



**PATIENT INFORMATION - PLEASE COMPLETE ALL PAPERWORK IN BLACK OR BLUE INK**

DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

ADDRESS: \_\_\_\_\_  
Number & Street P.O. Box City State Zip

TELEPHONE (HOME): ( ) \_\_\_\_\_ (CELL): ( ) \_\_\_\_\_ (WORK): ( ) \_\_\_\_\_

EMAIL: \_\_\_\_\_ Best way to be contacted: Home Work Cell SMS/Text Email

GENDER: M F MARITAL STATUS: S M D W NUMBER OF CHILDREN: \_\_\_\_\_

EMPLOYMENT STATUS: Full Time Part Time Retired Not Working

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

RESPONSIBLE PARTY (if different than patient): \_\_\_\_\_  
Last First MI

ADDRESS: \_\_\_\_\_  
Number & Street P.O. Box City State Zip

TELEPHONE (HOME): ( ) \_\_\_\_\_ TELEPHONE (WORK): ( ) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

**NEAREST FRIEND OR RELATIVE WHO MAY BE CONTACTED IN AN EMERGENCY:**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

YOUR INSURANCE COMPANY: \_\_\_\_\_

INSURED'S NAME (if different than patient): \_\_\_\_\_ INSURED'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

IS PRESENT CONDITION RELATED TO EMPLOYMENT? \_\_\_\_\_ Yes \_\_\_\_\_ No

WAS THIS THE RESULT OF AN ACCIDENT? (EX. AUTO, FALL, ETC...) \_\_\_\_\_ Yes \_\_\_\_\_ No

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR BEFORE? \_\_\_\_\_ Yes \_\_\_\_\_ No WHEN? \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

**OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT**

Coxon Lifestyle Management Clinic, LLC and Adam M. Coxon DC accepts assignment for Preferred Blue, BlueChoice, SC BlueCross State Health Plan, and other BlueCross BlueShield plans. We do not accept assignment for any other carriers out of the BlueCross network. We can and will file your claim with all other insurance carriers outside of the BlueCross network. The deductible and any amount that is not paid by the insurance company are the patient's responsibility.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize Coxon Lifestyle Management Clinic, LLC to release any medical information necessary to successfully process my insurance claims. This authorization will continue in effect until I give written authorization not to release such information. I further authorize payment of medical benefits to Adam M. Coxon DC for services provided.

**All account balances not paid within 60 days will automatically be charged to your credit card.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## CONFIDENTIAL HEALTH HISTORY

Please enter "P" (Previously), "C" (Currently), in front of all of the following signs and symptoms. Leave blank if not applicable. A complete history and understanding of your health will facilitate care.

### GENERAL

- Fever
- Chills
- Night sweats
- Loss of sleep
- Fatigue
- Nervousness
- Weight loss or gain
- Allergies
- Bleeding/bruising problems
- Anemia
- Diabetes
- Cancer
- Thyroid disease/goiter
- Heat/cold intolerance
- Alcoholism
- Drug abuse

### EYE, EAR, NOSE, THROAT

- Poor vision  
(glasses, glaucoma, etc.)
- Pain in eye(s)
- Deafness/difficulty hearing
- Ringing in ears
- Nosebleeds
- Nose problems
- Sinus trouble
- Dental problems
- Hoarseness
- Tonsillectomy

### GASTROINTESTINAL

- Poor appetite
- Poor digestion
- Difficulty swallowing
- Belching or gas
- Frequent nausea
- Vomiting blood
- Pain over abdomen
- Ulcer
- Black or bloody stools
- Liver problems
- Gall bladder problems
- Jaundice
- Hernia
- Diarrhea
- Bowel movement  
How often? \_\_\_\_\_
- Constipation
- Hemorrhoids
- Appendicitis

### RESPIRATORY

- Difficulty breathing
- Chronic cough
- Spitting phlegm
- Spitting blood
- Wheezing/asthma
- Pneumonia
- Tuberculosis
- Occupational/envirom.  
inhalation

### CARDIOVASCULAR

- Irregular heartbeat
- High blood pressure
- Pain over heart
- Previous heart trouble
- Ankle swelling
- Varicose veins
- Rheumatic fever
- Stroke
- Pain in legs after walking

### GENITOURINARY

- Frequent urination
- Painful urination
- Blood in urine
- Kidney disease
- Urinary infection
- Inability to control  
urination
- Difficulty starting  
urine flow
- Get up \_\_\_ times per  
night to urinate
- Breast lump or pain
- Venereal infection
- Sexual difficulties

### MEN ONLY

- Testicular swelling/pain
- Prostate problems

### WOMEN ONLY

- Painful periods
- Irregular cycles
- Menstrual flow:
  - How many days? \_\_\_\_\_
  - How many days between  
periods? \_\_\_\_\_
  - Date last period began:  
\_\_\_\_\_
  - Date of last Pap test:  
\_\_\_\_\_
- Vaginal burning/itching
- Hot flashes
- Pelvic pain
- Menopause What age? \_\_\_\_\_

### NEUROLOGIC

- Weakness
- Twitching
- Tremors
- Headache
- Fainting
- Dizziness
- Convulsions
- Epilepsy
- Numbness/tingling
- Arm/leg pain
- Mental disorder
- Head trauma

