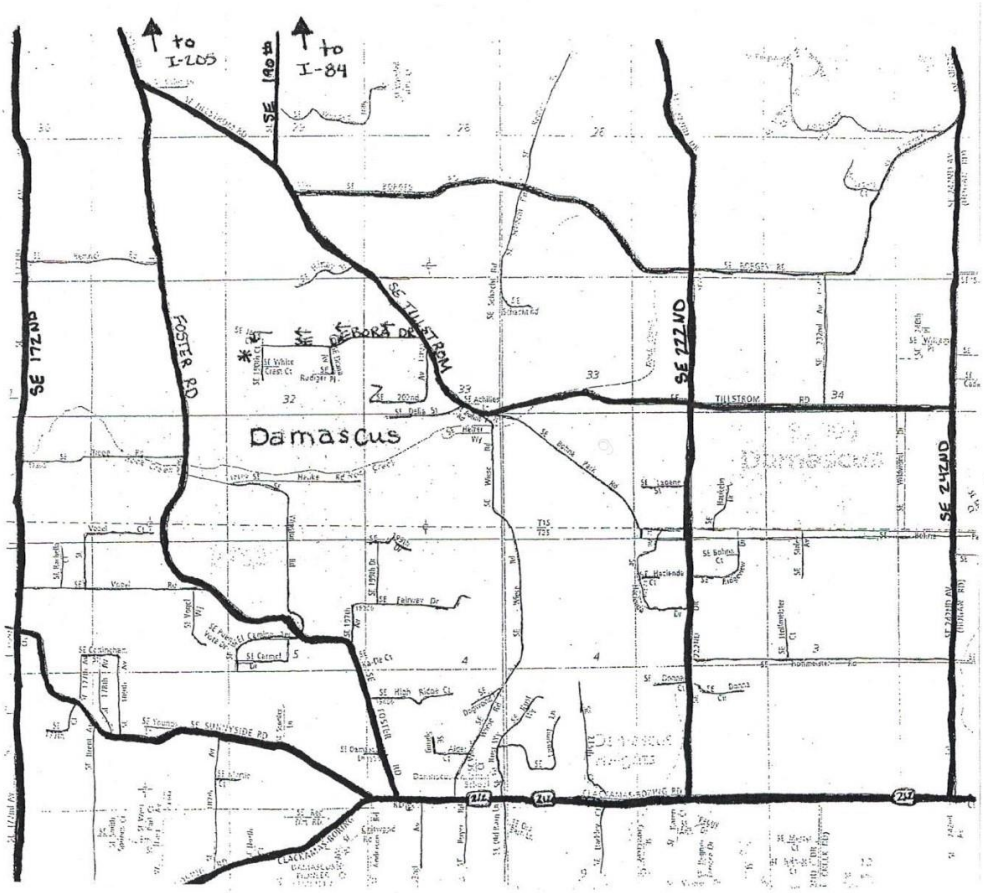
Therese M. Scott, D.O.
11131 S.E. 190th Court
Damascus, OR 97089
503-558-8918



From I-84: Take 181st exit south. At Stark it turns into 182nd, continue south on 182nd, (changes to 190th) to Tillstrom Road, which is 2.9 miles from 182nd and Powell. Turn left on Tillstrom and go .8 miles to Debora Drive. Turn right. Follow up the hill until it makes a 90 degree turn to the left onto 190th Court. Immediately on the right is a brick mailbox and sign stating "Scott and Heberlein". Take the paved driveway. The office is on the right as you look at the house.

From 205: Take Foster Road exit east. 4.7 miles from the exit on the left is Pleasant Valley School. Travel .5 miles, then turn left on Tillstrom and go 1.4 miles to Debora Drive. Turn right. Follow up the hill until it takes a 90 degree turn to the left onto 190th Court. Immediately on the right is a brick mailbox and sign stating "Scott and Heberlein". Take the paved driveway. The office is on the right as you look at the house.

From Hwy 26 (Sandy): Take Hwy 212 West to S. E. 222nd Drive. Go 1.5 miles to Tillstrom Road, turn left, travel 1.2 miles and turn left on Debora Drive. Follow up the hill until it makes a 90 degree turn onto 190th Court. Immediately on the right is a brick mailbox and sign stating "Scott and Heberlein". Take the paved driveway. The office is on the right as you look at the house.

