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: _____

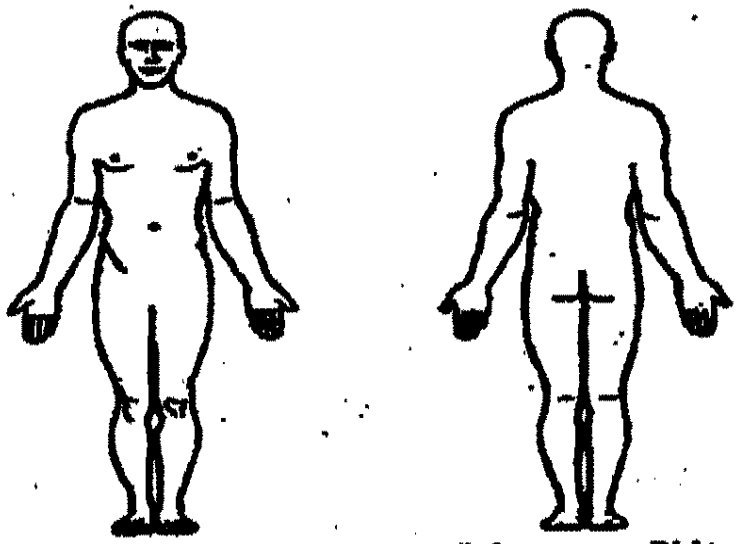
Visual Analog Scale

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 2023

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

2023 Insurance Update

Patient Information

Patient Name: _____

Address: _____ Zip: _____

Phone Number: _____ Patient DOB: _____

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 2023? 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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DR.JULIE HILBERT AND DR.BURTON YOUNG
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513.777.9428 (FAX) 513.777.3628

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: _____

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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

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Update paperwork under Massage therapy Agreement

West Chester Acupuncture and Chiropractic

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7665 Monarch Ct. Suit 110 West Chester OH, 45069 - 513-77-9428

Medical Intake Form For Massage

Date: _____

Please take a moment to complete the following questionnaire. This will help to ensure a safe and comfortable massage session for you. All information is confidential.
Have you received massage in this office in the past? ( ) Yes ( ) No If yes, please inform the therapist before continuing.

Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

E-mail: _____

Emergency Contact: _____

Relationship to you: _____ Phone #: _____

PCP: _____ Phone #: _____

Do you give permission to contact your Physician: ( ) Yes ( ) No

Are you pregnant? ( )Yes ( ) No If Yes....How many weeks_____

Have you ever had a massage before: ( ) Yes ( ) No If yes, when? _____

Do you smoke? ( ) Yes ( ) No Do you consume alcohol? ( ) Yes ( ) No

Do you have any areas that you want specific attention? _____

Do you have allergies to any skin oils, lotions or fragrances: ( ) Yes ( ) No If yes, explain? _____

_____

Are you currently taking any blood thinners?

❑ Coumadin ❑ Lovenox ❑ Heparin ❑ Any Pain Medication: _____

Are you taking any cancer medication? ? ( ) Yes ( ) No

If yes, please list: _____

Are you taking any muscle relaxants? ? ( ) Yes ( ) No

If yes, please list: _____

Have you taken any medications in the last 24 hours? ( ) Yes ( ) No

If yes, please list: _____

Have you had surgery within the last 5 years? ( ) Yes ( ) No

If yes, what & when: _____

Have you had any implants within the last 9 months? ( ) Yes ( ) No

If yes, what & when: _____

Do you currently have any of the following?

- ☐ Acute inflammatory conditions (ex. Phlebitis or Cellulites)
- ☐ Arthritis/ Tendonitis (Stenosis, Spondylitis or Spondylolisthesis)
- ☐ Blood clots
- ☐ Blood thinners (Coumadin, Heperin, Aspirin 325mg/day)
- ☐ Breast implants within last 9 months
- ☐ Broken/cracked ribs
- ☐ Cancer - list below type, benign or active
- ☐ Chemotherapy or radiation therapy
- ☐ Depressed immune system (Lupus, Epstein, Barr, Mononucleosis, HIV/AIDS)
- ☐ Diabetes (Insulin pump? Yes or No)
- ☐ Dialysis (need MD's written permission)
- ☐ Fever
- ☐ Fibromyalgia
- ☐ Fractures/dislocations- list below type and when
- ☐ Hemorrhoids
- ☐ Herniated or protruded discs (Area: _____)
- ☐ High blood pressure
- ☐ Injections recently at joint or muscle junctures
- ☐ Injuries – list below type and when
- ☐ Irritable Bowel Syndrome
- ☐ Joint surgery, joint replacement (ex. Steel rods)
- ☐ Kidney or Liver disorder (including Dialysis)
- ☐ Neck/back injuries
- ☐ Neuropathy (from disease or chemo)
- ☐ Osteoporosis
- ☐ Pacemaker/heart conditions
- ☐ Scoliosis
- ☐ Skin – boils, skin lesions or abscesses, psoriasis, acute conditions, acne, skin cancer, shingles, burns, eczema, recent surgery by dermatologist – list below
- ☐ Sprains/strains
- ☐ Surgery – list below any recent surgeries
- ☐ TMJ dysfunction
- ☐ Tuberculosis, Thrombosis or Aneurysm (circle)
- ☐ Varicose veins

Note: Clients who have undergone any surgery including Lasik eye surgery must avoid massage for 72 hours. Massage must be avoided by anyone who has consumed alcohol within 24 hours of appointment. If you have had a heart condition that required surgery, pacemaker, stint or shunt you will need to avoid massage for one year and you will need written approval from your surgeon in the form of a permission slip.

List any necessary details or additional information the therapist may need to know.

_____

_____

_____

*Please note, if we may be of any assistance with chiropractic care, please do not hesitate to schedule an appointment. There is no charge for a consultation. This allows you time to speak with the doctor about your health concerns. If you are currently receiving chiropractic care, some insurance companies cover massage therapy if recommended by the doctor.

Massage Therapy Informed Consent

I, _____, understand that the massage therapy provided by the licensed massage therapist is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that the massage therapy is not a substitute for medical diagnosis, medical treatment or medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions, and medications and I will keep the massage therapist updated on any changes. I give my consent to receive the treatment.

_____ _____

Client Signature Date

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2023 Insurance Update

Patient Information

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Address: _____ Zip: _____

Phone Number: _____ Patient DOB: _____

Email: _____

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