

# **Welcome to West Chester Acupuncture and Chiropractic**

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069 • 513-777-9428

So that we may best serve your healthcare needs, please complete the following information as accurately as possible. Thank you!

## **Confidential Information**

Today's Date \_\_\_\_\_

Legal Name \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

This will only be used to send periodic newsletters that discuss conditions chiropractic care can help,  
Plus you will receive our website address for general information/updates.

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

What sources did you first utilize to choose our office? Check all that apply:

1. Yellow Pages \_\_\_ 2. Internet \_\_\_ 3. Called Insurance \_\_\_ 4. Referred \_\_\_

Do you have health insurance you wish us to file? Yes \_\_\_ No \_\_\_

Do you have a secondary insurance through your spouse's employer?

Yes \_\_\_ No \_\_\_

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse \_\_\_\_\_ Employer \_\_\_\_\_

Name of Primary Care Physician and City \_\_\_\_\_

**Authorization for Examination and/or Treatment: fees are payable at the time examination or treatment is received unless prior arrangements have been made. X-rays remain the property of this clinic. I hereby give my permission for treatment.**

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18)

\_\_\_\_\_  
Date

Legal Name \_\_\_\_\_ Date \_\_\_\_\_

## **Present Complaint**

Please list the primary complain(s) for which you are seeking help:

\_\_\_\_\_  
\_\_\_\_\_

When did symptoms begin? \_\_\_\_\_

What caused this condition? \_\_\_\_\_

If this is due to a Personal Injury or Worker's Compensation, please notify  
receptionist immediately for additional forms.

Type of pain? Sharp Dull Throbbing Stiff Burning Tingling

Frequency of Pain? Constant Intermittent

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Have you ever had similar symptoms in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when and cause (if known)? \_\_\_\_\_

List other doctors seen for this condition \_\_\_\_\_

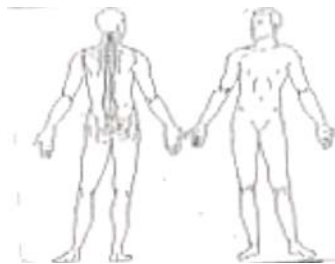
Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what kind and what are you taking it for? \_\_\_\_\_

Have you ever been to a chiropractor Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of chiropractor and last treatment date \_\_\_\_\_

Mark areas of pain on figure below:



Put a mark on the scale to indicate your present level of pain

No \_\_\_\_\_ Worse Possible \_\_\_\_\_  
Discomfort 1 2 3 4 5 6 7 8 9 10 Discomfort

### Health History

List known health conditions (high blood pressure, diabetes, etc.) \_\_\_\_\_

Previous surgeries (list dates) \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, due date \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how long? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been in an accident? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, briefly describe area injured and date(s) \_\_\_\_\_

Have you ever been told you had scoliosis? Yes \_\_\_\_\_ No \_\_\_\_\_

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## PERSONAL INJURY PROTECTION QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_

Please describe the accident in your own words: \_\_\_\_\_

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Please answer the following questions regarding your accident and injury.

