Daniel C. Cox, D.C., P.C. 8370 Main St. Williamsville, NY 14221 Phone: (716) 632-3435 Fax: (716)632-8491

2017 NEW PATIENT INTAKE FOR INSURANCE, MEDICARE AND PRIVATE PAY (CASH) PATIENTS 1 of 3

Patient Name:_____ **Date:**_____

Address:_____ **City:**_____ **ST:**_____ **Zip Code:**_____

Phone #: Home _____ **Cell:**_____ **Work:**_____

Email Address:_____ **Nick Name:**_____

Date of Birth:_____ **SS#**_____-_____-_____ **Height**_____ **Weight**_____**LBS**

Sex: ____Male ____Female **Marital Status**: ____Married ____Single ____Divorced ____ Widowed

How did you hear of this office? ___Sign ___Location ___Internet ___ Referred by:_____

Work status: ____Full Time ____Part Time ____ Retired ____ Student ____ Unemployed ____Homemaker

Employer: _____ **Occupation:**_____

Work Address:_____

Date Symptoms began:_____ **Time:**_____ **am / pm**

Purpose of this appointment & how did your symptoms begin:_____
_____

Condition related to: ____ An Illness ____A Gradual Onset ____No Obvious Reason

Please notify our staff if condition is related to: ____ Auto Accident ____Work Accident ____Personal Injury

Describe your current symptoms:
___ sharp pain ___dull ache ___soreness ___stiffness ___tenderness ___numbness ___spasm ___loss of sensation

How often do you experience your symptoms:

_____ Constantly (100% of the time)
_____ Frequently (75%of the time)
_____ Intermittently (50% of the time)
_____ Occasionally (25% of the time)

WHAT makes your condition WORSE:

___ interrupted normal sleep pattern
___ substantial difficulty getting out of bed
___maintaining a seated position
___ standing from seated position
___getting in and out of a vehicle
___driving associated with lower back/ leg pain
___driving associated with limited neck mobility
___turning the neck to either side

Please check current Functional Limitations below :

___ bending at the waist
___using a computer
___ doing laundry
___reading
___ cleaning around the house
___having sexual relations
___ the inability to carry or handle bags of groceries
___getting dressed
___ putting one's shoes on
___ duties regarding child care

Please check what makes your condition BETTER: ___application of ice ___application of heat

___OTC strength pain relievers ___movement in general ___ recumbent rest ___use of inversion table
___sleeping in a recliner ___stretching ___exercise ___therapeutic massage
___chiropractic adjustments ___topical analgesics ___meditation

Other Doctors seen for this condition and when:_____

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2017 NEW PATIENT INTAKE FOR INSURANCE, MEDICARE AND PRIVATE PAY (CASH) PATIENTS 2 of 3

Patient Name:_____**Date**:_____

In regards to **YOUR HEALTH HISTORY**: Please check the **C box if you CURRENTLY** have this condition and the **P box if you PREVIOUSLY** had this condition.

C	P	**MUSCULOSKELETAL**	C	P	**CONSTITUTIONAL**	C	P	**EYES / VISION**
		Low Back pain			Weight Loss			Blindness
		Mid back pain			Weight Gain			Blurred vision
		Pain between shoulders			**ENDOCRINE**			Cataracts
		Neck pain			Diabetes			Glaucoma
		Arm problems: Rt or Left			Abnormal freq. of urination			Headaches
		Leg Problems: Rt or Left			Hair loss			**EARS, NOSE & THROAT**
		Swollen, stiff, painful joints			Bladder trouble			Ringing in ears (tinnitus)
		Sore and/or weak muscles			**SKIN**			TMJ problems
		Walking problems			Rash			Hearing loss
		Spasms			History of skin disorders			Nosebleeds
		Broken bones			**Cardiovascular/Respiratory**			Snoring
		Shoulder pain Rt or Left			Chest pain			Dizziness
		GASTROINTESTINAL			Low blood pressure			**FEMALES**
		Abdominal Pain			High blood pressure			Irregular Menstruation
		Jaundice			Heart problems			Birth Control
		Gall bladder problems			Heart murmur			Breast Lumps / Pain
		Hemorrhoids			Asthma			**MALES**
		NERVOUS SYSTEM			**PSYCHOLOGIC**			Prostate problems
		Numbness			Anxiety			Erectile dysfunction
		Seizures			Bi-polar disorder			Urination problems
		Strokes			Depression			**OTHER – PLEASE LIST**
					Insomnia			

