Hamilton Health Associates

6531 Winford Avenue, Hamilton, Ohio 45011
(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 Psychological Care? Y / N If Yes, Who? ______________________________

What medications or drugs are you taking? (Check those that apply): Pain Killers____ Psych____ Cholesterol Meds____ Birth Control ____ Blood Pressure Meds____ Muscle Relaxers____ 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.

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. 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 ______________________________

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. 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 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 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

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 ___________

Dr. David P. Schwartz, Ph.D.
Dr. Tricia M. Giessler Zaferes, Psy.D.

Psychotherapist-Patient Services Agreement (OHIO)

Welcome to our practice. This document (the Agreement) contains important information about our professional services, business policies, and HIPPA (Health Insurance Portability and Accountability Act). Please read the *Ohio Notice Form* for details explaining your privacy rights. The law requires that we (Drs. Schwartz or Dr. Giessler Zaferes) obtain your signature acknowledging that we have provided you with this information. Although these documents are very long, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. This document is an agreement between you and your psychologist (Dr. Schwartz or Dr. Giessler Zaferes). Statements that follow use the term "I" to refer to your psychologist.

PSYCHOLOGICAL SERVICES

Risks and benefits You may experience uncomfortable feelings like sadness, guilt, anger, or anxiety. On the other hand, therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Initial sessions Our first session or two will focus on an evaluation of your needs. Following the evaluation I will offer my impressions and a treatment plan. You will have the opportunity to agree or disagree with my impressions and make any additions or deletions to the treatment plan. If you feel comfortable with working with me, you may decide to continue therapy. However, if you have doubts or questions about my procedures, please bring them up so we can discuss them. If you prefer to find another mental health professional, I will be glad to assist you as needed.

Meetings If you decide to continue in therapy, we will meet for 50 minute sessions either weekly, bi-weekly or monthly, depending on your needs. **You are expected to pay for schedule sessions unless you provide 24 hours advance notice of cancellation. (Insurance companies do not provide reimbursement for cancelled sessions.) In some circumstances I may waive these charges.**

Professional Fees Psychological evaluations: $300.00
Legal consultations (including preparation and travel time): $200/per hour.
Report writing (other than evaluations), telephone conversations lasting longer than 10 minutes, consultation with other professionals, preparation of records or treatment summaries, or any time spent performing any other services you request of me will be charges at a rate of $25 each 10 minute period.

Contacting me You may contact me by calling the office (513-863-2273). I will return your call as soon as possible during the work week. Calls made on the weekend will be returned on Monday. In an emergency, you may reach Dr. Schwartz or Dr. Giessler Zaferes at 513-863-2273 or you may contact your family physician or go to the nearest emergency rom. If I am away for an extended period, I will provide you with the name of a colleague to contact for emergency purposes.

Limits on Confidentiality The law protects the privacy of all communications between a patient and a psychologist except for certain exemptions. In most cases I can only release information about your treatment if you sign a written authorization form which meets the legal requirements imposed by HIPAA. Other situations require only that you provide written, advance consent. Some of these situations include 1) Patient filing BWC claims, 2) Consultations with other health or mental health professionals who are also legally bound to keep information confidential, 3) Staff that performs health insurance billing (staff members have been trained in protecting your privacy and have agreed not to release any information outside of the practice, 4) Disclosures required

by health insurers or to collect overdue fees. **In some situations I am required to disclose information without your consent or authorization.** These include 1) If you are involved in a court proceeding, your PHI is protected by the psychologist-patient privilege law, however I will release information if you or your legal representative five written authorization. I must release information if there is a court order (a subpoena is not a court order. 2) If a government agency requests information for health oversight activities, I may be required to provide it. 3) If a patient files a complaint or a lawsuit against me, I may disclose relevant information in order to defend myself. 4) If a patient files a worker's compensation claim, the patient must sign a release so that I may release the information, records or reports relevant to the claim. **In some cases I am legally obligated to take actions to protect others from harm.** These include 1) If there is suspicion of abuse or neglect to a child under the age of 18 or to a mentally retarded, developmentally disabled, or physically impaired child under the age of 21, I must file a report with the Public Children's Services Agency and I may be required to provide additional information. 2) If senior adult is being abused, neglected, or exploited, I am required to report this to the county Department of Job and Family Services. 3) If I know or have reasonable cause to believe that a patient has been the victim of domestic violence, I must note that information in the patient's records. 4) If I believe a patient presents a clear and substantial risk of imminent serious harm to him/herself or someone else, I must disclose that information to appropriate public authorities, potential victims, relevant professional workers, and family members. **Under these circumstances, I will make every effort to fully discuss the situation with you and to limit my discloser to what is necessary. The laws governing confidentiality can be quire complex and I am not an attorney, in situations where specific advice is required, formal legal advice may be needed.**

