**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:** (_____) _____- _____
**Race:** ☐ Caucasian ☐ American Indian ☐ Asian ☐ Black ☐ Pacific Islander ☐ Declined ☐ Other
**Ethnicity:** ☐ Hispanic ☐ non-Hispanic ☐ Declined
**Language:** ☐ English ☐ Other _____ **Primary Care Physician**: _____

**EMERGENCY CONTACT INFORMATION:** Relationship: _____
Name: _____ Phone Number: (_____) _____-_____

**BILLING INFORMATION:** ☐ Out of Pocket (no insurance) ☐ Health Insurance ☐ Auto Insurance ☐ W/C

**General Consent Form:** The undersigned hereby consents to evaluation and treatment (s) rendered by the Doctors of Chiropractic in this office and their assistants according to the applicable standards of care. As with any health care procedure, there are certain risks and possible complications that may arise during treatment. These complications are very rare and may include but are not limited to: muscle strains, rib fractures, disc injuries. An extremely rare complication of an upper neck adjustment is a vertebrobasilar incident which could cause a stroke in progress to worsen. The most recent research suggests that this can occur in 1 in 1,000,000 times. None of these complications have occurred while Dr. Scott has been in practice. I will rely on the doctors' expertise to identify if I may be susceptible to this kind of injury. I understand that these risks have been disclosed and that as a patient I have a responsibility to disclose any and all health information to the doctor and to notify the providers of any changes to my health status or health history. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from any treatment. I understand that all requests for release of my records must be in writing. Protected health history will be released with written authorization, with minimal disclosure necessary as related to your care. Please see the Notice of Privacy Practices for more detailed information. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Financial Awareness and Consent:** Our staff makes every effort to verify your chiropractic benefits before your appointment. Your insurance policy is a contract between the insurance company and you. Although we verify your coverage, specific details regarding your benefits may change. I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance, and other health plans 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. I understand that any accounts that are 90 days overdue are subject to collection proceedings, regardless of case type. Please be aware that a $20.00 fee will be assessed for any check returned for non-sufficient funds.

*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 rebilled.

** If you have a deductible on your insurance plan, a minimum of $55.00 is due at the time of service for each visit. Remaining charges applied to your deductible will be billed to you after it is processed by your insurance company.

'*Payment at time of service' discount*: I understand that I may pay for my treatment in full at the time of service and will receive any and all treatments for a $65 flat rate (subject to change). This *does not* include exams, x-rays, dry needling, rehab, or manual therapy work. If I choose to bill any insurance company, all services will be itemized and will exceed $55. I also authorize J.S. Chiropractic to release any protected health information required to secure payment.

**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.

***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. Payment will be required within 14 days of missed appointment. (s).***

Please be aware that any patients arriving late for their scheduled appointment may be required to wait until the next available opening or reschedule their appointment and thus will be subject to the above stated cancellation policy.

Patient's Signature: _____ Date: _____/_____/_____
Responsible Party's Signature (if patient is a minor): _____ Date: _____/_____/_____

What is your **major** complaint? _____

**When** did your condition develop? _____

**How** did your condition develop? _____

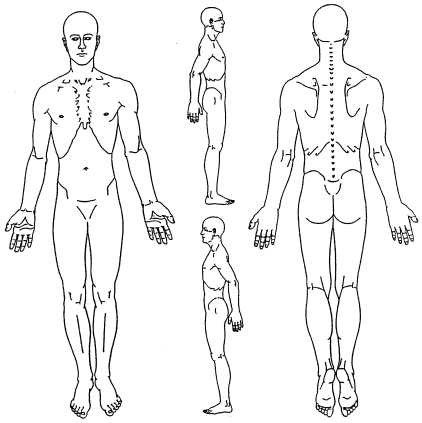
Has your condition been getting better, worse or staying the same? _____

What makes your condition better? _____ What makes it worse? _____

On a scale from **1-10** (10 being the worst pain you have ever felt), where is your pain level today? _____