PRIOR IMAGING: please check below and complete to the best of your ability:

XR	MRI	CT	BODY PART	WHICH FACILITY	APPROX. DATE

Primary Physician:_____ **Date of last Physical Exam:**_____

Spouse:_____ **Date of Birth:**_____

Emergency Contact:_____ **Relationship:**_____**Phone #**_____

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Patient Name:_____**Date**:_____

2017 NEW PATIENT INTAKE FOR INSURANCE, MEDICARE AND PRIVATE PAY (CASH) PATIENTS 3 of 3

In order to meet current healthcare guidelines and to have current medical records of your general health status. Please answer any and all questions that apply to **YOUR HEALTH HISTORY**.

HOSPITALIZATIONS, SURGERIES, INJECTIONS, SERIOUS ILLNESS & TRAUMA: Please list.

Year	Hospital	Reason for hospitalization & Outcome

WHAT ARE YOUR <u>DAILY</u> HEALTH HABITS (please include frequency: example- 2x, 5x, etc):

___ water (8oz) ___ exercise ___caffeine ___soda ___ tobacco (# years _____) ___recreational drugs

Please list all REGULAR MEDICATIONS and VITAMINS you take daily:

_____

Please list all ALLERGIES:_____

_____

FEMALES ONLY: **Are you pregnant? _____ YES _____ NO Date of last menstrual period:**_____

PREGNANCY HISTORY (Please list YEAR OF BIRTH as well as any complications):

_____

BELOW: FAMILY HISTORY ONLY-please complete to the best of your ability.

Relation	Age	State of health	Age of Death	Cause of Death	X if your blood relatives have any of the following Diseases		Relationship
Father						Arthritis, rheumatoid arthritis	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Diabetes	
						Heart Disease, Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						High Cholesterol	

All Medical information on intake paperwork reviewed with patient by: _____

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PATIENT NAME: _____ **DATE**:_____

How do you plan on paying for your care? _____ Personal Health Insurance _____ Private Pay (NO INSURANCE)

Who is responsible for payment? _____Self _____Spouse _____ Parent _____ Other

INSURANCE (PRIMARY)

CARRIER:_____

ID#:_____

Insured:_____

Date of Birth (Insured):_____

Relationship:____Self ____Spouse ____Parent ____Other

INSURANCE (SECONDARY)

CARRIER:_____

ID#:_____

Insured:_____

Date of Birth (Insured):_____

Relationship:____Self ____Spouse ____Parent ____Other

NOTICE OF PRIVACY PRACTICE & HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 (HIPAA): Please see additional green colored pages that are attached to your clipboard. Please inform any front desk staff member if you would like a copy to take home. We would be happy to furnish one for you.
I acknowledge that I have read and understand the Notice of Privacy Practices & HIPAA for the office of Daniel C. Cox, D.C., P.C. which went into effect April 14, 2003, with the latest revision August 20, 2013.

PATIENT or PARENT / GUARDIAN SIGNATURE:_____Date:_____

Authorization and Assignment of Benefits:
I certify that I am the patient or parent/ legal guardian and I have read, completed and certify the information on this patient intake form to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office. I authorize treatment and agree to pay all fees and charges for such treatment. I hereby authorize the doctor to release all information necessary to any insurance company, attorney or adjustor for the purpose of claim reimbursement of charges incurred by me. I grant the use of this signed statement of authorization with my signature for required insurance submissions. I authorize my insurance carrier to make direct payment to this office of any sum I now or hereafter owe you. I understand that fees for professional services will become immediately due if I do not have any health care benefits, or upon suspension or termination of my health insurance carrier coverage and/ or suspension or termination of my care or treatment.
Upon receipt of patient statements, I agree to pay all charges for myself, members of my family, shown by these statements. Charges shown on statements are agreed to be correct and reasonable, unless protested within 30 days of the billing date. I agree that if my account is referred to an outside agent for collections, I am responsible for all collection and / or attorney fees.

Records Release
To the office of Daniel C. Cox, D.C., P.C., I hereby authorize you to release to any and all insurance carrier(s) and / or attorney(s) information from this day forward, including the diagnosis and medical records of treatment or examination(s) rendered.

I acknowledge that I have read and understand the AUTHORIZATION AND ASSIGNMENT OF BENEFITS AND RECORDS RELEASE as stated above.