Professional Records

You should be aware that, pursuant to HIPAA, I keep protected health information about you in two sets of professional records. One set constitutes tour Clinical Record. It includes your initial evaluation, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $2.74 per page for the first ten pages, 57 cents per page for pages 11 through 50, and 23 cents per page for pages in excess of fifth, plus $15 fee for records search, plus postage. The exceptions to this policy are contained in the Ohio Notice Form. If I refuse your request for access to you Clinical Record, you have the right to review, which I will discuss with you upon request. In addition, I also keep a set of Psychotherapy Notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, and, except for BWC, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Except for BWC, insurance companies cannot require your Authorization as a condition of coverage nor personalize you in any way for your refusal. You may ask to examine and/or receive a copy of your Psychotherapy Notes. I have the right to determine the appropriateness of such a disclosure. We can discuss this if it becomes a relevant issue.

Patient Rights

HIPAA Provides you with several new or rights including requesting that I amend your record; requesting restrictions on what information is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. In the case of worker's compensation some of these rights may not apply. I am happy to discuss any of these issues with you.

Minors and Parents

Patients under 14 years of age who are not emancipated, and their parents should be aware that the law allows parents to examine their child's treatment records unless I decide that such access would injure the child or we agree otherwise. **Children between 14 and 18** may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment. For children 14 and over, it is my policy to request an agreement between my patient and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss, the matter with the child, if possible, and do my best to handle any objections he/she may have.

Billing and Payments

You will be expected to pay for each session **at the time of service,** unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.] If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

Insurance Reimb.

If you have health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however; **you (not your insurance company)** are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you and once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.] **You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of y our entire clinical record.** In such situations I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a

computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. **By signing this Agreement, you agree that I can provide requested information to your carrier.** Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what we will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. [Unless prohibited by contract].

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature: ______________________________ Date: ____________________

OHIO NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

I. Uses and Disclosures for Treatment, Payment, and Healthcare Operations

Psynergy Behavioral Health may *use* or *disclose* your ***protected health information*** (PHI), for *treatment, payment, and healthcare operations* purposes with you *consent.*
To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- **"PBH"** refers to Psynergy Behavioral Health (Dr. David P. Schwartz)
- **"HHA"** refers to Hamilton Health Associates (Dr. Tricia M. Giessler Zaferes)
- *"Treatment, Payment and Healthcare Operations"*
    - *Treatment* is when PBH, HHA or provides, coordinates or manages your healthcare and other services related to your healthcare. An example of treatment would be when your psychologist consults with another healthcare provider, such as your family physician or another psychologist.
    - *Payment* is when your psychologist obtains reimbursement for your healthcare. An example of payment is when your PHI is disclosed to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
    - *Healthcare Operations* are activities that relate to the performance and operation of our practice. An example of healthcare operations is quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities outside of our office, clinic, practice group, etc., such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of our office, clinic, practice group, etc., such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. Am *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and healthcare operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your

psychotherapy notes. *"Psychotherapy notes"* are notes that have been made about our conversation during a private, group, joint, or family counseling session, which have kept separate from the rest medical record. These notes age given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that:

1) PBH or HHA has relied on that authorization; or
2) The authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to consent the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

PBH or HHA may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** if, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally disabled, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physically or mentally wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are ***required by law*** to immediately report that knowledge or suspicion to the Ohio Department of Children Services, or a municipal or a county peace officer.

- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect or exploitation, we are ***required by law*** to immediately report such belief to the Ohio Department of Job and Family Services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records therefor, such information is privileged under state law and we will not release this information without written authorization from you or your persona of legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious threat to Health of Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm to yourself or another person, we ***may*** disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the

intent and ability to carry out the threat, then we are ***required by law*** to take one or more of the following actions in a timely manner:

1) Take steps to hospitalize you on an emergency basis,
2) Establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional,
3) Communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information:

    a. The nature of the threat,
    b. Your identity, and
    c. The identity of the potential victim(s)

- **Worker's Compensation:** If you file a worker's compensation claim, we are required to give your mental health information to relevant parties and officials.

IV. Patient's Right and Psychologist's Duties

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On you request, we will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization

(As described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise any policies and procedures, we will provide a copy of the new policy to current clients at the time of their next treatment session, or by mail to past clients who are actively pursuing information about their treatment with me.

V. Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may discuss this with Dr. Schwartz, or Dr. Giessler Zaferes, who serve as the privacy officer for their own patients. The telephone number is 513-863-2273.

You may also send written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on August 18th, 2012.

PBH and HHA reserve the right to limit or restrict a use or disclosure in specific circumstances. However, PBH and HHA must use or disclose information that is required by law or, when in good faith, information must be used or disclosed to avert a serious threat to the health or safety of a person or the public. Such use or disclosure is made to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat).

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.

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 services and treatment she has rendered on my behalf on my claim(s), 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 herby 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 herby 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
6531 Winford Avenue, Hamilton, Ohio

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

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? 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: ______________

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:** ______________