1. What was your position in the car? \_\_\_\_\_ driver \_\_\_\_\_ passenger  
\* If passenger, were you in \_\_\_\_\_ front seat \_\_\_\_\_ right rear seat \_\_\_\_\_ left rear seat
2. Were you wearing a seat belt? \_\_\_\_\_ yes \_\_\_\_\_ no  
\* If so, what type? \_\_\_\_\_ lap \_\_\_\_\_ shoulder
3. Did your seat have a head restraint (headrest)? \_\_\_\_\_ yes \_\_\_\_\_ no  
\* If so, what was the position of the head restraint? \_\_\_\_\_ low \_\_\_\_\_ midposition \_\_\_\_\_ high
4. Did your vehicle strike the other vehicle? \_\_\_\_\_ yes \_\_\_\_\_ no
5. Was your vehicle struck by the other vehicle? \_\_\_\_\_ yes \_\_\_\_\_ no
6. Was the impact from: \_\_\_\_\_ the front \_\_\_\_\_ the rear \_\_\_\_\_ the left side \_\_\_\_\_ the right side
7. What was the approximate speed at the time of impact?
  - Your vehicle \_\_\_\_\_ mph
  - Other Vehicle \_\_\_\_\_ mph
8. What were the road conditions? \_\_\_\_\_ dry \_\_\_\_\_ wet \_\_\_\_\_ icy
9. At the time of impact were you: \_\_\_\_\_ looking straight ahead \_\_\_\_\_ looking to the right  
\_\_\_\_\_ looking to the left \_\_\_\_\_ looking down \_\_\_\_\_ looking up
10. Were both hands on the steering wheel? \_\_\_\_\_ yes \_\_\_\_\_ no  
\* Of no, which hand? \_\_\_\_\_ right \_\_\_\_\_ left
11. Was your foot on the brake? \_\_\_\_\_ yes \_\_\_\_\_ no  
\* If so, which foot? \_\_\_\_\_ right \_\_\_\_\_ left
12. Were you braced at the time of impact? \_\_\_\_\_ yes \_\_\_\_\_ no
13. Did you strike anything at the time of impact? \_\_\_\_\_ yes \_\_\_\_\_ no  
\*If so, please specify: \_\_\_\_\_ seatbelt restraints \_\_\_\_\_ steering wheel \_\_\_\_\_ dashboard  
\_\_\_\_\_ windshield \_\_\_\_\_ side door \_\_\_\_\_ side window \_\_\_\_\_ other \_\_\_\_\_  
\* Please state part of body: \_\_\_\_\_ chest \_\_\_\_\_ head \_\_\_\_\_ chin \_\_\_\_\_ face \_\_\_\_\_ Rt/Lt knee  
\_\_\_\_\_ Rt/Lt shoulder \_\_\_\_\_ Rt/Lt hand \_\_\_\_\_ other \_\_\_\_\_
14. Immediately after the accident were you: \_\_\_\_\_ conscious \_\_\_\_\_ dazed \_\_\_\_\_ unconscious

15. Did you go to the hospital? \_\_\_\_\_ yes \_\_\_\_\_ no  
\*If so, when?: \_\_\_\_\_ at time of accident \_\_\_\_\_ next day \_\_\_\_\_ other \_\_\_\_\_

16. How did you get to the hospital? \_\_\_\_\_ ambulance \_\_\_\_\_ private transportation  
\* If by ambulance, did the ambulance attendants place you in a: \_\_\_\_\_ neck brace \_\_\_\_\_ back brace  
\_\_\_\_\_ other \_\_\_\_\_

17. If you went to the hospital, please answer the following:

- Name of hospital \_\_\_\_\_
- Name of doctor \_\_\_\_\_
- Diagnosis \_\_\_\_\_
- Treatment received \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

**FOR DOCTOR'S USE ONLY**

Picture

Pt vehicle #1

Other vehicle #2

\_\_\_\_\_ Requested medical records from:  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

\_\_\_\_\_ Requested accident report

\_\_\_\_\_ Accident Questionnaire reviewed with patient by Dr. \_\_\_\_\_

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Main Complaints 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

Other Concurrent Therapies \_\_\_\_\_

### Past Medical History

#### General

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Poor appetite     | <input type="checkbox"/> Heavy appetite              | <input type="checkbox"/> Change in appetite (how) _____ |  |
| <input type="checkbox"/> Poor sleep        | <input type="checkbox"/> Heavy sleep                 | <input type="checkbox"/> Insomnia                       | <input type="checkbox"/> Trouble falling asleep    |
| <input type="checkbox"/> Waking at night   | <input type="checkbox"/> Trouble waking              | <input type="checkbox"/> Trouble going back to sleep    | <input type="checkbox"/> Hours of sleep _____      |
| <input type="checkbox"/> When to bed _____ | <input type="checkbox"/> When to wake _____          | <input type="checkbox"/> Dreams                         | <input type="checkbox"/> Fatigue                   |
| <input type="checkbox"/> Tremors           | <input type="checkbox"/> Vertigo                     | <input type="checkbox"/> Cold hands                     | <input type="checkbox"/> Cold feet                 |
| <input type="checkbox"/> Cold back         | <input type="checkbox"/> Cold abdomen                | <input type="checkbox"/> Fevers                         | <input type="checkbox"/> Chills                    |
| <input type="checkbox"/> Night sweats      | <input type="checkbox"/> Sweat easily                | <input type="checkbox"/> Cravings                       | <input type="checkbox"/> Localized weakness        |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sudden energy drop          | <input type="checkbox"/> Sudden increase in energy      | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Strong thirst     | <input type="checkbox"/> Bleeding or bruising easily | <input type="checkbox"/> Best time of day _____         | <input type="checkbox"/> Worst time of day _____   |