PATIENT or PARENT / GUARDIAN SIGNATURE:_____ Date: _____

********** BELOW: MINOR CONSENT FORM: FOR MINOR PATIENTS ONLY (To be filled out by PARENT or Guardian)*********

PARENT / GUARDIANS Name: _____ Relationship:_____

Address (If different than child)_____ Phone #_____

As the parent or Guardian of this patient, I authorize the doctors in this office of chiropractic to administer examinations and chiropractic care as deemed necessary to this minor.

PARENT or GUARDIAN Signature (**Minors only**):_____

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Patient Name:_____ **Date**:_____

INFORMED CONSENT

Chiropractic as well as other types of healthcare, is associated with the potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic is remarkably safe, one must be aware of the potential risks involved before to consenting to treatment.

SPECIFIC RISK POSSIBLILITIES ASSOCIATED WITH CHIROPRACTIC CARE:

Stroke: Stroke is the most serious complication of Chiropractic treatment. It is, however, extremely rare. Vertebral arteries, which supply the brain with blood, are located within the bones of the upper spine. Cervical treatment therefore, poses a small risk for stroke (temporary or permanent brain dysfunction). Recent studies estimate the risk of stroke to be one in every three million upper cervical adjustments. The risk of fatal stroke following a cervical spine adjustment is 0.00025%. As a comparison the risk of death from NSAIDS (aspirin, ibuprofen, naprosyn, etc) is 0.04%. In other words, the risk of death or serious complications is 100-400x greater for the use of NSAID then through cervical manipulation.

Soreness: Chiropractic adjustments are sometimes accompanied by post traumatic soreness. While soreness is normal you should advise our doctors if it occurs.

Soft Tissue Injury: Occasionally, chiropractic treatment may aggravate a disc injury or cause a minor joint, ligament, tendon or other soft tissue injury.

Rib Injury: Manual adjustments to the thoracic spine, in rare cases, may cases a rib injury or fracture. Precautions such as pre-adjustment X-rays are taken in cases that are considered at risk. Treatment is performed carefully to minimize risk potential.

Chiropractic is a system of health care delivery, therefore, as with any healthcare delivery system, we cannot promise a cure for any systems, conditions or disease. An attempt to provide the best chiropractic care is our goal, and if results are not successful, we will refer you to another healthcare provider. If you have any questions the doctors would be happy to answer them.

HAVING CAREFULLY READ THE ABOVE, I HEREBY GIVE MY INFORMED CONSENT TO HAVE CHIROPRACTIC TREATMENT ADMINISTERED.

_____

PATIENT or PARENT / GUARDIAN (if minor) SIGNATURE

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Patient Name:_____ **Date**:_____

HOW WE MAY USE AND / OR DISCLOSE YOUR HEALTH INFORMATION

We will use your information for treatment: Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnose medical conditions and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment: Your health plan, No Fault carrier or Workers Compensation carrier may request and receive information on dates of service, the services provided and the medical condition being treated in order to pay for service rendered to you.

Business Associated: In some instances we have contacted separate entities to provide services for us. These "Associates" require your health information in order to accomplish the tasks we ask them to provide. Some examples would be a billing service collection agency, answering service, computer software provider or note service.

Communication with family: Due to the nature of our field, we will use or best judgment when disclosing health information to a family member or any other person who is involved in your care that you have authorized to receive this information. Please inform the practice when you DO NOT wish a family member or other individual to have authorization to receive information.

Health care oversight: Federal requires us to release your information to an appropriate health oversight agency, public health authority, attorney or other Federal / State appointees if there are circumstances that require for us to do so.

Your legal representatives: If you are involved in a Personal, Worker's Compensation or No Fault case, and are being represented by an attorney, information requested by the attorney will be provided to them.

Public health reporting: Your health information may be disclosed to public health agencies as required by law.

Law enforcement: Your health information may be disclosed to law enforcement agencies without your permission to support government audits and inspections, to facilitate law enforcement investigation and comply with government mandated reporting.

Appointment reminders: Can be sent upon patient's approval via telephone, text or email.

Other uses and disclosures: Disclosure of your health information or its use for any purpose other than listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not undo any use or disclosure of information that occurred before you notified us of your decision. If you believe that your privacy rights have been violated please contact the aforementioned practice Privacy Official or you may file a complaint with the Office of Civil Rights or the United States department of Health and Human Services. There will be no retaliation for filing with either office.