**Please mark on the diagram to explain and locate the areas of complaint.**

| A = ACHE | B = BURNING | C = STABBING |
|---|---|---|
| N = NUMBING | P = PINS & NEEDLES | O = OTHER |



| Do you currently or in the past have? | | |
|---|---|---|
| **Please mark all that apply** | When? | # Episodes |
| ☐ Back pain or stiffness | | |
| ☐ Shoulder pain | | |
| ☐ Hip pain | | |
| ☐ Foot pain or trouble | | |
| ☐ Swollen or painful joints | | |
| ☐ **Numbness** or pain in the arms, hands, or fingers | | |
| ☐ **Numbness** or pain in the legs, feet, or toes | | |

**TESTS:** Please list the MOST recent date:
Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

| **HABITS:** | YES | NO | If yes, please describe: |
|---|---|---|---|
| Smoking | ☐ | ☐ | Packs per day: 0 – ½ ☐ ½ - 1 ☐ 2 or more ☐ Duration _____ |
| Alcohol Consumption | ☐ | ☐ | # Drinks per day _____ Drinks per week _____ |
| Coffee or Tea Consumption | ☐ | ☐ | Cups per day _____ |
| Other Drug Use (Street Drugs) | ☐ | ☐ | _____ |
| Exercise | ☐ | ☐ | Daily ☐ Weekly ☐ Monthly ☐ Type _____ |

**MEDICINES:** Please list all currently used medicines. Include prescription & non-prescription drugs, vitamins, & herbs. _____

_____

**ALLERGIES:** Please list all known allergies, especially to medicines. _____

_____

**TREATMENT YOU ARE RECEIVING OR HAVE RECEIVED:**
☐ Chiropractic Care If yes, when, and with whom? _____

☐ Other (Physical Therapy, Acupuncture, Massage etc. Please Specify) _____

**FEMALES ONLY**:
Do you have: ☐ Menstrual problems ☐ Breast lumps or pain ☐ Tubal Infections ☐ Problems getting pregnant
Are you currently or possibly pregnant? _____

**MALES ONLY**:
Do you have: ☐ Changes in urine stream ☐ Prostate trouble ☐ Lump in testicles

HOSPITALIZATIONS, SURGERIES AUTO ACCIDENT or WORK INJURIES EVALUATIONS & TREATMENT/ YEAR
(Please be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you currently or have you had: Please mark all that apply.

| | Current | Past |
|---|---|---|
| **Sleep Problems** | ☐ | ☐ |
| Disabled | ☐ | ☐ |
| Nervous tension | ☐ | ☐ |
| Irritability | ☐ | ☐ |
| **Mood Swings / changes** | ☐ | ☐ |

Do you currently or have you had: Please mark all that apply.

| | Current | Past |
|---|---|---|
| More frequent urination | ☐ | ☐ |
| Pain or blood with urination | ☐ | ☐ |
| Kidney or bladder infection | ☐ | ☐ |
| Kidney stones | ☐ | ☐ |
| Recurrent abdominal pain | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Heartburn | ☐ | ☐ |
| Swallowing problems | ☐ | ☐ |
| Hernia | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ |

Do you currently or have you had: Please mark all that apply.

| | Current | Past |
|---|---|---|
| Arthritis or gout | ☐ | ☐ |
| Bursitis | ☐ | ☐ |
| Fractured bones | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Tremor | ☐ | ☐ |
| Passing out | ☐ | ☐ |
| Speech problems | ☐ | ☐ |
| Trouble concentrating | ☐ | ☐ |
| Diarrhea or constipation | ☐ | ☐ |
| Varicose veins | ☐ | ☐ |

## FAMILY HISTORY:

Please note any family history of any of the below Conditions and include relationship of relative to you.

