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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CHILD NEW PATIENT FORM

PERSONAL INFORMATION:

Child's Name _____ DOB: _____ Age: _____ Sex: M F

Address_____City_____State_____Zip_____

Parent's Information: Name (s): _____

Primary Cell #: _____ Email:_____ Referred By:_____

Child's Health Care Providers: Pediatrician: _____Last seen for:_____

Chiropractor: _____ Last seen for:_____

PRESENT CONDITION:

Primary reason for your child's visit today:_____

This began: Date_____ How?(Include history with details)_____

_____

If pain, describe: __ Sharp __Dull __Ache __Pinch __Throb __Shooting __Burning __Tingle __Numb __Random __Constant ___On & Off ___Other: _____ Radiate/travel to other body parts? _____

Is this auto accident related? Yes_____ No_____ Current Litigation? Yes_____ No_____

Previous tests or treatments for this problem:_____

_____

Rate your pain: 1(least) to 10 (most severe)___ This problem occurs?___Hourly ___Daily ___Weekly ___Monthly

List anything that makes it worse: _____

List anything that makes it better: _____

Is your child's condition interfering with their: __Play __Sleep __Eating __Exercise ___Other:_____

Where do you rate your child's overall health now? Sick- 1 2 3 4 5 6 7 8 9 10 -Healthy

PRENATAL HISTORY:

Pregnancy Complications:_____

Medications During Pregnancy_____Cigarette/Alcohol Use During Pregnancy?__Y__N

Location of Birth:__Hospital__Home Birth Intervention:__Induced __Forceps__Vacuum Extraction__C-Section

Meds during Delivery: __Pitocin __Epidural __Other Explanation_____

Birth Weight_____Genetic Disorders or Disabilities: _____Jaundice?_____

FEEDING HISTORY (if 5 yrs. old or under):

Breast Fed__Y__N How long?_____Formula Fed__Y__N How long?_____Type:_____

Difficulty latching on?_____Food Intolerances__Y __N List_____

CASE HISTORY:

Surgeries and hospitalizations with dates:_____

Current prescription medications and what they are for:_____

Current vitamins/herbs and what they are for:_____

Family history of cancer, diabetes or heart illness? Y N Please list:_____

☑ Please check the areas of stress that apply to your child.

	Physical Stress
	Birth Trauma
	Fall on head
	Car Accidents
	High Contact Sports
	Physical Abuse
	Poor Posture
	Sleep on stomach
	Heavy Backpack
	Continuous sitting/standing
	Bone Fractures
	Surgery

	Emotional Stress
	Relationships/Siblings
	Children
	Homework
	High Stress
	Hold in Feelings
	Quick Tempered
	Verbal Abuse
	Perfectionist
	Sickness/loss of loved one
	Self Esteem
	Other

	Chemical Stress
	Second hand smoke
	Poor diet
	Caffeine—amount?
	Excessive Sugar
	Processed/Fast Food
	Artificial Sweeteners
	Soda
	Antibiotics
	Prescription Meds
	Over the counter meds
	Other

☑ Please check any of the following conditions that apply to your child:

	Acid Reflux
	ADHD
	Allergies
	Asthma
	Anxiety
	Bed wetting
	Bladder Problems
	Colds (frequent)
	Chronic Sinus

	Colic
	Cough
	Diarrhea/Constipation
	Dizziness/Vertigo
	Ear infections
	Epilepsy
	Food Sensitivities
	Growing Pains
	Headaches

	Scoliosis
	Seizures
	Skin Conditions
	Stomach Aches
	Tongue Tie
	Torticollis
	Temper Tantrums
	Vaccine Reaction
	Other

AUTHORIZATION FOR CARE OF A MINOR:

I hereby authorize this office and its Doctor to administer care to my Son/Daughter as they deem necessary.
I clearly understand and agree that I am personally responsible for payment of all fees charged by this office

Printed Patient Name: _____

Printed Parent/Guardian Name: _____

Parent/Guardian 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 Name Parent Signature Date Signed