From Gresham: Take Hogan (242nd) approx 3 miles to Tillstrom. Turn right, and at the next stop sign (222nd), travel through this intersection and go approx 1.5 miles, turn left on Debora Drive. Follow up the hill until it makes a 90 degree turn onto 190th Court. Immediately on the right is a brick mailbox and sign stating "Scott and Heberlein". Take the paved driveway. The office is on the right as you look at the house.

THERESE M. SCOTT, D.O.

⊛ ⊛ ⊛ ⊛ ⊛ PATIENT REGISTRATION ⊛ ⊛ ⊛ ⊛ ⊛

Please Print

Name: _____ Date: _____
Last First Initial

Address: _____ Birth date: _____ Age: _____

_____ Home #_(___)_____ ❒

Zip: _____ Work #_(___)_____ ❒

Cell #___(___)_____ ❒
(Check ❒ "preferred contact #")

Employer name: _____

Address: _____ 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: _____

Policy holder's Soc Sec #: _____ Policy holder's birth date: _____

Date of Accident: _____

Have you seen anyone for these injuries? ___ ___ If "Yes" please state where and

when: _____

⊛ ⊛ ⊛ ⊛ ⊛ OTHER PARTY'S MVA INSURANCE ⊛ ⊛ ⊛ ⊛ ⊛

Ins. Co.: _____ Telephone #: _____

Address: _____ Claim number #: _____

_____ Policy #: _____

➡ ➡ ➡ Please turn over ➡ ➡ ➡

⊛ ⊛ ⊛ ⊛ ⊛ IF WORKING WITH AN ATTORNEY ⊛ ⊛ ⊛ ⊛ ⊛

Name of attorney:_____

Address:_____

Telephone:_____

⊛ ⊛ ⊛ ⊛ ⊛ PRIMARY HEALTH INSURANCE ⊛ ⊛ ⊛ ⊛ ⊛

Insurance co: _____ Phone # _____

Address: _____ Group #_____

_____ I.D. or Policy #:_____

Policy in who's name? _____ Relationship to pt: _____

Policy holder's Soc Sec #: _____ Policy holder's birth date: _____

Primary Doctor's name: _____ Phone #_____

Address: _____ Relationship to pt: _____

_____ Phone #: _____

Person responsible for account: _____ Employer's 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.

Signature_____(print name)

Signature_____(Pt. S ignature)

Date:_____

Thersese M. Scott, D.O.
11131 S.E. 190th Court
Damascus, OR 97089
503-558-8918 Office
503-558-9712 Fax

Patient Medical History

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:

List current medications, including dose and strength:

List current herbal preparations, vitamins, and homeopathics:

Previous surgeries, dates and procedures done:

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

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

Side: ☐ Left ☐ Right ☐ Lasik ☐ Radial Keratotomy

Describe any other hospitalization:

********** PLEASE TURN OVER **********

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

Date of diagnosis:	Problem:
_____	_____
_____	_____
_____	_____

Are you: ☐ married ☐ single ☐ with significant other (check)

Do you, or have you ever smoked, or chewed tobacco? (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 mother (or at time of death) and any health problems:

Age of father (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? ___

Dental problems? If yes, explain_____

Female patients: Date of last menstrual period _____

*Number of Pregnancies:*_____ *Any problems with delivery?*

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

Describe 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.
11131 S. E. 190th Court
Damascus, Oregon 97089
Office # 503-558-8918
Fax # 503-558-9712

NEW MVA INJURY REPORT

Name _____ Date: _____

Date and time of the accident: _____

Describe what happened in the accident:

_____
_____
_____
_____

You were the: ☐ driver ☐ passenger

If you were not the owner of the vehicle, who is the owner, and what is the relationship to you?_____

Type of vehicle you were in?

| | Type_____ | | Make_____ | | Year_____

Your vehicle was an ☐ automatic ☐ clutch?

Were you wearing a seat belt and shoulder harness? [

How fast were you moving?

The other vehicle(s:

| | Type_____ | | Make_____ | | Year_____

How fast was the other vehicle(s) moving?_____

Was a police report made?

Were the police at the scene?

Was anyone cited for the accident?

If so, who was it issued to?_____

Who was at fault?_____

Was the accident reported to your insurance company?

Was the accident reported to the other insurance company?

What were the road conditions?_____

What was the position of your body at the time of impact?

