors for other family members (eg, driving the children to school).

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dinning out, and other social functions.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes nonpaying jobs as well, such as that of the housewife or volunteer worker.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

HAMILTON HEALTH ASSOCIATES

6531 Winford Avenue, Hamilton, Ohio 45011
513-863-2273 – phone; 513-863-6022

Doctor's Lien/Assignment

Personal Injury/Auto Accident

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 on _____.

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 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 doctors 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: _____

Workers Compensation

Patient:_____ Claim Number: _____

Should I elect to settle my Worker's Compensation claim(s) either fully or in part, the 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 services and treatment rendered on my behalf on my claim(s), agree that the cost of all unpaid services and treatment rendered by Hamilton Health Associates on by 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.

_____ _____
Signature Claimant Witness

_____ _____
Signature Attorney Witness

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** If yes, 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, Street Name _____
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 what number of 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** If yes, 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? **Y/N** If yes, 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:** _____