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Headaches _____
- ☐ High Blood Pressure _____
- ☐ Arthritis _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Spine or Back Disorder _____
- ☐ Multiple Sclerosis _____
- ☐ Psychological Problems _____

Do you currently or have you had: Please mark all that apply:

| | Current | Past |
|---|---|---|
| **History of trauma** | ☐ | ☐ |
| Infection | ☐ | ☐ |
| **Unexplained weight loss** | ☐ | ☐ |
| Unusual fatigue | ☐ | ☐ |
| Dizziness / Poor balance | ☐ | ☐ |
| Vomited blood | ☐ | ☐ |
| Bloody or black stools | ☐ | ☐ |
| Change in appetite | ☐ | ☐ |
| Fevers | ☐ | ☐ |
| Night Sweats | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| Chest Pain | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Chronic cough | ☐ | ☐ |
| **Stroke** | ☐ | ☐ |
| Heart disease or murmur | ☐ | ☐ |
| Loss of bowel or bladder control | ☐ | ☐ |
| **Headaches** | ☐ | ☐ |
| **Muscle weakness or paralysis** | ☐ | ☐ |
| Memory loss | ☐ | ☐ |
| Severe trauma | ☐ | ☐ |
| Direct head trauma | ☐ | ☐ |
| Lost consciousness | ☐ | ☐ |
| Poor coordination | ☐ | ☐ |
| **Night pain** | ☐ | ☐ |
| Difficulty Swallowing | ☐ | ☐ |
| **Recent infection** | ☐ | ☐ |
| **History of osteoporosis** | ☐ | ☐ |
| **History of cancer** | ☐ | ☐ |
| Difficulty breathing | ☐ | ☐ |
| Abdominal pain | ☐ | ☐ |
| Use of corticosteroids | ☐ | ☐ |
| Use of anticoagulants | ☐ | ☐ |
| Use of birth control pills | ☐ | ☐ |
| **Numbness in groin** (saddle anesthesia) | ☐ | ☐ |
| Loss of anal sphincter tone, fecal incontinence (bowel accidents) | ☐ | ☐ |
| Pain fails to improve with rest | ☐ | ☐ |
| **Pain greater than 4 weeks** | ☐ | ☐ |
| Prolonged use of corticosteroids | ☐ | ☐ |
| Intravenous drug use | ☐ | ☐ |

Do you currently or have you had: Please mark all that apply.

| | Current | Past |
|---|---|---|
| Asthma | ☐ | ☐ |
| Eczema | ☐ | ☐ |
| Hay Fever | ☐ | ☐ |
| Sinus Problems | ☐ | ☐ |
| **Diabetes** | ☐ | ☐ |
| High cholesterol or triglycerides | ☐ | ☐ |
| Thyroid trouble | ☐ | ☐ |
| Liver trouble | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Bleeding or bruising tendency | ☐ | ☐ |

**Any other serious illnesses not mentioned here:** _____

**SCOTT CHIROPRACTIC ON LAKE LOVELAND**
**JS CHIROPRACTIC**
**750 W EISENHOWER BLVD, STE 301**
**LOVELAND, CO 80537**
**CONSENT FORM AND RELEASE OF INFORMATION**

It is my understanding that if I become a patient in this office, I agree to the following:

**CONSENT TO TREATMENT:**

I authorize JS Chiropractic* to perform chiropractic adjustments, treatments and procedures upon me. I also consent to x-ray examination, and other diagnostic procedures if found medically necessary to complete the evaluation of my case.

**(INSURANCE) RESPONSIBLE PARTY INFORMATION**

Policy Holder Name:_____Date of Birth_____
Policy Holder Address:_____

**RELEASE OF INFORMATION:**

JS Chiropractic* may disclose information from my records to doctors or others for continuous care, and to any third party who requires that information in order to receive reimbursement for any charges incurred by me as a result of professional services rendered, per HIPAA guidelines. 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. Providing your phone number(s) is not a condition of receiving our services.
I/We have read this disclosure and agree that we may be contacted as described above.

**JS CHIROPRACTIC:**

A) is required by federal law to maintain the privacy of PHI and to provide you with this privacy notice detailing JS Chiropractic*'s legal duties and privacy practices with respect to your PHI.

B) May be required by state law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

C) Is required to abide by the terms of this privacy notice.

D) Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for your entire PHI that it maintains.

