

WEST CHESTER ACUPUNCTURE and CHIROPRACTIC

Dr. Julie B. Hilbert, DC, FIAMA, Dipl.Ac.
Dr. Burton T. Young, DC, FIAMA, Dipl.Ac.
7665 Monarch Court, Suite 110
West Chester, OH 45069
513-777-9428
513-777-3628 fax

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Julie Hilbert, DC, FIAMA, Dipl.Ac. and/or Burton Young, DC, FIAMA, Dipl.Ac. to administer treatment

as she/he so deems necessary to my _____
Son/Daughter

Please print child's full name

Date _____

Signature of Parent or Guardian

Relationship to Minor

Parent or Guardian address for
Patient statement

Witness

New Patient Registration

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

Today's Date ____/____/____

Legal Name _____

First Name you would like to be called: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ *Email Address: _____

* This will only be used to send email offers thru Constant Contact, office closings, special offers, Holidays, conditions we treat, etc. Also If you choose to have appointment reminders sent here.

Gender: Male Female **Marital Status:** Single Married Separated Divorced Widowed

Date of Birth _____ SS# ____ - ____ - ____ Age: _____

Emergency Contact: _____ Relationship _____
Phone: _____

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

1. Referred __ (name) _____ 2. Internet ____ 3. Called Insurance ____ 4. Angie's List ____

How you would like to receive appointment reminders: (check below)

Text message Phone (home/cell) Email None

*Employer _____ Occupation _____

Do you have health insurance you wish us to file? Yes ___ No ___ Have you seen another Chiropractor? Y / N

Name of Insurance Subscriber (policy card holder) _____ Subscriber's DOB: _____

Relationship to Subscriber _____ Subscriber's employer _____

Name of Primary Care Physician and City _____

Do you have a secondary insurance? Yes _____ No _____

Signature of Patient (or Guardian if under 18) Date ____/____/____

Print Name _____ Date ____/____/____

MEDICAL HISTORY

Patient Name _____

Main Complaints 1 _____ 2 _____ 3 _____

When did symptoms begin? _____ What caused this condition? _____

****If this is due to a Personal Injury (auto accident) or Worker's Compensation, please notify front desk immediately.**

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"/> Waking at night | <input type="checkbox"/> Trouble waking | <input type="checkbox"/> Trouble going back to sleep |
| <input type="checkbox"/> When to bed: _____ | <input type="checkbox"/> When to wake | <input type="checkbox"/> Dreams |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Cold back | <input type="checkbox"/> Cold abdomen | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Sudden increase in energy |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleeding/bruising easily | <input type="checkbox"/> Best time of day _____ |
| | | <input type="checkbox"/> Hours of sleep: _____ |
| | | <input type="checkbox"/> Hours of sleep _____ |
| | | <input type="checkbox"/> Fatigue |
| | | <input type="checkbox"/> Cold feet |
| | | <input type="checkbox"/> Chills |
| | | <input type="checkbox"/> Localized weakness |
| | | <input type="checkbox"/> Peculiar tastes/smells |
| | | <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 type="checkbox"/> Pimples | <input type="checkbox"/> Purpura | <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Changes in hair/skin: _____ | | <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: _____ | | |

Cardiovascular

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other: _____ |

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MEDICAL HISTORY

Patient Name _____

Respiratory

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Production of phlegm | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Difficulty when laying down |
| <input type="checkbox"/> Other lung problems: _____ | | | |

Gastrointestinal

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Sensitive abdomen | <input type="checkbox"/> Pain or cramps | <input type="checkbox"/> Bloody stools, odor |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Undigested food | |

Genitourinary

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Urgency to urinate |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Unable to complete | <input type="checkbox"/> Dribbling | <input type="checkbox"/> STD |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Wake to urinate |

Gynecology Pregnancy

- | | | | |
|--|------------------------|---|---------------------------------------|
| Age at first menses _____ | Pregnancies # _____ | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Menopause |
| Last PAP _____ | Births # _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Clots |
| Last Menses _____ | Miscariages _____ | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Birth Control | Premature births _____ | <input type="checkbox"/> Changes to body/psyche prior to menstruation | |

Neuropsychological

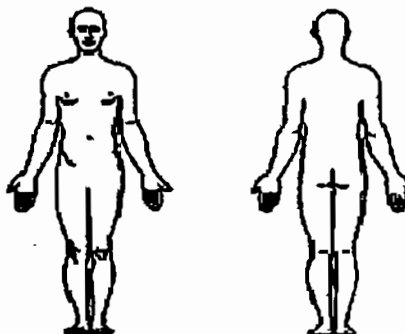
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Treated for emotional problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Considered/Attempted suicide | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Poor memory | | <input type="checkbox"/> Seizures |

Musculoskeletal

- | | |
|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Better/worse with heat |
| <input type="checkbox"/> Limb pain | <input type="checkbox"/> Better/worse with cold |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Better/worse with movement |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Better/worse with pressure |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Fixed location |
| <input type="checkbox"/> Sharp quality | <input type="checkbox"/> Dull quality |
| <input type="checkbox"/> Distending quality | <input type="checkbox"/> Radiating quality |
| <input type="checkbox"/> Burning quality | <input type="checkbox"/> Stabbing quality |

