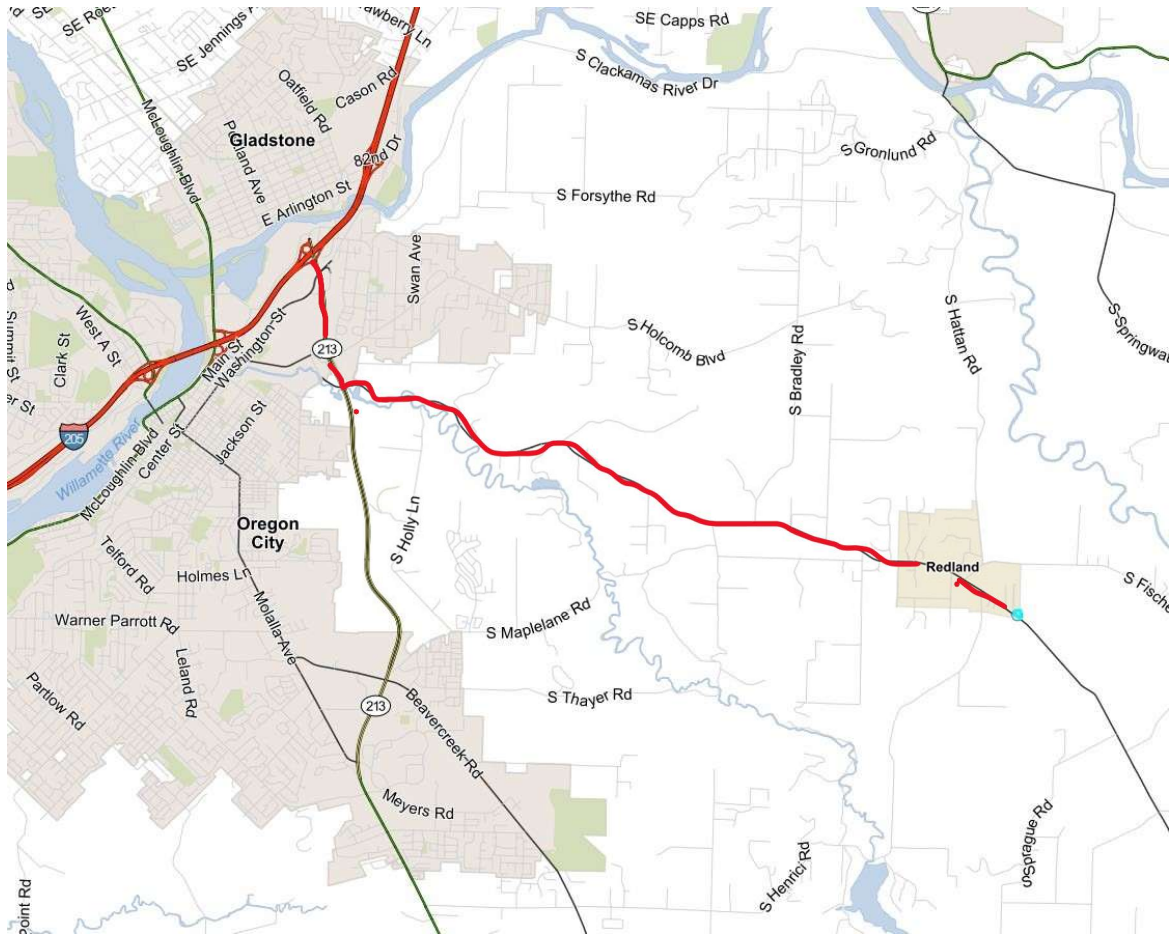


Therese M. Scott, D.O.
18475 S. Redland Rd.
Oregon City, OR 97045
503-558-8918



From 205 take exit 10 to Oregon City/Molalla. At the second light turn right onto Redland Rd. and continue for approximately 6 miles. You will pass a fire station and Catholic church. The driveway is just past Scott Lane on the left side. Look for a yellow house and a yard spinner at the driveway entrance. The office door is on the left side of the house.

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From Gresham, Sandy, Troutdale, etc. you will take Hwy 212 west left to Hwy 224. Follow the signs to Carver. At the second light you will turn right and go over the bridge, continue left to Hatton Rd. which is on your right. Stay on Hatton Rd. until it T's at Fischer Mill Rd. Turn right. At the stop sign turn left on Redland Rd. The driveway is .5 miles from this point. You will pass a fire station and Catholic church. The driveway is just past Scott Lane on the left side. Look for a yellow house and a yard spinner at the driveway entrance. The office door is on the left side of the house.

TERESE M. SCOTT, D.O.

Please Print

Name: _____
Last First Initial

Date: _____

Preferred Name: _____

Preferred Pronouns: _____

Address: _____

Birth date: _____ Age: _____

Home # (____) _____

Emergency Contact: _____

Work # (____) _____

Phone: _____

Cell # (____) _____

(Check "preferred contact #")

Employer name: _____

Occupation: _____

Referred by: _____
(Dr., friend, yellow pages, Ins co., etc.)

