Scott Chiropractic
on Lake Loveland

Manual Therapy Client Intake

W E L C O M E

Legal Name: _____ **Today's Date:** ____/_____/_____

☐ **Male** ☐ **Female** **Date of Birth** _____/_____/_____ **Age**_____ **Height** _____ **Weight** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Other
Education: # of years completed: _____ ☐ Full time student ☐ Part time student ☐ non-student

Home Address: _____
Street Address/P.O. Box City State Zip Code
Home Phone Number: (_____) _____-_____ **Cell Phone Number:** (_____) _____-_____

Email address: _____ **How did you hear about us**? _____
Employment: ☐ Fulltime ☐ Part Time **Job Satisfaction:** ☐ Unsatisfied ☐ Satisfied ☐ Very Satisfied
Work Status: ☐ Working without restrictions ☐ Working with restriction's ☐ Not working/off since _____
Occupation: _____ **Work Phone:** (_____) _____- _____
Primary Care Physician: _____

Race: ☐ Caucasian ☐ American Indian ☐ Asian ☐ Black ☐ Pacific Islander ☐ Declined ☐ Other
Ethnicity: ☐ Hispanic ☐ non-Hispanic ☐ Declined
Language: ☐ English ☐ Other _____ **Emergency Contact:** _____

Relationship: _____ **Emergency Contact Phone:** (_____) _____- _____

General Consent: I understand that I am receiving therapeutic muscle treatments intended to increase my quality of life. I agree to all treatments within the treatment parameters of the certified massage therapist. I will not hold the therapist or J. S. Chiropractic* liable for any injuries, accidents, communication differences, conflicts, or physical ailments that may occur during or after treatments. I understand that the massage therapist does not diagnose, and I am responsible for seeking care with any other health professionals for any concerns regarding a condition/ailment or diagnosis. I agree to be responsible for all charges for services rendered. I also understand and have read the HIPPA agreement that I was given to review. By providing us with your landline, cell phone number(s), and email you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns.

Financial Awareness and Consent: I understand I am financially responsible, whether my insurance company pays, for all charges incurred by me. I hereby assign my massage therapy/manual therapy benefits to J.S. Chiropractic*. I understand that all plans are different, and I may have one or more of the following that I am responsible for: referral from PCP/deductible/co-pays/percentage owed for each date of service/or *no* massage therapy benefits. I understand that if I choose to bill any therapies to my insurance company all services will be itemized, and the charges will exceed our discounted out of pocket rate. I understand that any accounts that are 90 days overdue are subject to collections proceeding, regardless of case type. I also authorize Scott Chiropractic on Lake Loveland* (J.S. Chiropractic) to release any protected health information required to secure payment.

*Payment for services is required at the time of service. Any balances left unpaid are subject to a $15.00 billing fee and will incur an additional $15.00 billing fee each time a balance is re-billed.

Cancellation Policy: *I understand that I will be financially responsible for failure to cancel or reschedule my appointment within 24 hours of my scheduled appointment. The massage schedule is limited; therefore, we strictly enforce this policy. Payment will be required within 14 days of missed appointment. Please also be aware that any patients arriving late for their scheduled appointment may be required to shorten their treatment time, wait until the next available opening, or reschedule their appointment and thus be subject to the above stated cancellation policy*.

Release of Records: I authorize J.S. Chiropractic to release all health records necessary for my treatment and/or evaluation. I understand and accept financial responsibility for the medical records released on my behalf.

Patient's Signature: _____ Date: _____/_____/_____

Responsible Party's Signature: _____ Date: _____/_____/_____

* If patient is a minor *J.S. Chiropractic includes Dr. Julie Scott, D.C., and all therapists employed.

What is your reason for getting massage/manual therapy? _____

Have you ever had massage/manual therapy before? Yes / No

If yes, what type of pressure do you prefer? Circle one: Light (relaxing) / Medium / Deep Pressure

If yes, do you prefer talking during your massage? Yes / No

Were you referred by a friend or other health care professional? Yes / No

If yes, by whom? _____

List all or any medications that you are currently taking:

_____

List all or any allergies: _____

List all or any herbal or other supplements you are currently taking:

_____

_____

List any injuries in the past 5 years: _____

List any surgeries / broken bones in the past 5 years:

_____

_____

WOMEN: Are you currently pregnant? Yes / No If yes, how many weeks: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR BODY AND HEALTH:

GENERAL:
- o Sinus problems / allergies
- o Numbness / Tingling
- o Weakness
- o Arthritis
- o Seizures
- o Fainting
- o Dizziness
- o Memory Loss
- o Varicose Veins
- o Diabetes
- o Shortness of breath
- o Heart Problems
- o Blood Clots
- o Lupus
- o Multiple Sclerosis
- o Skin Conditions
- o Pain with Coughing / Sneezing
- o Nausea
- o Low Back Pain / Neck Pain
- o Cancer
- o Headaches
- o High / Low Blood Pressure

HIPS / LEGS / FEET:
- o Leg / Foot Cramps
- o Swollen Ankles
- o Tingling / Burning
- o Shooting Pains
- o Ticklish Feet

ARMS / HANDS:
- o Weakness
- o Clumsiness
- o Shooting Pains

NECK / SHOULDERS
- o Stiffness
- o Tightness
- o Burning
- o Decreased Range of Motion
- o Shooting Pains
- o Popping / Clicking
- o Ringing in Ears

LATENESS &

24 HOUR CANCELLATION POLICY

To be respectful of the needs of other patients, please be courteous and TEXT/CALL the office within **24 HOURS** if you are unable to attend your appointment. Time has been set aside for your appointment, and if canceled in a timely manner, this high demand appointment time will be reallocated to someone who needs quality, individualized, medical care.

- ✓ I understand I will be responsible for the following charges for failure to cancel or reschedule my appointment(s) within **24 hours** of its scheduled time or if I am more than 10 minutes late to my appointment and my appointment must be rescheduled. All normal prices listed below are the 'payment of time- of -service' discounted rates.

- ✓ _____ **(INITIAL HERE)**

  - **$50 -Chiropractic Treatment (normally $65)**
  - **$75 -60 Minute Soft Tissue Treatment (normally $90)**
  - **$100 -90 Minute Soft Tissue Treatment (normally $150)**
  - **$130 -2 Hour Soft Tissue Treatment (normally $180)**
  - **$65 -Dry Needling Treatment (normally $80)**
  - **$50 -Class IV Laser Treatment (normally $60)**

  ****PRICES SUBJECT TO CHANGE****

- ✓ I understand any missed appointments cannot be billed to my insurance company.
  _____ **(INITIAL HERE)**

- ✓ I understand payment will be required within 14 days of the missed appointment(s). After those 14 days, the balances left unpaid will be subject to a $15 billing fee and will incur an additional $15 billing fee each time a balance is rebilled.
  _____ **(INITIAL HERE)**

To cancel appointments, please call **or text 970-889-1897**. If you do not reach a staff member, you may leave a detailed message on our voicemail, or send a text. We will return your call or text as soon as possible.

Patient's Signature:_____Date: _____/_____/_____

Responsible Party's Signature: _____ Date:_____/____/_____

(If patient is a minor)