Hands?_____

Left foot?_____

Right foot?_____

Eyes?_____

Head?_____

Do you remember striking any part of your body on any part of the vehicle?

What part of your body?

Did you hit your head on the headrest or anything else?

Did you loose consciousness?

Were you able to think clearly after the accident?

Were you able to walk away from the vehicle?

If not, were you taken by ambulance to a hospital?

If so, which hospital?_____

What tests were done at the hospital?_____

Were you given any prescriptions? (list names and strengths)

Have you been able to go to work since the accident?

If so, have you been able to complete all your regular duties at work?

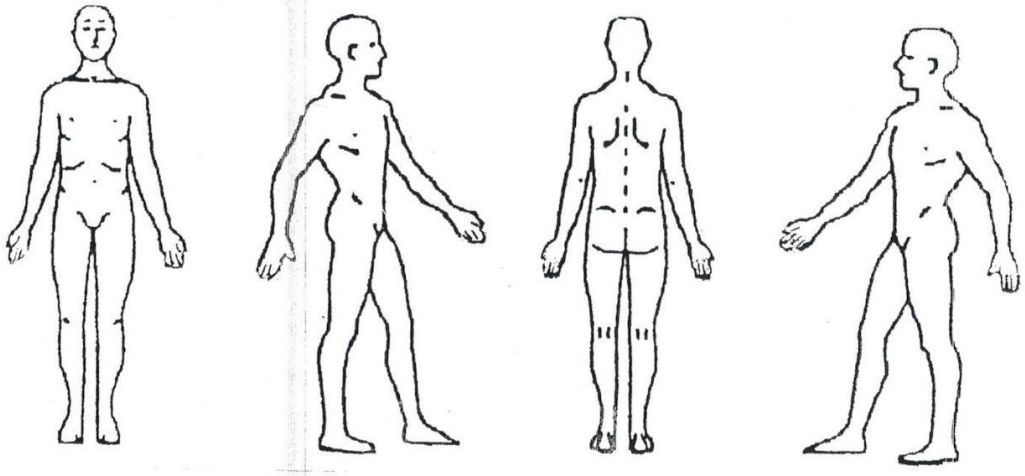
As a result of the accident have you been unable to perform any particular household duties?

Describe your symptoms at the time of the impact:

Describe your symptoms currently:

Describe your medical care for your condition:

On the diagrams below, shade the area(s) where you feel pain. "X" the areas that hurt the most.



Select the type of pain you have, hold down the Ctrl key to select more that one item

Aching
Burning
Continuous
Exhausting
Gnawing
Intermittent
Miserable
Nagging
Numb
Penetrating
Sharp

What makes your pain better?_____

What makes your pain worse?_____

Have you noticed any of the following symptoms? Click on those that apply, hold the Ctrl key to select multiple items

Blurred or Double Vision
Buzzing in ears
Chest pain
Clicking in Jaw
Cold sweats
Constipation
Depression
Diarrhea
Dizziness
Fainting
Fatigue
Fear of driving or sitting in a car
Feet or hands hot or cold
Fever
Head seems heavy
Headache
Irritabilty
Jaw Pain
Knee or ankle pain
Light bothering eyes
Loss of balance
Loss of memory
Loss of smell
Loss of taste
Low back Pain
Mid back pain
Nausea
Neck Pain
Neck stiffness
Nervousness
Numbness/fingers or toes
Pins/needles in arms
Pins/needles in legs
Ringing in ears
Shortness of breath
Shoulder pain
Sleeping difficulties
Stomach upset
Tension
Wrist or elbow pain

Other Symptoms

THERESE M. SCOTT, D.O.
11131 S. E. 190th Court
Boring, Oregon 97009
(503)-558-8918

CONSENT FOR OSTEOPATHIC TREATMENT

I understand that, in consenting to undergo Osteopathic Manipulative Treatment, I recognize that any of the following could occur:

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.

3. My body may change through these treatments, seeking it's 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.

Signature:_____ Date: _____

Parent or legal guardian:_____
(if patient is 17 years of age or younger)

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. If other arrangements are made for payment, 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 $75.00 for an established patient and $100.00 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

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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 24 hours prior, or fail to show up for your appointment. You will be charged a fee of $50.00 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

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 Initials ____
2. My medical or billing record my contain information in reference to HIV/AIDS testing and/or treatment, I agree to its release. 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:

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Office (503) 558-8918
Fax (503) 558-9712