#### Skin & Hair

- |   |                                  |  |                                      |
|---|----------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Dandruff                     | <input type="checkbox"/> Eczema  | <input type="checkbox"/> Hives                       | <input type="checkbox"/> Itching     |
| <input checked="" type="checkbox"/> Pimples           | <input type="checkbox"/> Purpura | <input type="checkbox"/> Rash                        | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Changes in hair/skin texture |                                  | <input type="checkbox"/> Other hair or skin problems | _____                                |

#### Head, Eyes, Ears, Nose & Throat

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Concussions                 | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Poor hearing    | <input type="checkbox"/> Facial pain                 | <input type="checkbox"/> Facial paralysis       | <input type="checkbox"/> Eye strain      |
| <input type="checkbox"/> Eye pain        | <input type="checkbox"/> Poor vision                 | <input type="checkbox"/> Blurry vision          | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Spots in eyes          | <input type="checkbox"/> Nosebleeds      |
| <input type="checkbox"/> Sinus problems  | <input type="checkbox"/> Mucus                       | <input type="checkbox"/> Dry throat             | <input type="checkbox"/> Dry mouth       |
| <input type="checkbox"/> Copious saliva  | <input type="checkbox"/> Teeth problems              | <input type="checkbox"/> Gum problems           | <input type="checkbox"/> Jaw clicks      |
| <input type="checkbox"/> Grinding teeth  | <input type="checkbox"/> Sores on lips or tongue     | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Other head or neck problems |   | _____                                    |

#### Cardiovascular

**Respiratory**

- Cough
- Coughing up blood
- Production of phlegm
- Asthma
- Bronchitis
- Pneumonia
- Tight chest
- Difficulty when laying down
- Other lung problems \_\_\_\_\_

**Gastrointestinal**

- Nausea
- Vomiting
- Diarrhea
- Gas
- Belching
- Constipation
- Bad breath
- Rectal pain
- Black stools
- Sensitive abdomen
- Pain or cramps
- Bloody stools Odor
- Hemorrhoids
- Laxative use
- Undigested food

**Genitourinary**

- Pain with urination
- Blood in urine
- Cloudy urine
- Urgency to urinate
- Unable to hold urine
- Unable to complete
- Dribbling
- STD
- Urinary Tract Infection
- Kidney stones
- Prostate problems
- Wake to urinate

**Gynecology and Pregnancy**

- Age at first menses \_\_\_\_\_
- Pregnancies # \_\_\_\_\_
- Irregular periods
- Menopause
- Last PAP \_\_\_\_\_
- Births # \_\_\_\_\_
- Painful periods
- Clots
- Last Menses \_\_\_\_\_
- Miscarriages # \_\_\_\_\_
- Vaginal Discharge
- Breast lumps
- Birth control
- Premature births
- Changes in body / psyche prior to menstruation

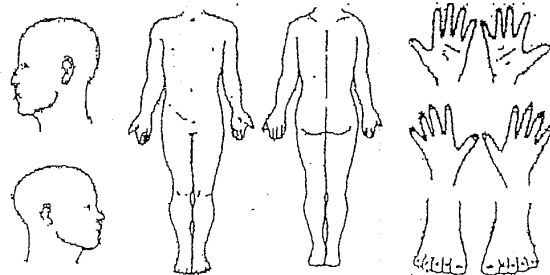
**Neuropsychological**

- Seizures
- Areas of numbness
- Poor memory
- Concussion
- Depression
- Anxiety
- Bad temper
- Easily stressed
- Treated for emotional problems
- Considered / attempted suicide
- Other neurological or psychological problems \_\_\_\_\_

**Musculoskeletal**

- Neck pain
- Better / worse with heat
- Limb pain
- Better / worse with cold
- Back pain
- Better / worse with movement
- Muscle pain
- Better / worse with pressure
- Joint pain
- Fixed location
- Sharp quality
- Dull quality
- Distending quality
- Radiating quality
- Burning quality
- Stabbing quality

