Personal Injury Information (Auto accident) Date:_____

***Your Auto Insurance will be billed. We do NOT bill at fault or third parties. Have you contacted your Auto Insurance for your claim # and Med Pay amount?

We will need **copy of Auto insurance** card **and** Medical Ins. Card.

Patient Name:_____

Date of Birth_____ Patient Phone #_____

Reported Med pay Claim# _____ Date of Injury_____

State where accident occurred_____

First office appointment scheduled_____ (date/Employee initials)

Do you have an attorney? Y or N / If yes, Name: _____Phone#_____

Do you own the Auto that was in accident? Y or N

If no, Owner of Auto: _____Phone#:_____

Does the police report list you as at fault? Y or N (circle one)

At the time of the accident were you on company business or in Company vehicle? Y N

Patient's Auto Insurance Company Name: _____

Address:_____

_____

Claim adjuster Name _____Phone#_____

FAX billing#_____

Med Pay Amount $_____ Treated anywhere else on this claim?_____

If accident occurred out of Ohio: Ask if it's a PIP state: Y or N

(Personal Injury Protection: If yes, means med pay is not an issue and patient can be treated)

Office use Only:

Insurance called before appointment?_____ (Date/Your initials)

****Scan this information immediately:** **Subject line should state: PI –"Last name of patient"** (PI-Doe) to the Billing e-mail (initials)_____ and scan the **completed** paperwork to the patient file_____

**Entry:

Folder Label Color Purple

Account Category: PI

Type of Account : 9

Accounting Method: Claim Record

Claim Receiver: Paper

Insurance id: Claim #

Major Medical Ins. _____

(Scan into patient PI file)

Condition Tab: (No expiration date), initial treatment, and last exam = Date first TX

DX date, = Date DX has been created

Condition date and Accident Date = **Date of Injury**

"Patient Condition related to" area: check appropriate boxes.

DR. JULIE HILBERT, DC, FIAMA, Dipl.Ac*
DR. BURTON YOUNG, DC, FIAMA, Dipl.Ac*
Authorization for Records

I hereby authorize the release of my medical records as described below (please check the one that applies):

Dr. _____
Center or Clinic _____
_____ Address _____
City _____ State _____ Zip _____
Phone Number _____
Fax Number _____

Transfer the records to:
Dr. Julie Hilbert/Dr. Burton Young
7665 Monarch Court, Suite 110, West Chester, Ohio 45069
Phone:513-777-9428 Fax:513-777-3628

__OR__

Transfer the records from Dr. Julie Hilbert/Dr. Burton Young
Dr. _____
_____ Address _____
City _____ State _____ Zip _____
Phone Number _____
Fax Number _____

Requesting Records (enter dates) **From** _____ **to** _____

_____ **Office Notes/Medical File**
_____ **Diagnostic Results for Any Studies such as:**
Plain Film X-Rays Reports, CT, MRI, US Imaging, EMG, etc.
_____ **Medication List**
_____ **MRI films and/or Report**
_____ **Other** _____

This authorization shall be in force and effect for 5 years after the date I sign this agreement, thereafter this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing. This may be accomplished by contacting the practice's Privacy Officer at 777-9428 and requesting a Revocation of Authorization form. I understand that such a revocation is not effective to the extent that my physician has relied on the use or discloser of the protected health information of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and no longer be protected by federal or state law. My physician will not condition my treatment and/or payment on whether I provide authorization for the requested use or disclosure. I understand I have the right to: 1) Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). 2) Refuse to sign this authorization.

