NYGREN CHIROPRACTIC & ACUPUNCTURE

OFFICE POLICIES, CONSENTS AND COMMUNICATIONS

Payment Policy: Our office is private pay (we are not in any insurance networks) and payment is expected at the time of service. We accept VISA, Master Card, American Express, Discover or personal checks. I understand that I am financially responsible for all services rendered. Any returned checks will incur a **$20 fee** and a monthly billing charge of **$25** will be added to all accounts 30 days past due. **Initials:** ____

Insurance Release: *(For Medicare patients and any others needing assistance processing their insurance claims)*
I hereby authorize the release of any medical or other information necessary to process my insurance claim. This is a permanent authorization that I may revoke at any time by written notice. **Initials:** _____

Missed Appointment Policy: We ask that you notify us at least 24 hours in advance if you need to cancel or reschedule your appointment. We do allow 1 initial missed appointment per year. Any other missed appointments or cancellations without notice will result in a $25 fee. Inclement weather, acute illness, or family emergencies are exceptions to this policy. If we are not here to take your call, just leave a message.
Initials: _____

Informed Consent To Chiropractic Treatment: I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests and physical therapy techniques. I understand that chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contraindicated. I do not expect the doctor to be able to anticipate and explain all risks and complications. It is my responsibility to make it known, or to learn through healthcare procedures what I'm suffering from--latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the doctor. Furthermore, I have had an opportunity to ask questions regarding chiropractic treatment, and by initialing I agree to the previously named procedures. I intend for 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. **Initials:** ____

Informed Consent To Needle Acupuncture Treatment: I hereby request and consent to needle acupuncture and any other procedure in the scope of practice including dry needling, gua sha, cupping, laser or electrico-acupuncture. I understand that acupuncture is usually beneficial and seldom causes any problems. I have been given the opportunity to review the acupuncture information leaflet provided for me, explaining any risks. I intend for 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. I**nitials:** _____

Informed Consent To Clinical Muscle Testing, Dietary Suggestions & Supplements: I have been given the opportunity to read the informational leaflet about clinical muscle testing and understand that it is not a method for "diagnosing" or "treating" of any disease including cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. I also understand that no guarantee has been made regarding the results of muscle testing, dietary suggestions or supplement recommendations, and I am not obligated to purchase supplements if they are recommended. **Initials:** _____

HIPAA Privacy: I have reviewed the notice of privacy practices and know my right to privacy. **Initials:** ____
Communications: In the event we need to communicate your health information, to whom may we do so? Please name below:
Spouse: _____Children:_____
Others:_____ ___ No One
May we leave messages on any answering device? ___cell phone voicemail ___home answering machine ___work voicemail ___ none

Email/Text: We use Square, a HIPAA compliant service for online scheduling and appointment reminders, via text and e-mail. We also use Hushmail, a HIPAA compliant email server, for general information, exchange of ePHI, and periodic office updates. By initialing here, you consent to these services through e-mail &/or text. **Initials:** _____

PLEASE SIGN THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION ON OUR POLICIES, INSURANCE RELEASE, CONSENTS, HIPAA, AND COMMUNICATIONS.

_____

Printed Name of Patient Signature of Patient Date

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CONSENT TO EVALUATE AND TREAT A MINOR OR THOSE PHYSICALLY OR MENTALLY UNABLE:

I, _____, being the parent, legal guardian, or court appointed legal representative, of _____, have read and fully understand the above terms and policies, and hereby grant permission for him/her to receive care from Dr. Nygren.

_____

Signature of Patient's Parent, Legal Guardian, or Court Appointed Legal Representative Date

In the event that I am not able to attend the above named patient's appointment, I hereby grant permission for the following person(s) to bring him/her to their visit and communicate their personal health care information with Dr. Nygren & staff.