Mark Location of Pain or Injury





**Patient – Please fill out # 1-5 in the box below**

WEST CHESTER ACUPUNCTURE AND CHIROPRACTIC  
Verification of Insurance Benefits

1. **Patient's Name:** \_\_\_\_\_
2. **Is patient the PRIMARY INSURED/CARDHOLDER? Yes or No** \_\_\_\_\_
3. **If no, who is Primary Insured/Cardholder? (Please state name and relationship)** \_\_\_\_\_
4. **Primary Cardholder's Employer:** \_\_\_\_\_
5. **PRIMARY CARDHOLDER INFORMATION: Social Security#:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Identification #** \_\_\_\_\_ **Grp #** \_\_\_\_\_

**COVERAGE:**

Is Doctor in network? Y or N {GIVE TAX ID TO CONFIRM} Is there coverage for Chiropractic care? Y or N

Is referral (Y or N) or pre-authorization needed? (Y or N) If so, for 1<sup>st</sup> or all visits \_\_\_\_\_

**TYPE OF POLICY:** Effective date \_\_\_\_\_ Cal or Policy - If policy, what is date range: \_\_\_\_\_

**DEDUCTIBLE:** Amount of Deductible \_\_\_\_\_ Family or Individual: F or I

\*\*Is Chiropractic deductible separate: Y or N Amount of Deductible Met \_\_\_\_\_

If Large DED is there an HRA or HSA ? (circle if yes) Amount: \$ \_\_\_\_\_

Notes about Insurance: \_\_\_\_\_

**PAT RESP: CO-INS** \_\_\_\_\_ % or **COPAY** \$ \_\_\_\_\_ per visit/ exam code? \_\_\_\_\_ Out-of-Pocket Max \$ \_\_\_\_\_

**\*\*If secondary insurance, ask if they cover primary insurance's copay: Y or N**

**VISIT LIMIT:**

Max yearly number of visits: SP \_\_\_\_\_ PT \_\_\_\_\_ or Max yearly benefit \$ \_\_\_\_\_

After SP limit is reached are PT visits covered if billed by Chiropractor? Yes No

**Max \$ per visit** \_\_\_\_\_ Who is responsible for balance on allowed amount? Patient or Doctor

**SPECIFIC COVERAGE:** Does this policy cover: \_\_\_\_\_

Exams: Y or N If yes, separate copay? \_\_\_\_\_

Spinal Manipulations: Y or N

\*Extremity Manipulation (98943): Y or N

\*BC/BS tell them we are an Ohio provider, esp for code 98

Moist Heat/Ice (97010): Y or N

Electrical Stim (97014)/ UHC (G0283): Y or N

Ultrasound (97035): Y or N

\*\*\*Is there a limit on modalities per visit: \_\_\_\_\_

\*\*\*IF ANTHEM or UHC: IS PRECERT NEEDED FOR MRI?

**MASSAGE:**

Massage Therapy (97124): Y or N

Manual Therapy Techniques (97140): Y or N

**ORTHOTICS:**

Orthotics (97760) Y or N

(L3020): Y or N

Do they need pre-certification: Y or N

Letter of medical necessity: Y or N

If yes, what is coverage \_\_\_\_\_ % Is there a per year pair limit: \_\_\_\_\_

If pre-certification is needed, fax number to send report: \_\_\_\_\_

If yes, mailing address: \_\_\_\_\_

<p><b>CAM Coverage: Y or N</b> (COMPLIMENTARY ALTERNATIVE MEDICINE)</p> <p>NOTES: _____</p> <p><b>Acupuncture (I): Y or N</b></p> <p>NOTES: _____</p> <hr/> <p>Copay: _____ Visit Limit _____</p>
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**PRACTICE'S REQUIREMENTS**

The Practice:

- (a) Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with a Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI unless a copy has not been requested as acknowledged below by the patient's signature.
- (b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for 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.

This notice is effective as of April 15, 2003.

**PATIENT ACKNOWLEDGEMENT**

(Choose one)

- By subscribing my name below, I acknowledge my understanding and agreement to these terms. I do not want a copy of my HIPPA laws at this time.
- By subscribing my name below, I acknowledge receipt of a copy of the above-mentioned notice and my understanding and agreement to its terms. I have requested a copy of my HIPPA laws at this time.

