

Worker Compensation:

New Patient Information

Name: _____ Date of Birth _____

Phone # _____

Have you already seen someone for this injury? Y N

*****If no...Do not schedule and refer patient to Billing (Ann)for a call back

Did you receive a card for this claim? It should have the following information:

Claim# _____ Date of Injury _____

MCO: _____

*****Office use:** Folder Label Color Red

General Tab: Account Category: WC
Type of Account : 9
Accounting Method: Claim Record

Insurance Tab: Plan: Worker's Comp
Claim Receiver: Paper
Insurance ID: Claim Number on BWC Card
Benefits: Other
Employer: Name of Company (must be entered!)

Conditions Tab: Diagnois Date=Date of Injury Expiration Date: blank
Condition Date: Date of Injury
Patient Condition related to: Employment---Yes.....no on Auto & Other

First office appointment _____ Exam Only
E-mail this form to billing@wcacuchiro.com _____ (intials)



Bureau of Workers' Compensation

Notice to Change Physician of Record

The physician selected must be BWC certified or the injured worker will be responsible for payment.

Instructions for the injured worker

• Please complete all of Part I of the form.

• Sign in the space provided, and submit all copies to your managed care organization (MCO) to record your change of physician.

Part I

Injured worker's name		Date of injury	Claim number
Address		Phone number ()	
City	State	Nine-digit ZIP code	
Please change my physician of record for the above listed claim as follows:			
From physician		Provider number	
Address		Phone number ()	
City	State	Nine-digit ZIP code	
To physician		Provider number	
Address		Phone number ()	
City	State	Nine-digit ZIP code	
Reason for change			
<input type="checkbox"/> Physician moved	<input type="checkbox"/> Physician no longer practicing	<input type="checkbox"/> I moved	<input type="checkbox"/> Physician is not a BWC-certified provider
<input type="checkbox"/> Physician terminated patient-provider relationship Please explain: _____ _____ _____	<input type="checkbox"/> Dissatisfied with physician's treatment Please explain: _____ _____ _____	<input type="checkbox"/> Other, please explain: _____ _____ _____	
Have you been treated by the new physician for the condition(s) allowed in your claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes give date of first treatment _____			
Injured worker's signature			Date

Instructions for the MCO

• MCO to complete PART II.

• MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.

• Return signed copies per distribution listed below.

Part II

We have received and recorded your request for change of physician. You may bill only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical-management guidelines to the MCO or the self-insured employer. The allowed conditions for this workers' compensation claim with corresponding ICD-9-CM codes are as follows: _____

MCO name	Phone number ()
MCO case manager	Date

Distribution: White-MCO Claim file • Yellow-Injured worker • Pink-Requested physician • Goldenrod-Former physician



First Report of an Injury, Occupational Disease or Death

By signing this form, I

- I elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
I waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
I agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
I confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

WARNING:

Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

Injured worker and injury/disease/death info.

Form section for injured worker and injury/disease/death info. Includes fields for: Last name, first name, middle initial; Social Security number; Marital status; Date of birth; Home mailing address; Sex; Number of dependents; City; State; 9-digit ZIP code; Country if different from USA; Department name; Wage rate; What days of the week do you usually work?; Regular work hours; Has been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation?; Occupation or job title; Employer name; Mailing address; Location; Was the place of accident or exposure on employer's premises?; Date of injury/disease; Time of injury; If fatal, give date of death; Time employee began work; Date last worked; Date returned to work; Date hired; State where hired; Date employer notified; State where supervised; Description of accident; Type of injury/disease and part(s) of body affected.

Benefit application release of information - I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, the Ohio State Board of Pharmacy, the Ohio Department of Job and Family Services and the Ohio Rehabilitation Services Commission to release medical, psychological, psychiatric, pharmaceutical, vocational and social information. I understand this may include personally identifying information that is casually or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's managed care organization and any authorized representatives. My previous or future BWC claims may affect decisions made in this claim. Proper administration of the present claim may require BWC to share claims information with the employers of record (or their authorized representatives) and/or my authorized representative for any and all such previous or future claims. The released claims information may include any record maintained in my claim files.

Form section for treatment info. Includes fields for: Health-care provider name; Telephone number; Fax number; Initial treatment date; Street address; City; State; 9-digit ZIP code; Diagnosis(as); Will the incident cause the injured worker to miss eight or more days of work?; Is the injury causally related to the industrial incident?; E code; 11-digit BWC provider number; Date; Health-care provider signature.

Form section for employer info. Includes fields for: Employer policy number; Telephone number; Fax number; E-mail address; Federal ID number; Manual number; Was employee treated in an emergency room?; Was employee hospitalized overnight as an inpatient?; If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code; Certification - The employer certifies that the facts in this application are correct and valid; Rejection - The employer rejects the validity of this claim for the reason(s) listed below; For self-insuring employers only: Clarification - The employer clarifies and allows the claim for the condition(s) below; Medical only; Lost time; Employer signature and title; Date; OSHA case number.