_____

Name(s) and Relationship

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Fertility New Patient Form

Personal Information:

Name_____ DOB: _____ Age: _____
Address_____City_____State_____Zip_____
Cell Phone _____ Email: _____
How did you hear about us? _____
Occupation:_____Work Duties:_____
Exercise routine:_____
Other recreational activities/hobbies?_____
Marital Status: S M D W Name of Spouse_____Number of children_____
Emergency Contact: Name_____Relationship_____Phone _____
Health Care Providers: Medical Doctor: _____ Last seen:_____
Previous Chiropractor: _____ Last seen:_____
Massage Therapist: _____ Last seen:_____
Acupuncturist/Other:_____ Last seen: _____
Ob/Gyn:_____ Last seen: _____
Fertility Specialist:_____ Last seen: _____

Menses Information:

What day of your menstrual cycle are you currently on? _____
Average Cycle duration? _____ Pads/Tampons/Other:_____
Average days of flow? _____ Describe flow: _____
Been on birth Control before? Y N How long? _____ Type? _____
Giardisil vaccine? Y N
PMS symptoms? Y N List: _____
When do you have PMS during your cycle? _____
(1=least/low, 10= high/most) Rate your stress 1-10: _____ Rate your fatigue 1-10: _____
Excessive body or facial hair: Y N Rate your sex drive 1-10: ____ Frequent yeast infections? Y N
History of any sexually transmitted diseases? Y N List: _____

Fertility Tracking:

Do you take your basal temperature? Y N App Tracking? Y N
Cervical mucus checking? Y N Cervix position checking? Y N Ovulation Kits? Y N
Notes: _____
How long have you been trying to conceive? _____
Any miscarriages? _____
Treatments you've already tried or are currently trying: _____
_____
Have you had any tests run on your uterus, fallopian tubes or ovaries? Y N List: _____
_____

Partner Information:

Please list any tests your partner has had run: _____
Results: _____
General health status of your partner: _____

Nutritional Habits:

Typical Breakfast: _____

Typical Lunch: _____
Typical Dinner: _____
Supplements to help fertility: _____
Cravings: _____
Caffeine: _____
Household/environmental toxin exposure: (cleaning products, candles, scents, detergents, etc.): ____
_____

Case History:
Past accidents, falls, or injuries: _____
_____
Surgeries and hospitalizations with dates:_____
_____
Current prescription medications, vitamins & herbs and what they are for: _____
_____
_____

Family history of the same condition you have? Y N Family history of cancer, diabetes or heart illness? Y N Please list: _____

☑ Other health issues:

☑	Symptom:
	Acid Reflux
	Allergies
	Asthma/COPD
	Bladder Problems
	Cancer
	Depression
	Diabetes
	Diarrhea/Constipation
	Dizziness/Vertigo
	Epilepsy
	Fatigue/Fibro
	Gallbladder

☑	Symptom:
	Gout
	Headaches
	Heart Condition
	Hepatitis
	High Blood Pressure
	High Cholesterol
	HIV
	Insomnia
	Joint Pains
	Kidney Problems
	Menopause Symptoms
	Night Sweats

☑	Symptom:
	Pacemaker
	Skin Conditions
	Sleep Apnea
	Stomach Problems
	Stress!
	Stroke
	Thyroid Problems
	Tremors
	Vaccine Reaction
	Varicose Veins (Severe)
	Weight gain (unexplained)
	Other:

☑	Eating Habits:
	Caffeine—amount:
	Frequent Sugar (candy, cookies, donuts)
	Frequent Processed Foods (chips, boxed meals, etc)
	Artificial Sweeteners
	Soda—amount
	Energy Drinks—amount
	Frequent Fast Food
	4-8 Veggies/day
	1-3 Fruits/day
	6-8 glasses of water/day
	Special diet:

Patient Signature: _____ Date: _____

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Dr. Nichole Nygren, DC Dr. Tyler Nygren, DC
118 1/2 N. Walnut St. Van Wert, Ohio 45891
419-238-4387

Right to Receive a Good Faith Estimate of Expected Charges

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost under the No Surprises Act as of January 01, 2022

Under the new law, chiropractors are required to give patients who don't have insurance or who are not using insurance ***the option*** of a ***written*** estimate of out of pocket expenses while under care.

During your call to set up your new patient appointment we ***verbally*** went over your out of pocket fees for the exam and possible adjustments or acupuncture treatments. At that time you were asked if you wanted a *written* estimate sent to you prior to your first appointment and we did so accordingly.

We are now notifying you of your option to receive a ***written*** *e*stimate for the cost of your **follow-up visits**, including fees for treatments needed in your care plan.

If you prefer a Good Faith Estimate ***in writing*** for your follow-up visits, please specify below and you will receive an estimate at your next appointment.

For questions or more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises**

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I acknowledge that I have received this notice and understand my rights and options as stated above.

I have been verbally explained the expected out of pocket fees for services at this office during my new patient phone call and I

_____ still do ____ do not wish to receive an estimate *in writing for my follow-up visits.*

_____

Patient Signature Date Signed