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: _____

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. _____

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

Skin & Hair

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

Head, Eyes, Ears, Nose & Throat

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

Cardiovascular

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

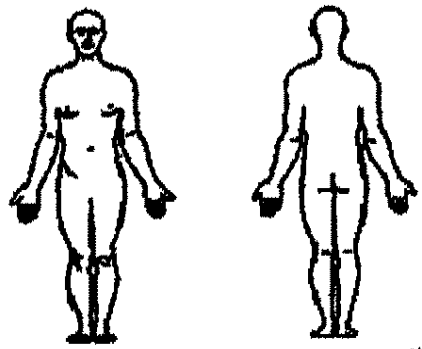
Musculoskeletal

- ☐ Neck pain
- ☐ 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:



4/28/2020

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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)

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 2023

Payments/deductibles and/or co-payments are due at the time of service. A payment of $55.00 OR your Copay (if clearly marked on your insurance card) will be required at the time of service until we have verified your insurance. 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.

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.

Please check which one of the following applies:

_____ **INSURANCE**
(□ Check here for VA patients with active authorization)
If your insurance is a high deductible plan, the office will collect in anticipation of your finalized claim. Once your Deductible has been met, your co-insurance will be collected each visit.

_____ **MEDICARE/Advantage Plans (See ABN form)**

_____ **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. Exams are not covered

_____ **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 recommends that you immediately file a claim with your automobile insurance. We bill med-pay first. When all med-pay funds have been used we will bill your health insurance. At the time of service you will 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. A late fee of $25 per month will be added to the balance, beginning at 90 days after service is rendered. Balances over 90 days past due will be forwarded to our collection agency.

_____ _____
Signature of Patient (Parent/Guardian) Date

_____ _____
Print Name of Patient (Parent/Guardian) Date

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DR. JULIE HILBERT, DC, FIAMA, Dipl.Ac*
DR. BURTON YOUNG, DC, FIAMA, Dipl.Ac*
7665 Monarch Court, Suite 110, West Chester, Ohio 45069
Phone:513-777-9428 Fax:513-777-3628

Authorization for Records

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

___ Requesting Transfer of Records be sent to the Office of Dr. Julie Hilbert/Dr. Burton Young

FROM: Dr._____
Center OR Clinic_____
Address_____
City_____ State_____ Zip_____
Phone:_____ Fax_____

OR

_____ Transfer Records From Our Office to:

Send to: Dr._____
Center OR Clinic_____
Address_____
City_____ State_____ Zip_____
Phone:_____ Fax_____

Requesting Records (enter visit 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

2023 Massage Therapy Agreement

PAYMENT: 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 requires 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.

CHRONIC NO SHOW POLICY: This policy applies to all patients including VA or WC patients. If two appointments are missed, or less than 4-hour notice to cancel is given within a two-month period, then we will not be able to schedule, any future massage appointments in our office for the patient.

4-hour cancellation notice is required, 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. If this notice is not given, then you will be charged a $40.00 missed appointment fee 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. This policy does not apply to VA or WC patients.

By signing below, I agree to these terms:

_____ _____

Patient Signature Date

_____

Print Name

WEST CHESTER ACUPUNCTURE AND CHIROPRACTIC
DR. JULIE HIBERT AND DR. BURTON YOUNG
7665 MONARCH COURT, SUITE 110, WEST CHESTER, OHIO 45069
(PHONE) 513.777.9428 (FAX) 513.777.3628