Print Patient Name	Date of Birth	Signature of Patient	Date

If Applicable, Print Name of Guardian	Describe Relationship to Patient

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_____

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

Print Name _____ Date _____/_____/_____

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7665 Monarch Court, Suite 110, West Chester, OH 45069 • 513-777-9428

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PERSONAL INJURY PROTECTION QUESTIONNAIRE

Name: _____ Date of Accident: _____ Time: _____

Your Auto Insurance Claim# _____

Please describe the accident in your own words: _____

_____

_____

_____

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/lLt 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. _____

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

◻ Poor Appetite	◻ Heavy appetite	◻ Change in appetite: (how) _____	
◻ Poor Sleep	◻ Heavy sleep	◻ Insomnia	◻ Hours of sleep:
◻ Waking at night	◻ Trouble waking	◻Trouble going back to sleep	◻ Hours of sleep_____
◻ When to bed:_____	◻ When to wake	◻ Dreams	◻ Fatigue
◻ Tremors	◻ Vertigo	◻ Cold Hands	◻ Cold feet
◻ Cold back	◻ Cold abdomen	◻ Fevers	◻ Chills
◻ Night Sweats	◻ Sweat easily	◻ Cravings	◻ Localized weakness
◻ Poor coordination	◻ Sudden energy drop	◻ Sudden increase in energy	◻ Peculiar tastes/smells
◻ Strong thirst	◻ Bleeding/bruising easily	◻ Best time of day_____	◻ Worst time of day_____

Skin & Hair

◻ Dandruff	◻ Eczema	◻ Hives	◻ Itching
◻ Pimples	◻ Purpura	◻ Rashes	◻ Ulcerations
◻ Changes in hair/skin: _____		◻ Other hair or skin problems: _____	

Head, Eyes, Ears, Nose & Throat

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

Cardiovascular

◻ High blood pressure	◻ Low blood pressure	◻ Chest pain	◻ Irregular heartbeat
◻ Dizziness	◻ Fainting	◻ Cold hands/feet	◻ Swelling in hands/feet
◻ Blood clots	◻ Phlebitis	◻ Difficulty breathing	◻ Other:_____

MEDICAL HISTORY

Patient Name_____

Respiratory

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

Gastrointestinal

- ◻ Nausea
- ◻ Belching
- ◻ Black stools
- ◻ Hemorrhoids
- ◻ Vomiting
- ◻ Constipation
- ◻ Sensitive abdomen
- ◻ Laxative use
- ◻ Diarrhea
- ◻ Bad Breath
- ◻ Pain or cramps
- ◻ Undigested food
- ◻ Gas
- ◻ Rectal pain
- ◻ Bloody stools, odor

Genitourinary

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

Gynecology Pregnancy

Age at first menses _____
Last PAP _____
Last Menses_____
◻ Birth Control

Pregnancies #_____
Births #_____
Miscarriages
Premature births_____

- ◻ Irregular Periods
- ◻ Painful periods
- ◻ Vaginal Discharge
- ◻ Changes to body/psyche prior to menstruation
- ◻ Menopause
- ◻ Clots
- ◻ Breast lumps

Neuropsychological

- ◻ Depression
- ◻ Treated for emotional problems
- ◻Other: _____
- ◻ Areas of numbness
- ◻Anxiety
- ◻Poor memory
- ◻ Bad temper
- ◻ Considered/Attempted suicide
- ◻ Concussion
- ◻ Easily stressed
- ◻Seizures

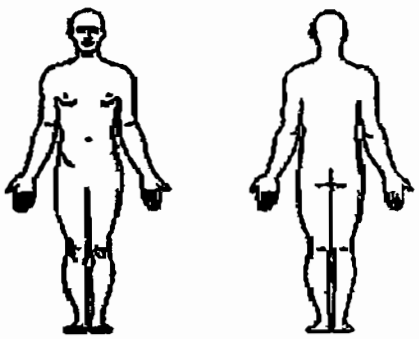
Musculoskeletal

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



12/21/2018

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7665 Monarch Court, Suite 110, West Chester, OH 45069 • 513-777-9428

MEDICAL HISTORY

Patient Name_____

Significant Illnesses (list date of diagnosis)

- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV
- ☐ Surgeries (type & date):
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Seizures

Other:_____

☐ 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

- ☐ Cancer
- ☐ Stroke
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ High Blood Pressure
- ☐ Asthma
- Other: _____
- ☐ Allergies
- ☐ Heart disease

Notes (please add anything of note)

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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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