

**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 vertebralbasilar 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 \$55 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? _____

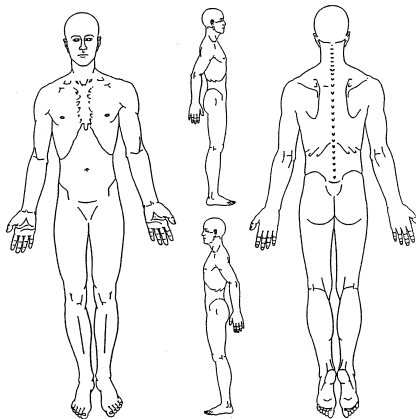
Has your condition been getting better, worse or staying the same? _____

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
<input type="checkbox"/> Back pain or stiffness		
<input type="checkbox"/> Shoulder pain		
<input type="checkbox"/> Hip pain		
<input type="checkbox"/> Foot pain or trouble		
<input type="checkbox"/> Swollen or painful joints		
<input type="checkbox"/> Numbness or pain in the arms, hands, or fingers		
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: 0 - 1/2 <input type="checkbox"/> 1/2 - 1 <input type="checkbox"/> 2 or more <input type="checkbox"/> Duration _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Nervous tension	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings / changes	<input type="checkbox"/>	<input type="checkbox"/>

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

	Current	Past
More frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Pain or blood with urination	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

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

	Current	Past
Arthritis or gout	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Fractured bones	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>
Passing out	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>

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

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

	Current	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>

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 \$45.00 per visit (subject to change) Chiropractic: Office visit \$55.00 (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. Any and 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, 99211: \$25, 99212: \$45, 99213:\$65

Manipulation Codes- 98940: \$69.60, 98941: \$79.60, 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*

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 decrease 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 risk may occur. I wish to rely on the expertise of the doctor to exercise judgement during the course of treatment. (_____)

I understand results are not guaranteed. (_____)

I understand that if I am pregnant, suspect that I am pregnant or become pregnant during the course of 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 infection 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 \$60.00 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

24 HOUR CANCELLATION POLICY

Our goal is to provide quality, individualized, medical care in a timely manner. “No-Shows” and cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of treatment.

In order to be respectful of the needs of other patients, please be courteous and 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 time will be reallocated to someone who is in need of treatment. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely treatment.

Patients will be responsible for the following charges for failure to cancel or reschedule appointment(s) within **24 Hours** of scheduled appointment.

Any missed appointments cannot be billed to your insurance company.

- **\$55** for a Chiropractic Appointment (payment at time of service discount).
- **\$75** for a 60-minute Soft Tissue Treatment (payment at time of service discount).
- **\$45** for a 30-minute Soft Tissue Treatment (payment at time of service discount).
- **\$55** for a Trigger Point Dry Needling Appointment (payment at time of service discount).
- **\$60** for a 60-minute Rehabilitation Appointment (payment at time of service discount).

Payment will be required within 14 days of 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.

To cancel appointments, please call **970-203-9997**. If you do not reach the receptionist, you may leave a detailed message on our voicemail. We will return your call as soon as possible.

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

Responsible Party's Signature (If patient is a minor): _____ Date: ____ / ____ / ____