★ ★ ★ ★ ★ IF THIS IS FOR A MOTOR VEHICLE ACCIDENT ★ ★ ★ ★ ★

If Not: Please turn over for private health insurance information.

Your MVA Ins. Co.: _____

Telephone# _____

Address: _____

Claim# _____

Policy # _____

Policy is in who's name? _____

Relationship to patient: _____

Policyholder's birth date: _____

Date of Accident: _____

Have you seen anyone for these injuries? [] Yes [] No If "Yes" please state where and

when: _____

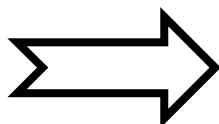
★ ★ ★ ★ ★ OTHER PARTY'S MVA INSURANCE ★ ★ ★ ★ ★

Ins. Co.: _____

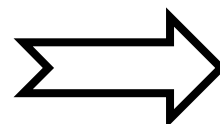
Telephone #: _____

Address: _____

Claim number #: _____



PLEASE TURN OVER



★ ★ ★ ★ ★ IF WORKING WITH AN ATTORNEY ★ ★ ★ ★ ★

Name of Attorney: _____

Address: _____

Telephone: _____

★ ★ ★ ★ ★ PRIMARY HEALTH INSURANCE ★ ★ ★ ★ ★

Insurance Co: _____ Phone # _____

Group# _____ I.D. or Policy #: _____

Policy in whose name? _____ Relationship to pt: _____

Policyholder's birth date: _____

.....

Primary Doctor's name: _____ Phone # _____

Address: _____

In consideration of medical services rendered by Therese M. Scott, D.O., I guaranty payment of all charges incurred. I understand that I may not receive total reimbursement from my insurance company. I authorize payment from insurance company to Therese M. Scott, D.O. I authorize the companies listed herein, or their representative, and any and all information or copies with respect to any illness, prescription, or treatment. This information may be used only for the verification of claims for medical treatment and may not be re-released to anyone other than specified. If I carry group insurance through my employer, I understand my employer may be informed of my diagnosis. This authorization may be revoked by the undersigned, following written notice received by the provider, to take place at the time received by provider.

Print Name _____ Date: _____

Signature _____

(If minor under age 15, signature of legal guardian)

FINANCIAL POLICIES

PLEASE READ CAREFULLY

Patient Responsibility:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Therese M. Scott, D.O. and staff will prepare any necessary reports and forms to assist in making collections from the insurance company, and that any amount authorized to be paid directly to Therese M. Scott, D.O., will be credited to my account on receipt. By signing below, I authorize my insurance company to pay and hereby assign directly to Therese M. Scott, D.O. all owed benefits. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment for such services.

It is further understood and agreed that any and all costs incurred by Therese M. Scott, D.O., in collecting on a past due account, including collection costs and attorney fees, both at trial and on appeal, shall be payable by myself (the patient, or patient's guardian, or parent). Interest will be charged on balances over 60 days, 18% per annum.

Insurance Information:

Medicare: Therese M. Scott, D.O., does not bill Medicare for any services performed. Dr. Scott has opted out of Medicare and cannot except any form of Medicare, including Advantage plans. If, while under Dr. Scott's care, I become eligible for Medicare, I will immediately inform the front desk regarding this.

Workers Compensation: In order to file a Workers' Compensation claim, the name of your insurance carrier, the date of injury, and claim number, if available, is needed. I will notify the front desk if the visit is due to an injury covered by Workers' Compensation.

Private Insurance: For the convenience of our patients, we will bill private insurance with assignment of payment to Therese M. Scott, D.O. If you have a co-payment plan, your co-payment is due at the time of service. Other balances on the account will be billed to you when we receive payment from the insurance company. We do not bill secondary insurance companies.

Motor Vehicle Insurance: In order to bill for a motor vehicle accident, the name of your insurance company, date of accident, and claim number is needed. The office will bill your vehicle insurance directly. If your insurance company does not pay for the services rendered it is your responsibility to pay for the services and receive reimbursement from your motor vehicle insurance.

Same Day Payments: A reduction in fees is available to patients paying at the time of the visit with cash or check. If other arrangements are made for payment or a card is used, cash reduction does not apply. The office does accept Cash, Check, and Credit/Debit cards.

Cancellation Policy: The office of Therese M. Scott, D.O. requires 48 hours notice if you must cancel your appointment. Otherwise, you will be charged a fee of \$100.00 for an established patient and \$150.00 for a new patient for a non-cancelled visit, which must be paid in advance of a future appointment. Insurance companies do NOT reimburse such charges. Please note that I have allotted a 45 to 60 minute slot that is dedicated entirely to you, and I appreciate your consideration of my schedule.

I have read and understand the above information.