### MUSCULOSKELETAL

- Neck stiffness/pain
- Pain between shoulders
- Low back pain
- Swollen joints
- Painful joints
- Muscle aches/soreness
- Arthritis

### SKIN

- Itching
- Change in mole(s)
- Skin cancer

### HABITS

- Smoking  
\_\_\_\_\_packs/day
- Drinking alcohol  
\_\_\_\_\_drinks/week
- Recreational drug use

### EXERCISE

- None
- 1-2 times/week
- 3-5 times/week
- 6-7 times/week

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## FAMILY HISTORY

Include Information on brothers, sisters, parents and grandparents. **DO NOT INCLUDE YOURSELF.**

Diabetes: \_\_\_\_\_ High/Low Blood Pressure: \_\_\_\_\_  
Thyroid Disease/Goiter: \_\_\_\_\_ Heart Disease: \_\_\_\_\_  
Tuberculosis: \_\_\_\_\_ Cancer: \_\_\_\_\_  
Kidney Disease: \_\_\_\_\_ Muscle, Bone or Nerve Disease: \_\_\_\_\_

## MISCELLANEOUS

Psychiatric Problems: \_\_\_\_\_  
Other health items of concern \_\_\_\_\_  
Hobbies: \_\_\_\_\_

## PAST HISTORY

Please indicate if you have ever had the following: **(Include dates and descriptions where applicable.)**

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Supplements/Nutrition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Serious Illnesses (ex. rheumatic fever, pneumonia, mononucleosis, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hospitalizations/Operations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fractures/Dislocations/Sprains: \_\_\_\_\_  
\_\_\_\_\_

Severe Trauma/Accident/Falls (ex. car accident, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **FINANCIAL POLICY**

**Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans for crisis care and pain relief. As discussed we will do what we can for your insurance to reimburse you for services performed in this office. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.**

### **OUT OF NETWORK - GROUP OR INDIVIDUAL INSURANCE**

Your insurance policy is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, **the benefits quoted to us by your insurance company are not a guarantee of payment**. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment. Payment will be due by you at the time of service or once we receive written notification of a decision of the claim from your insurance company. You may not keep a balance for more than 60 days. If you are unable to pay in full, we can establish a payment plan.

### **PERSONAL INJURY OR AUTOMOBILE ACCIDENTS**

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will bill your automobile med-pay or you may choose to pay as you go. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

### **FLEX PLANS/MEDICAL SAVINGS ACCOUNTS**

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

### **PATIENTS WITHOUT INSURANCE**

We are happy to accept your check, cash, MasterCard, Visa, Discover, or American Express. We offer a "Time of Service" (TOS) discount for any of our patients, especially those without insurance (or without Chiropractic coverage). In order to receive the TOS discount, payment must be rendered on the same day of service.

### **INSURANCE FORMS/PAYMENT**

**If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please call us or bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to our office instead of you. If this should happen we will provide a credit to your account.**

*I have read and understand the payment policy of Coxon Lifestyle Management Clinic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Coxon Lifestyle Management Clinic, LLC and my insurance company. I request that Coxon Lifestyle Management Clinic, LLC prepares the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, fees will be due and payable immediately.*

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Patient's signature (or guardian if patient is a minor)

Date

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Witness



## CREDIT CARD AUTHORIZATION FORM

\_\_\_\_\_ authorizes Coxon Lifestyle Management Clinic, LLC to charge the credit card listed below for unpaid balances over 60 days from date of service, and for missed appointments.

*Missed Appointment Policy: If you are unable to make your appointment, please call our office as soon as possible. You will not be charged a missed appointment fee if you call 5 minutes before the start of your appointment. If you call within 5 minutes of the start of your appointment, or do not call at all, you will be charged \$50.00 to the card listed below.*

VISA      MASTERCARD      DISCOVER      AMEX

CARD # \_\_\_\_\_

EXPIRATION DATE \_\_\_\_\_

CCV# \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

I, \_\_\_\_\_ [Name of Individual] consent to Coxon Lifestyle Management Clinic, LLC (“the Practice’s”) use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority

## INFORMED CONSENT TO TREATMENT

State law requires us to obtain your informed consent before starting treatment.

I, \_\_\_\_\_, of \_\_\_\_\_ (City/State) do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. I have made my decision voluntarily and freely.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are other risks and possible complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis or other minor abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that this serious side effect is reported to occur once in one million to once in ten million treatments. Once in ten million is about the same chance as aspirin or Tylenol causing death. Once in a million are the same odds as getting hit by lightning.

Dizziness: Temporary symptoms like dizziness and nausea are also rare.

Physical Therapy Burns: Some of the machines used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication and I freely assume these risks. I also understand that there are possible benefits associated with this procedure including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of chiropractic/medicine is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

### ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, exercises and possible surgery and/or medications.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long term or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercises: It has been explained to me that simple bed rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of home therapy exercises.

Surgery: Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, more inflammation, and worsening of pathology. The aforementioned may complicate treatment making recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction **PRIOR TO MY SIGNING THIS CONSENT FORM.**

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of patient: \_\_\_\_\_

Date and time: \_\_\_\_\_

Signature of witness: \_\_\_\_\_