West Chester Acupuncture and Chiropractic
Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.
7665 Monarch Ct, Suite 110, West Chester, OH 45069
513-777-9428

Patient Name: _____ Date: _____

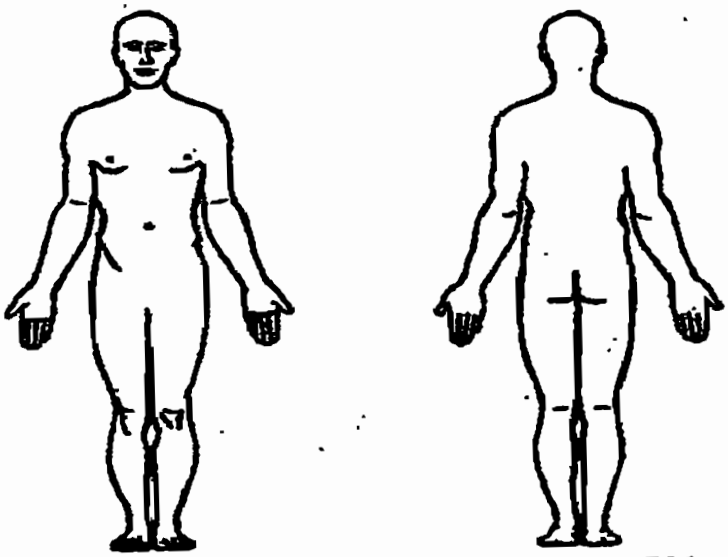
Visual Analog Scale

INSTRUCTIONS: Circle the number (0 = no pain; 10 = unbearable pain) that best describes the question being asked.

1. What is your pain level RIGHT NOW? 0 1 2 3 4 5 6 7 8 9 10
2. What is your pain AT IT'S BEST? 0 1 2 3 4 5 6 7 8 9 10
3. What is your pain AT IT'S WORST? 0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Comments: _____



Using the symbols listed below, mark on the figure above the areas of your body where you feel the described sensations:

Numbness	═══	Hot Burning	xxxxxx
Dull Ache	0000000	Sharp Stabbing	//////////
Pins and Needles	++++++	Other	_____

Welcome to West Chester Acupuncture and Chiropractic

Case History Update 2019

In order for us to best serve you, and so that we may bring your original case history up-to date, please provide us with the following information:

Please Print:

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ E-Mail: _____

Emergency Contact: (name & Phone #) _____

*****Is this visit regarding an injury at work or auto accident? YES NO**

Insurance Information: Has your insurance changed? YES NO

****IF your insurance is new, please present the receptionist with your card so they can make a copy to keep on file****

Complaints Update:

1. List present complaints (describe fully): _____
   _____
2. How long have you had the above complaints? _____
3. What do you believe caused this condition? Describe any falls, surgery, and/or accidents since last visit: _____
4. Have you received additional treatment from another doctor or clinic for the above listed condition(s)? YES NO
   Dr. or Clinic name: _____
   Describe treatment received and your response to treatment: _____
   _____
5. Are you pregnant? YES NO
   Is there any possibility that you COULD be pregnant? YES NO
6. Other information you feel the doctor should know regarding this condition?
   _____
   _____

_____ _____

Patient or Legal Guardian Signature Date

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

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

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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 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

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2019 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

2019

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