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 and Dr. Julie Scott is not a preferred provider for all companies. 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 $41-$50 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 may exceed $65. 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? _____

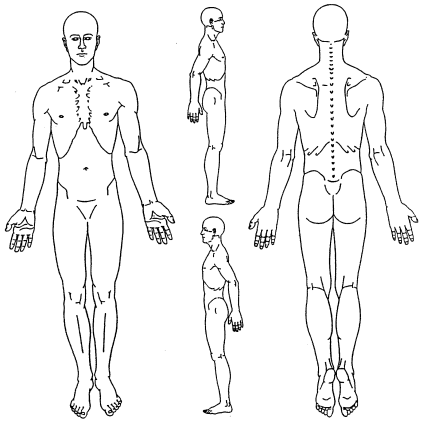
Has your condition been getting better, worse or staying the same? _____

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. **All subject to change**.
Exam Codes- 99202: $65, 99203: $91.14, 99212: $45, 99213: $65
Manipulation Codes- 98940: $55.00, 98941: $65.00, 98942: $89.60, 98943: $44.63
Massage- 97124: $32 (per unit), Manual Therapy-97140: $41 (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*

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)

Intramuscular Manual Therapy (Trigger Point Dry Needling- TDN) Consent

IMT/TDN involves placing a small needle into the muscle at the trigger point which is typically in an area where the muscle is tight and may be tender. It is the intent to cause the muscle to contract/twitch and release. This improves flexibility of the muscle and therefore decreases the symptoms. The performing doctor will not stimulate any auricular points during the dry needling treatment and is not performing acupuncture. The doctor may use an electrical stimulation unit during your treatment.
IMT/TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications, while these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

Risk of Procedure:
Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days or weeks. A more severe lumbar puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel related symptoms immediately contact your IMT/TDN provider. If pneumothorax is suspected you should seek medical attention from your physician or if necessary, go to the emergency room.

Other risks may include bruising, achiness, infection, nerve injury and a feeling of faintness or dizziness. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. The doctor does use sterile needles, gloves, and maintains a clean and safe environment. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT/TDN is unlikely. Please consult your IMT/TDN practitioner if you have any questions regarding the treatment above.

I understand that the doctor applying this technique is level 1 certified and will only perform TDN to points associated in level 1 training. **(_____)**

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I wish to rely on the expertise of the doctor to exercise judgement during treatment. **(_____)**

I understand results are not guaranteed. **(_____)**

I understand that if I am pregnant, suspect that I am pregnant or become pregnant during treatment, I am responsible to inform the doctor. **(_____)**

I confirm that I am **not** currently taking any prescription blood thinners or daily aspirin. **(_____)**

Do you have any known diseases or infections that can be transmitted through bodily fluids? YES NO

If you marked YES, please discuss with your doctor.

CANCELLATION POLICY: I understand that the doctor has a specific blocked out time for my appointment. I understand that I will be financially responsible for a fee of $80.00 (**subject to change**) for failure to cancel or reschedule my appointment within 24 hours of my scheduled appointment time. **(_____)**

By voluntarily signing below, I show that I have read this consent form and have been told about the risks and benefits of IMT/TDN. I have had an opportunity to ask questions. I will not hold Dr. Julie Scott D.C. or J.S. Chiropractic (Scott Chiropractic on Lake Loveland) liable for any injuries, accidents, conflicts, or physical ailments that may occur after treatment.

_____
Print Name

_____ _____
Signature **Date**