E) Will distribute any revised privacy notice to you prior to implementation. We will not retaliate against you for filing a complaint.

**PATIENT ACKNOWLEDGEMENT**

By subscribing my name below, I acknowledge receipt of a copy of this notice, my understanding and my agreement to its terms.
I understand that J.S. Chiropractic (DBA-Scott Chiropractic on Lake Loveland) offers different discounted chiropractic and massage packages when payment is made in full at time of purchase/service.
Senior/Student: Office visit for $55.00 per visit (subject to change) Chiropractic: Office visit $65.00 (subject to change)
The above services do not include any in-office exams/re-exams or referrals for diagnostic testing. I understand that at any time I may be released from package agreements and written notice must be given to the office and doctor. All reimbursement will be prorated to our normal charges listed below.

Below are the normal and customary Colorado charges which are itemized for each therapy and/or procedure.
Exam Codes-99201: $45, 99202: $65, 99203: $91.14, 99212: $45, 99213: $65
Manipulation Codes- 98940: $55.00, 98941: $65.00, 98942: $89.60, 98943: $44.63
Massage- $32 (per unit), Manual Therapy-97140: $49 (per unit), Neuro-Re-ed-97112: $40, Therapeutic exercises- 97110: $32 (per unit), Estim, ultrasound-97032, 97035: $35

_____
**Patient Name**

_____
**Today's Date**

**JS Chiropractic includes all providers and clinic, Scott Chiropractic on Lake Loveland*

# Rehabilitation Consent Form

Rehabilitation is a treatment designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible. Our goal is to improve joint mobility, increase muscle elasticity and specifically strengthen any muscles associated with your condition.

The purpose of rehabilitation is to restore some or all of the patient's physical, sensory, and mental capabilities that were lost due to injury, illness, or disease. Rehabilitation includes assisting the patient to compensate for deficits that cannot be reversed medically. It is prescribed for many types of injury, illness, or disease.

All of the rehabilitation exercises/stretches have been specifically chosen by Dr. Scott to meet the individual needs of each patient's condition. These may be performed with Dr. Scott or by a personal trainer that has been trained in specific rehabilitation procedures. Each patient's specific diagnosis, indications for rehabilitation and possible contra indications, have been discussed between the doctor and a personal trainer.
It is important to follow the exercise instructions carefully. It is also important to perform only those exercises prescribed and reviewed in the office for home rehabilitation. If any of the home exercises or stretches cause pain, you should refrain from doing them and discuss them with the personal trainer or doctor at your next appointment.

**Financial Awareness and Consent:** I understand that I may pay for my treatment in full at the time of service, "payment at time-of-service discount" and will receive rehabilitation treatments for a $85 flat rate (subject to change). If I choose to bill any insurance company, all services will be itemized and will exceed $40. I also authorize J.S. Chiropractic to release any personal health information required to secure payment.

**Cancellation Policy:** I understand that I will be responsible for an office rehabilitation visit of $80 (subject to change) for failure to cancel or reschedule my appointment within 24 hours of my scheduled appointment. Payment will be required within 14 days of the missed appointment. Please be aware that patients arriving late for their scheduled appointment may be required to wait until the next available opening or reschedule their appointment and thus will be subject to the above stated cancellation policy.

Patient's Signature_____ Date: _____

Responsible Party's Signature_____ Date: _____
*If patient is a minor

*J.S. Chiropractic includes Dr. Julie Scott, D.C.

# 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 has to be rescheduled.
  **_____(INITIAL HERE)**
  - **$65 - Chiropractic Treatment (payment at time-of-service discount).**
  - **$90 - 60-minute Soft Tissue Treatment (payment at time-of-service discount).**
  - **$150- 90-minute Soft Tissue Treatment (payment at time-of-service discount).**
  - **$180- 2 Hour Soft Tissue Treatment (payment at time-of-service discount).**
  - **$80 - Dry Needling Treatment (payment at time-of-service discount).**
  - **$80 - 60-minute Rehabilitation Visit (payment at time-of-service discount).**
  - **ALL 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)