"**THIS RELEASE IS FOR THE PURPOSE OF GIVING INFORMATION TO THE REQUESTING PARTIES. I HEREBY AUTHORIZE DR. DANIEL C COX TO FURNISH ANY RECORDS PERTAINING TO MY MEDICAL HISTORY, SERVICES RENDERED, INVESTIGATION OR EVALUATION FOR THE CLAIM"**

_____ _____

PATIENT OR PARENT/GUARDIAN SIGNATURE DATE WITNESS

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HEALTH INFORMATION RELEASE FORM TO FAMILY MEMBERS

In accordance with the Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff at Daniel C. Cox, D.C, P.C. to discuss your condition with members of your family or other individuals you designate, we must obtain your authorization prior to do so.

BELOW, please read <u>all</u> selections and check those that apply:

_____ **I DO** authorize Daniel C. Cox, D.C, P.C. to leave messages with anyone in my household OR on an answering machine / voicemail regarding my care.

_____ **I DO NOT** authorize Daniel C. Cox, D.C, P.C. to leave messages with anyone in my household OR on an answering machine / voicemail regarding my care.

_____ I **DO** authorize Daniel C. Cox, D.C, P.C. to release billing information or to discuss my condition to **any individual listed below**.

_____ I **DO NOT** authorize Daniel C. Cox, D.C, P.C. to release billing information or to discuss my condition with anyone other than myself.

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

PATIENT NAME: _____Date:_____

PATIENT or PARENT / GUARDIAN SIGNATURE_____

WITNESS SIGNATURE:_____

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PATIENT NAME_____

2017 Patient Financial Policy

(Please initial each paragraph that applies to you to express your understanding)

_____ **Medicare Eligible Patients**: This office is a participating provider with Medicare and most managed Medicare policies. Please check with our staff to determine whether your plan is one of these. Our office will submit all services to the carrier. **PLEASE NOTE:** Medicare policies only cover approved Spinal Manipulation. ***Medicare does NOT cover maintenance/ wellness care or chronic conditions, Exams, ultrasounds, cold laser, or spinal decompression*.** Patients are required to pay any amount due for annual deductibles, copays, coinsurances and non-covered services at the time of each visit.

_____ **Private Pay / Personal Payment Patients:** Patients who do not have Insurance Coverage or do not have Chiropractic included in their insurance coverage are expected to pay for services rendered at the time of each visit.

_____ **All Insurance Patients:** This office will accept assignment of benefits, which are covered by approved insurance plans. We shall assist in all possible ways in helping you process and obtain all of the benefits for which you are eligible; but the financial obligation is yours. Please remember, patient responsibility amounts are determined by your insurance carrier - not Dr. Cox. These amounts are part of your contract with your individual insurance plan. The patient is responsible for understanding his/her own policy benefits and limitations.

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service and are ultimately the patient's responsibility.

_____ **Auto Accident (No Fault Case):** Patients fully understand they are responsible to provide all correct and pertinent information for the auto accident case (insurance carrier, date of injury, claim#, phone#, and claim adjustor**). In the case of services being provided, billed and applied to the patient's deductible, you would be responsible for payment of this deductible**. If you retain an attorney, you are required to sign a Doctor's lien which will be sent to the attorney.

_____ **Workers Compensation Patients:** Patient fully understands they are responsible to provide all correct and pertinent information for the worker's compensation case (employer, date of injury, carrier, WCB case #, carrier case #, body part that was injured).

_____ **ALL Types of Coverage**: ***I have read and understand the Patient Financial Policy*** as it pertains to my financial responsibility. I understand that I am responsible for any ***balance due at the time of service***. I agree, if I discontinue my care for any reason, I will pay the balance in full at that time. If after my services are not billed to any health insurance carrier or after by my insurance carrier and a balance is due on my account, I am responsible for payment of this balance due upon acknowledgment or receipt of a statement sent to me. If my account is not paid in full upon receipt of statement, billing fees will be applied. (over 30 days:$5.00, over 60 days: $10.00, and over 90 days: $15.00) If needed, payment arrangements can be established. Should collection services be required, fees for those services will be added to my account and will be my responsibility. I understand that a 24 hour notice is required for cancelling appointments and without that adequate notice, a fee may be charged to me. This charge is NOT covered by insurance carriers.

_____ _____

PATIENT OR PARENT / GUARDIAN SIGNATURE **DATE**