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

NYGREN CHIROPRACTIC & ACUPUNCTURE

NEW PATIENT FORM

Personal Information:

Name_____ DOB: _____ Age: _____ Sex: M F
Address_____City_____State_____Zip_____
Phone _____ Email: _____
How did you hear about us? _____
Occupation:_____ Marital Status: S M D W
Exercise routine/hobbies:_____
Emergency Contact: Name_____ Number:_____
Health Care Providers: Medical Doctor: _____ Last seen:_____
Previous Chiropractor: _____ Last seen:_____
Massage Therapist: _____ Last seen:_____
Acupuncturist/Other:_____ Last seen: _____

Describe your #1 issue you would like to be seen for: _____

_____

Is this #1 issue from an auto accident? Y N **Workmans Comp injury?** Y N
I would like the following the following treatment(s) for my #1 issue:

☐ Chiropractic ☐ Acupuncture ☐ Supplement Program ☐ Cold Laser ☐ Other: _____

Only answer the following questions as they pertain to your #1 issue:

What is your pain level at it's worst: 1 (least) to 10 (severe) _____ **At it's best?**: _____

This #1 issue began: ☐ Gradually ☐ Suddenly Approx. Date: _____ **Describe how:** _____

_____

_____

Treatments already tried for this #1 issue & results:_____

_____

Tests run for this #1 issue: (Please list labs, x-rays, MRI, etc) _____

_____

This issue is: ☐ constant ☐ comes & goes ☐ chronic ☐ severe ☐ intense ☐ mild ☐ nagging

Check all that apply to your #1 issue: ☐ Sharp ☐ Dull ☐ Throbs ☐ Swells ☐ Cramps

☐ Numb ☐ Stiff ☐ Aches ☐ Shooting ☐ Burns ☐ Tingles ☐ Other_____

_____

This issue occurs: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other_____

Activities that make it Worse (circle W), make it Better (circle B), make No Change (circle NC):

Sitting: W B NC **Standing:** W B NC **Walking:** W B NC **Bending:** W B NC
Work: W B NC **Sleep:** W B NC **Exercise:** W B NC **Driving:** W B NC
Dressing: W B NC **List other specific activities being affected**: _____

List past accidents, falls, or injuries: _____

_____

List surgeries and hospitalizations with dates:_____

_____

List current prescription medications, vitamins & herbs and what they are for: _____

_____

_____

Family history of the same #1 issue you have? Y N _____

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

_____

Females Only: Last menses: _____ **Pregnant**? Y N **Trying for pregnancy**? Y N

<u>If you have any other issues you would like addressed please list them here and describe:</u>

_____

_____

_____

Please use the back page to hand write any other details you would like to include in your history.

Check any of the following that apply to you:

	I have:
	Acid Reflux
	Allergies
	Arthritis
	Asthma/COPD
	Bladder Problems
	Cancer
	Depression
	Diabetes
	Diarrhea/Constipation
	Dizziness/Vertigo
	Epilepsy
	Fatigue/Fibro
	Fertility Issues

	I have:
	Gallbladder Issues
	Gout
	Headaches
	Heart Condition
	Hepatitis/Liver issues
	High Blood Pressure
	High Cholesterol
	Insomnia
	Joint Pains
	Kidney Problems
	Menopause Symptoms
	Menstrual Problems
	Night Sweats

	I have:
	Pacemaker
	Prostate Problems
	Skin Conditions
	Sleep Apnea
	Stomach Problems
	Stroke
	Thyroid Problems
	Tremors
	Varicose Veins
	Weight gain (unexplained)
	Weight loss (unexplained)
	Other:

	My Eating Habits:
	I consume caffeine by: Coffee, Tea, Energy Drinks
	I have a sweet tooth for: candy, cookies, donuts, pie
	I frequently eat processed foods like chips, boxed meals, deli meats, etc.
	I use artificial sweeteners
	I eat fast food frequently
	I eat several veggies daily
	I eat several fruits daily
	I drink many glasses of water daily
	I'm on a pecial diet:
	I avoid:

Patient Signature: _____ Date: _____

Parent or Guardian Signature (if patient is under 18)_____ Date: _____

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For Medicare Patients ONLY:

Medicare Coverage & Financial Responsibility for Services

Medicare is the federal health insurance program for people who are 65 or older, as well as for people with certain disabilities or diseases. **Medicare eligible patients must acknowledge and agree to the terms of this document prior to treatment at Nygren Chiropractic & Acupuncture.**

Does Medicare cover Chiropractic Care?

Medicare Part B (Medical Insurance) covers medically necessary chiropractic treatments for the correction of a vertebral subluxation. It does not cover any other service or test ordered or performed by a chiropractor. Non-covered services include examinations, diagnostic imaging, acupuncture, cold laser, cupping, dry needling, gua sha, and manual therapy. Note that chiropractic services performed for the purpose health maintenance do not meet Medicare's definition of medically necessary treatment and will not be covered.

What is My Financial Responsibility?

You will be responsible for the entire cost of treatment, with payment due on the day of service. Nygren Chiropractic & Acupuncture will then file your claim for Medicare reimbursement. If you have met your Medicare deductible, you will reimbursed directly for 80% of the Medicare approved amount.

Please certify the following:

I understand that I am responsible for the cost of all services rendered at Nygren Chiropractic and Acupuncture. I am aware of Medicare's limited coverage of chiropractic services, and its non-coverage of all other services performed by a chiropractor.

By signing below, you certify that you have read this document and understand its terms.

_____	_____	_____
Patient Name (Print)	*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**

****

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