Put a mark on the scale to indicate you present level of pain:
No Discomfort 1 2 3 4 5 6 7 8 9 10 **Worst possible Discomfort**

Mark location of pain or injury:



MEDICAL HISTORY

Patient Name _____

Significant Illnesses (list date of diagnosis)

- | | | | |
|---|--|--|--------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | Other: _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> Surgeries (type & date): | _____ | | |

Significant Trauma (type and date): _____

Miscellaneous Information:

Birth History (prolonged labor, premature, forceps delivery, etc.): _____

Allergies (drugs, chemicals, food, etc.): _____

Medication (name and dosage, include vitamins and herbs): _____

Occupational Stresses (chemical, physical, psychological): _____

Exercise (type and frequency): _____

Average daily diet (list morning, afternoon and evening): _____

Family History

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Multiple sclerosis | Other: _____ | |

Notes (please add anything of note)

Terms of Acceptance

Patient Name: _____

Date: _____

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 Dr. Julie B. Hilbert/Dr. Burton T. Young's office, 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.

Consent to medical records submission:

Periodically medical records are requested by your insurance company and upon that request I agree to have all visit information sent.

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

Acknowledgement

By subscribing my name below, I acknowledge my understanding and agreement to the notice of privacy practices (HIPAA effective as of 9/23/2013). I do NOT want a copy of my HIPAA laws at this time.

By subscribing my name below, I acknowledge my understanding and agreement to the notice of privacy practices (HIPAA effective as of 9/23/2013). I have requested a copy of my HIPAA laws at this time.

Print Name: _____

Signature: _____ **Date:** _____

Financial Policy 2020

Payments/deductibles and/or co-payments are due at the time of service. A current insurance card must be presented at the time service is provided. If charges are filed incorrectly due to outdated information, the complete balance then becomes your responsibility. Many of our families have Health Savings Accounts (HSA), or Health Reimbursement Accounts (HRA). You will be expected to pay at the time of service until your deductible is met. We accept cash, check, or any major credit card. Please check which one of the following applies:

_____ **INSURANCE** (Check here for Medicare and disregard below. See ABN)

(Check here for VA patients with active authorization)

If your insurance is a high deductible plan, the office will file your claim directly with the insurance. However a payment is required at the time of service until your deductible has been met, as listed below:

-Chiropractic ONLY \$25.00

-Chiropractic + Electrical Stimulation/Ultrasound \$30.00

-Chiropractic + Massage therapy \$50.00

-Acupuncture ONLY \$55.00

-Chiropractic + Acupuncture \$75.00

Once your deductible has been met, your co-insurance will be collected at the time of service. It is your responsibility to know the details of your insurance plan. As a courtesy, we will verify your insurance coverage; however it is not a guarantee of benefits.

_____ **MEDICAID (Molina/Caresource/Ohio Job and Family Services)**

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

_____ **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. Dr. Hilbert/Dr. Young recommend that you immediately file a claim with your automobile insurance. We bill med-pay first. After that is exhausted we can then bill your health insurance and you would be responsible for the deductibles, co-pays, etc. 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. 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.

_____ **NO INSURANCE COVERAGE**

Patient pays all fees on the day services are rendered by cash, check or all major credit cards.

I hereby authorize any holder of medical information to release to my insurance company or intermediaries any information needed to process a claim for payment. I request that payment be made to Julie B. Hilbert, DC, Inc. 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 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 either of doctors mentioned above. Balances over 90 days past due will be forwarded to our collections agency. A late fee of 5% per month will be added to the balance, beginning at 90 days after service is rendered.

Signature of Patient (Parent/Guardian)

Date

Print Name of Patient (Parent/Guardian)

Date

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2020 Massage Therapy Payment Agreement

Our office will verify your insurance benefits as a courtesy for you. However, a verification of benefits is never a guarantee of payment from the insurance company. For this reason, our office needs patients to sign a payment agreement to guarantee payment for their services. If for any reasons your insurance does not cover the services rendered, then you will be financially responsible for the entire amount owed to Dr. Hilbert, and/or Dr. Young.

In addition our office requires a 4 hour cancellation notice for all massage services or a fee will occur.

You must call or leave a message at the office at least 4 hours prior to your appointment to avoid a fee. You will be charged one of the according fees below on your credit card the same day that the late/missed appointment occurs. Reminder calls are done as a courtesy; you are ultimately responsible for keeping your appointment. If you are running late please call the office so that we may inform your massage therapist. There is no fee for being late however; your massage time may be cut short due to the schedule.

The fees for a missed or late cancellation of a massage are as follows:

30 Minute Massage (\$20.00) 60 Minute Massage (\$35.00) 90 Minute Massage (\$45.00)

By signing below, I agree to these terms:

Patient Signature

Date

Print Name

2020

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