\_\_\_\_\_  
Signature of Patient (or Guardian if under 18 years)

\_\_\_\_\_  
Date

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**FINANCIAL POLICY**

Please put a check by the form of payment you will be using

**CASH**

Patient pays all fees on the day services are rendered by cash, check, or credit card. We accept Visa, Mastercard, Discover and American Express.

**INSURANCE**

You are ultimately responsible for knowing what your insurance plan covers. As a courtesy, we will verify your insurance coverage, however this does not guarantee benefits. If you would like a copy of what we verify, please notify the receptionist. YOU are responsible for the portion your policy not covered such as deductibles, co-payments and non-covered services. Payment is due on the date services are rendered.

**WORKER'S COMPENSATION**

It is your responsibility to notify your employer and the doctor if you are seeking treatment from an injury sustained while on-the-job. This type of injury is classified as an industrial injury and will be billed accordingly. If the injury neglects to meet the requirements of the Industrial Commission and they will not pay, you are responsible for all charges incurred in this office. If you have an established claim, please notify the receptionist that you need to sign a transfer of physician form.

**PERSONAL INJURY**

We do not accept third-party payer. We do not bill the at-fault. If Dr. Hilbert/Dr. Young (dba West Chester Acupuncture and Chiropractic) are a preferred provider on your health insurance plan, then by Ohio State Law we are required to bill your health insurance first. Standard rules apply when billing your health insurance: any co-payments, co-insurance, deductibles or non-covered services are your responsibility to pay at the time services are rendered. Once the health insurance coverage has been exhausted for the benefit year, we will then collect full payment for services rendered. A copy of charges will be provided for you to be reimbursed by either your automobile insurance, which has med pay coverage for health care from injuries sustained in a motor vehicle accident or the at-fault party insurance. We recommend that you immediately file a claim with your automobile insurance. If you do not have health insurance or med pay, then you are responsible to pay as treatment is received on the day of each visit by cash, check or credit card. Financing is available – ask our front desk if you are interested. Each case is unique so please do not hesitate to ask the receptionist. Ultimately, you are responsible for all charges incurred for treatment in our office.

**MEDICARE**

Medicare does cover chiropractic treatment but with limitations. We have a handout specifically for Medicare patients, including those with secondary insurance that will explain in detail what you can expect with your current coverage. Please let the receptionist know if you would like a copy.

**MEDICAID**

If eligible, you must bring a current Medicaid card on the first visit and at the beginning of each month thereafter when receiving treatment.

I hereby authorize any holder of medical information to release to my insurance company or intermediates any information needed to process a claim for payment. I request that payment be made to West Chester Acupuncture and Chiropractic for any charges or services rendered to me by Julie B Hilbert, DC, FIAMA, Dipl.Ac. and/or Burton T Young, DC, FIAMA, Dipl.Ac.. I understand I am financially responsible to Julie B Hilbert DC, FIAMA, Dipl.Ac. and/or Burton T Young DC, FIAMA, Dipl.Ac. for any balance not covered. I agree to the terms in the financial policy as stated above for the acupuncture and/or chiropractic care rendered to me by Julie B Hilbert DC, FIAMA, Dipl.Ac. and/or Burton T Young DC, FIAMA, Dipl.Ac.. Balances over 90 days past due will be forwarded to our collections agency. A late fee of 1.5% per month will be added to the balance, beginning at 60 days after service is rendered.

\_\_\_\_\_  
Signature of Patient (Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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Due to HIPPA (privacy) regulations we are giving you the option, to provide in writing, your permission for our office to share your medical and/or billing information with the person(s) you assign.

\_\_\_\_\_ I do not wish to have this option.

\_\_\_\_\_ I hereby authorize the Doctors and/or Staff to discuss my medical information with the person(s) listed below.

Allowed person(s):

Relation

\_\_\_\_\_  
\_\_\_\_\_

We occasionally call your home regarding your appointment for two reasons. If you miss your appointment we are calling to reschedule and/or we would be calling to remind you of a massage appointment if applicable for the next day.

\_\_\_\_\_ I give my permission to call my home or cell for the above reasons.

\_\_\_\_\_ I do not give my permission to call my home or cell for the above reasons.

**\*\*Permission to leave messages on voice mail/answering machine?**

(Please circle)

Yes

No

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
(Please print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient/Guardian of minor/Legal Representative)