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

4 page ESTABLISHED PATIENT UPDATE (patient has not been seen in our office in over a year)

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:_____

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

WHAT ARE YOUR DAILY HEALTH HABITS: Please check list frequency :
___ water (8oz) ___ exercise ___caffeine ___soda ___ tobacco (# years _____) ___recreational drugs

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

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

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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

Other Doctors seen for this condition and when:_____

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

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

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

PATIENT NAME:_____**DATE**:_____

All Medical information reviewed with patient by: _____

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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.

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 NAME_____

X SIGNATURE _____ **DATE:**_____

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

PARENT / GUARDIAN 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 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 NAME_____

X SIGNATURE _____ **DATE:**_____

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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>BOTH</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**:_____

X SIGNATURE:_____

WITNESS SIGNATURE:_____