

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

CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up-to date, please provide us with the following information:

PLEASE PRINT

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Is this visit regarding an injury at work or auto accident? YES NO

Insurance Information: Is this new insurance? YES NO

If not, are you aware of any benefit and/or policy changes? YES NO

(If yes, list or explain here): _____

**Please present insurance card to front desk staff and fill out insurance verification form*

1. List present complaints (describe fully): _____

2. How long have you had the above complaints? _____

3. What do you believe caused this condition? Describe any falls, surgery, and/or accidents since last visit:

4. Have you received additional treatment from another doctor or clinic for the above listed condition(s)? YES
NO

Dr. or Clinic name: _____

Describe treatment received and your response to treatment _____

5. Are you pregnant? YES NO

Is there a possibility that you may be pregnant? YES NO

6. Other information you feel the doctor should know regarding this condition?

Patient Signature (Parent or Legal Guardian) Date _____

Date: _____ Talked to: _____

Verified by: _____ Entered by: _____

WEST CHESTER ACUPUNCTURE AND CHIROPRACTIC

Verification of Insurance Benefits

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

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 1st 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, espy 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?** Y N

MASSAGE:

Massage Therapy (97124): Y or N

Manual Therapy Techniques (97140): Y or N

ORTHOTICS:

Orthotics (97760) Y or N

(L3020): Y or N If yes, what is coverage _____% Is there a per year pair limit: _____

Do they need precertification: Y or N If precertification is needed, fax number to send report: _____

Letter of medical necessity: Y or N If yes, mailing address: _____

CAM Coverage: Y or N

(COMPLIMENTARY ALTERNATIVE MEDICINE)

Acupuncture (): Y or N

Pre-cert: Y or N If yes, phone # _____

If yes, bill to: _____

Co-ins: _____ \$ Max Pr Yr: _____

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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