Name (printed)

Driver's License Number and State

Patient signature (or guardian if patient is a minor under age 15, and relationship)

Date

**Therese M. Scott D.O.
18475 S. Redland Rd.
Oregon City, OR
503-558-8918
Fax 971-600-9151**

Cancellation Policy

Our office sees patients by appointment only. If you are unable to keep your appointment, please notify us as early as possible so that we are able to offer the time to another patient. Your account may be charged a cancellation fee if you cancel your appointment less than 48 hours prior, or fail to show up for your appointment. You will be charged a fee of \$100.00 for established patients and \$150.00 for new patients for a non-cancelled visit, which must be paid in advance of a future appointment. We do make exceptions for emergency's or in climate weather. Insurance companies do NOT reimburse such charges. Please note that I have allotted a 45 to 60 minute slot that is dedicated entirely to you, and I appreciate your consideration of my schedule.

Fragrance Free Office

A no Fragrance Policy is implemented in our office. Many of the patients, as well as Dr. Scott, are sensitive to certain scents such as perfumes, lotions, body sprays, oils, hair products, and cigarette smoke. We ask that you and anyone who comes with you be thoughtful of the people around you and refrain from wearing any fragrant products to our office.

By signing below you agree to these policies.

Patient Name (Print)

Date

Patient Signature

Therese M. Scott, D.O.

Patient Medical History Form

Name: _____ Date: _____

Current Problems/Complaints: (Please list your symptoms/problems)

Have you had x-rays, CT scans, MRI scans? _____ If yes, dates/place taken and results if known:

What makes your condition better and what makes it worse?

What are you not able to do that you could do before your injury/condition?

List allergies to medications and reaction (Ex. Morphine = rash):

List current medications, including dose and strength:

List current herbal preparations, vitamins, and homeopathics:

Previous surgeries, dates and procedures done (Ex. 2002 = left hip replacement):

Do you wear: ☐ Glasses ☐ Contact Lenses ☐ reading only (check)

Have you had eye surgery? If yes, Date: _____,

Side: ☐ Left ☐ Right Type: ☐ Lasik ☐ Radial Keratotomy ☐ Cataracts

Describe any other hospitalization:

Medical Problems, (example: high blood pressure, diabetes, etc.)

Date of diagnosis:

Problem:

Are you: ☐ married ☐ single ☐ in a relationship (check)

Do you, or have you ever smoked, chewed tobacco, or used electronic cigarettes? (describe amount)

Do you use alcohol, and if so how often and how much?

Describe your occupation:

Describe your children's names, age, and health:

Age of female parent (or at time of death) and any health problems:

Age of male parent (or at time of death) and any health problems:

Any medical illness that runs in your family (cancer, diabetes, etc.)?

Current weight: _____ Any gain or loss in the last year? ☐ Yes ☐ No

Dental problems: ☐ Yes ☐ No If yes, explain _____

Orthodontia issues: If yes, explain _____

Herbst Appliance ☐ Palatal Expander ☐ Age: From _____ To _____

Female patients: Date of last menstrual period _____

Number of Pregnancies: _____ *Any problems with delivery?* ☐ Yes ☐ No

Were **you** born from a C-section or vaginal birth? _____

What was your assigned sex at birth? _____

Describe any previous car accidents and injuries: (include dates)

Have you ever had: ☐ “the wind knocked out of you” ☐ blackout or concussion If so, please describe:

THERESE M. SCOTT, D.O.

18475 S. Redland Rd.
Oregon City, OR 97045
Office # 503-558-8918
Fax # 971-600-9151

CONSENT FOR OSTEOPATHIC TREATMENT

I understand that, in consenting to undergo Osteopathic Manipulative Treatment, I recognize that any of the following could occur usually up to 72 hours post treatment:

1. I could feel sore, experience more pain, headaches, or unusual fatigue for a few days following a treatment.
2. It is possible for complaints to worsen before getting better, with the possibility that discomfort could develop in new areas. Specifically, headaches may worsen before they get better.
3. My body may change through these treatments, seeking its own new balance point.

The intent of Osteopathic Treatment is to improve the functioning of the musculoskeletal system, and this often leads to an improved sense of well-being, but no guarantees are given about resolution of specific complaints.

Name: _____ Date: _____
(Printed)

Signature: _____
(Guardian if patient is a minor under 15 years, and relationship)

Authorization to Release Medical Information

Patient Name: _____

Address: _____

Date of Birth: _____

Phone: _____

I, or my authorized representative, request that the health information regarding my care and treatment be released to the below named Provider. In accordance with the privacy rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release ☐ YES ☐ NO Initials _____

2. My medical or billing record may contain information in reference to HIV/AIDS testing and/or treatment, I agree to its release. ☐ YES ☐ NO Initials _____

3. I have the right to revoke this authorization by submitting a notice in writing to the office of Therese M. Scott D.O. Unless revoked, This authorization will expire in 180 days or on the following date: _____.

4. Information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal or state law. The facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I hereby request:

_____ Phone or Fax _____

_____ Phone or Fax _____

_____ Phone or Fax _____

Information to be Released:

☐ Report and Films Date _____

☐ Medical Record Date from _____ to _____

☐ Emergency Report Date _____

☐ Other _____

Signature: _____ Date: _____

Please send this information to:

Therese M. Scott D.O.
18475 S. Redland Rd.
Oregon City, OR 97045
Office (503) 558-8918
Fax (971) 600-9151
admin@drscottosteo.com