Personal Injury Information (Car 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_____

First office appointment scheduled_____ (date/your initials)

Do you have an attorney? Y or N.

If yes, Name:_____Phone#_____

Does the police report list you as at fault? Y or N.

Patient's Auto Insurance Company Name: _____

Address:_____

_____

Claim adjuster name_____

Phone#_____

FAX billing to (phone #)_____

Med Pay Amount $_____

Treated anywhere else on this claim?_____

***Called Insurance before appointment_____(Date/Your initials)

****Scan this information immediately** to Billing e-mail (initials)_____ (call billing office/make aware)

***Office use: Folder Label Color Purple
Account Category: PI
Type of Account : 9
Accounting Method: Claim Record
Claim Receiver: Paper
Insurance id: Claim #
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.

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 _____

Address _____

City _____ State _____ Zip Code _____

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

Cell Phone (_____) _____

Emergency Contact: _____ Phone (_____) _____

*Relationship: _____

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 _____ Age _____ SS# _____ - ____ - _____

What sources did you first utilize to choose our office? Check all that apply:
1. Referred ___ 2. Internet ___3. Called Insurance ___ 4. Angie's List ___

*referred by: _____

Check below how you would like to receive appointment reminders:
□ Text message □ Phone (home/cell) □ Email □ None

*Employer _____ Occupation _____

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

Do you have a secondary insurance? Yes _____ No_____

Name of Insurance card holder _____DOB: _____

Relationship to card holder_____ Card holder employer _____

Name of Primary Care Physician and City _____

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

Legal Name _____ 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

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	◻ 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 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 to body/psyche prior to menstruation	

Neuropsychological

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

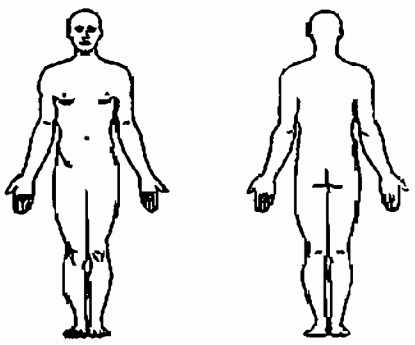
Musculoskeletal

◻ 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

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	◻ Diabetes	◻ High Blood Pressure	Other:_____
◻ Hepatitis	◻ Rheumatic Fever	◻ Thyroid Disease	_____
◻ HIV	◻ Heart Disease	◻ Seizures	_____
◻ 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

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

Notes (please add anything of note)

_____

_____

_____

_____

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Welcome to West Chester Acupuncture and Chiropractic

2019 Insurance Update

Patient Information

Patient Name:_____

Address:_____Zip:_____

Phone Number:_____

Email:_____

****PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD TO COPY WHETHER IT IS NEW OR THE SAME****

Insurance Information Is this a new insurance plan for 2019? YES NO

****IF YOU HAVE A NEW INSURANCE COMPANY PLEASE FILL OUT THE INFORMATION BELOW****

Insurance Company Name:_____

Primary Cardholder Name:_____

Primary Cardholder DOB:_____ Relation to Patient:_____

Insurance ID #:_____Group#:_____

Primary Cardholder Employer:_____

Check below how you would like to receive appointment reminders:

□ Text message □ Phone (home/cell) □ Email

HIPPA Privacy Act Laws

☐ 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) Date

WEST CHESTER ACUPUNCTURE AND CHIRIOPRACTIC
DR.JULIE HILBERT AND DR.BURTON YOUNG
7665 Monarch Ct. Suite 110, WEST CHESTER, OHIO 45069
513.777.9428 (FAX) 513.777.3628

Financial Policy 2019

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