

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 _____

Gender: Male Female **Marital Status:** Single Married Separated Divorced Widowed

Date of Birth _____ SS# ____ - ____ - ____ Age _____

Emergency Contact: _____ *Relationship: _____

Phone (____) _____

Check below how you would like to receive appointment reminders:

Text message Phone (home/cell) Email

What sources did you first utilize to choose our office? Check all that apply:

1. Referred by: _____ 2. Internet ____ 3. Called Insurance ____ 4. Angie's List ____

Employer _____ Occupation _____

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

Have you seen another chiropractor this year? Yes / No

Name of Insurance policy holder/subscriber _____ DOB: _____

Relationship to subscriber _____ Subscribers employer _____

Do you have a secondary insurance? Yes ____ No ____

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

Print Name _____ Date ____/____/____

MEDICAL HISTORY

Patient Name

Main Complaints 1. _____ 2. _____ 3. _____

General

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

Skin & Hair

- | | | | |
|--|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Purpura | <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Changes in hair/skin: _____ | | <input type="checkbox"/> Other hair or skin problems: _____ | |

Head, Eyes, Ears, Nose & Throat

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

Cardiovascular

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling in hands/feet |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> 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
- D Birth Control
- Premature births. _____
- Changes to body/psyche prior to menstruation

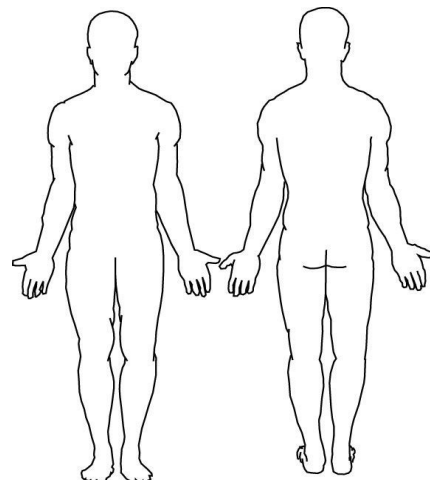
Neuropsychological

- 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
- Burning quality
- Stabbing quality

Mark location of pain or injury:



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

MEDICAL HISTORY

Patient Name, _____

Significant Illnesses (list date of diagnosis)

- | | | | |
|---|--|--|--------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | Other: _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures | _____ |
| <input type="checkbox"/> 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

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Multiple sclerosis | Other: _____ | |

Notes (please add anything of note)

A. Notifier: West Chester Acupuncture and Chiropractic
B. 7665 Monarch Court, Suite 110, West Chester, OH 45069 (P) 513-777-9428
C. Dr. Burton Young, DC, FIAMA, Dipl.Ac & Dr. Julie B. Hilbert, DC, FIAMA, Dipl.Ac
D. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.(services)** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.(services)** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New Patient Exam: 99201, 99202, 99203 Established Patient Exam: 99212, 99213 Moderate Complexity: 99214 Extremity Manipulation: 98943 Therapy: 97014, G0283 1 unit = 15 Minutes Acupuncture: 97810, 97811, 97813, 97814 Myofascial Release: 97140 30, 60 minutes Spinal Manipulation 98940 98941	Non-covered Services Non-covered Services Non-covered Services Non-covered Services Non-covered Services Non-covered Services Non-covered Services When not Medically Necessary	\$80.00 * \$50.00 * \$80.00* \$35.00 * \$15.00 each unit \$70.00 * \$40.00 *, \$70.00 * \$55.00 * *Time of Service Discount

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.(services)** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

<p>G. OPTIONS: Check only one box. We cannot choose a box for you.</p>
<p><input type="checkbox"/> OPTION 1. I want the D.(services) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</p> <p><input type="checkbox"/> OPTION 2. I want the D.(services) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.</p> <p><input type="checkbox"/> OPTION 3. I don't want the D.(services) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.</p>

H. Additional Information: Option 1 should be checked if you have secondary insurance that might cover Medicare deductible and co-insurance. **This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

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, 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: _____ No one

Others: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes No

Appointment Cancellation Policy:

Please provide 24 hour notice in the event that you need to reschedule. This will allow us the opportunity to provide care to another patient. A message can be left on our voicemail if we are unable to answer.

Repeated missed appointments without notice may result in termination of the physician/patient relationship.

As a courtesy, we make reminder calls, texts, e-mails one to two days in advance. If a reminder call or message is not received the cancellation policy remains in effect.

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: _____

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

Financial Policy 2025

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.

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.

_____ **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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