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 _____/_____/_____

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 _____
- 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

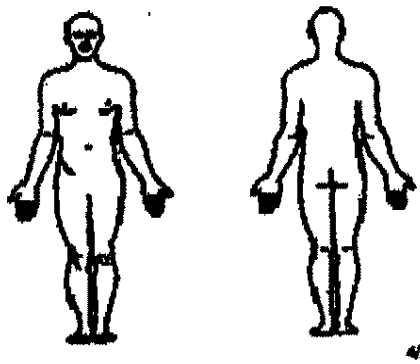
Musculoskeletal

- ☐ 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:



4/28/2009

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

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
- ☐ Allergies
- ☐ Heart disease

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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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
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