WORKER'S COMPENSATION HISTORY

Name _____ Age _____ Date of Birth _____ Male Female
Address _____ City _____ State _____ Zip _____
SS# _____ Drivers Lic # _____
Employers Name _____ Tel # _____
Address _____ City _____ State _____ Zip _____
Carriers Name _____ Tel # _____
Address _____ City _____ State _____ Zip _____
Have your retained legal counsel for this injury? Yes No If yes, give name and address _____

INJURY DESCRIPTION

Date present injury was received _____ Time of injury _____ AM PM Overtime: Yes No
Who saw the accident: Name _____ Title _____
Who reported the accident? Name _____ Title _____
What medical attention was rendered? _____
By whom? Nurse M.D. D.O. D.C. Other employee Other _____
How did the injury occur? _____
Chief complaint _____
Symptoms _____
Since the injury, are your symptoms: Improving The same Getting worse
If working on a machine, give description _____
Do you use foot or hand levers? Yes No Do you work overhead? Yes No
Do you have to reach? Yes No Where? _____
Movements on the job: Do you move to your Right Left Up Down Under Over
Do you pick up or lift? Yes No If yes, how much? _____ How often? _____
From where to where? _____ Do you lift from Ground Bench Platform
 Box Pallet Other (Please Describe) _____
Do you lift in or out of a machine? Yes No If working at a machine, do you Sit Stand Kneel
Is your work area cluttered? Yes No If yes, with what? _____
Is your work area Oily Dirty Slippery Other _____
In your job do you push or pull? Yes No If yes, give specifics _____
Do you use a cart? Yes No Two-wheel Four-wheel Type of wheels: Rubber Steel Plastic
Condition of cart Good Bad Other _____ Number of carts being pushed or pulled at once _____
Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK

If your injury has occurred from office work only, please fill out the following:

Sit at desk Walk Stand Stoop Hold Carry Other _____

Give percentage if applicable _____ Do you operate office machinery? Yes No

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc.

If walking, where to and job classification _____

Do you carry anything or pick anything up? Yes No If yes, what? _____

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? Yes No

Date _____ Doctor _____ Place _____

Have you ever applied for Workers' Compensation benefits before? Yes No Date _____

Reason _____

Was there a time loss from work? Yes No From _____ To _____ Year _____

State the degree of recovery _____

Did you retain legal counsel for these injuries? Yes No If yes, give name and address _____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____

Were you performing your normal job? Yes No What shift were you working? _____

How long have you been at your present job? _____ Has there been a time loss or absenteeism caused from job injury? Yes No If yes, explain _____

Average work week _____ Hours _____ Days _____

JOB CONDITIONS

Type of building _____

Type of floor Rough Smooth Wood Concrete Steel Other _____

Type of windows Open Closed No windows

Type of ventilation in the building Blower A/C Heat Exhaust None Other _____

Type of lighting in the building Fluorescent Overhead On machine Other _____

Are you tired when you go home at night? Yes No

Do you have any outside jobs? Yes No If yes, what type? _____

Do you participate in any company-sponsored programs such as exercise, sports, etc.? Yes No

If yes, describe _____

Type of shop Union Non-union

Has outside help been hired? Yes No If yes, why? _____

How many employees are in the plant? _____ How many employees per shift? _____

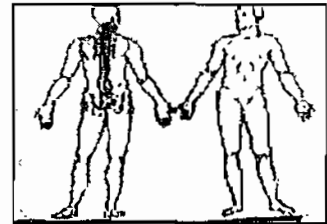
How many employees do your job? _____ What is the current injury ratio for that job? _____

How many employees have been injured doing your job? _____ Do you like your job? Yes No

If off work, do you want to return to your job? Yes No

What changes would you make in your job? _____

MARK PAIN AREA	
+++	BURNING
000	STABBING
---	SHARP
///	CONSTANT



Patient Signature

Date

Staff Signature

Date

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"/> Hours of sleep: _____ |
| <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/smells |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleeding/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 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: _____ |

Welcome to West Chester Acupuncture and Chiropractic
Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac.- Dr. Burton Young, DC, FIAMA, Dipl.Ac.
7865 Monarch Court, Suite 110, West Chester, OH 45069 • 513-777-9428

MEDICAL HISTORY

Patient Name _____

Page 2

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 _____ | Miscarriages _____ | <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

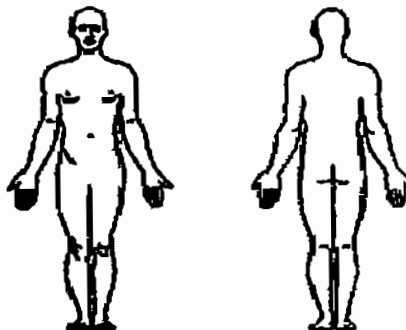
- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Treated for emotional problems | <input type="checkbox"/> Anxiety | <input type="checkbox"/> 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											Worst possible
Discomfort	1	2	3	4	5	6	7	8	9	10	Discomfort

Mark location of pain or injury:



12/21/2018

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

Welcome to West Chester Acupuncture and Chiropractic

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