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 Information for Acupuncture Smoking Cessation Program

Name_____ DOB: _____ Age: _____ Sex: M F
Address_____City_____State_____Zip_____
Phone _____ Email: _____
How did you hear about us? _____
Occupation:_____Work Duties:_____
Exercise routine/hobbies:_____
Marital Status: S M D W Name of Spouse_____Number of children_____
Emergency Contact: Name_____Relationship_____Phone _____

Smoking Questions:

What are 3 reasons why you want to quit smoking?
1. _____ 2. _____ 3. _____

What is your goal? ☐ Quit completely ☐ Reduce # smoked
How long have you been smoking? _____ How many a day? _____
Anyone else in your household smoke? ☐ No ☐ Yes: _____
Who is your support person during this time that you are quitting? _____
Previous treatments/methods to stop smoking?_____
Results: _____
If you've quit before, what's the longest it lasted? _____
Reason for relapse: _____
What's your typical day look like for where and when you smoke each cigarette?
_____

Do you have any cigarettes with you or in your car? ☐ Y ☐ N If yes, please proceed to throwing them away before your treatment begins.

Are you willing to get rid of all your smoking supplies today? ☐ Y ☐ N

Have you read through our entire smoking program guidelines? ☐ Y ☐ N

Are you willing to follow them exactly for 2 weeks? ☐ Y ☐ N

Health Questions:

Do you have a tendency to bleed easily? ☐ Y ☐ N
Have you tested positive for Hepatitis A, B, C, HIV or any other disease with high transfer risk through blood? ☐ N ☐ Yes: _____

Females: Is there any possibility that you are pregnant? ☐ Y ☐ N

Do you have a pacemaker? ☐ Y ☐ N
Please list any health condition we should be aware of: _____

Patient Signature: _____ Date: _____

Dr. Nygren Exam

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Oxygen: _____

Heart: Rhythm ☐ IPP ☐ WNL Lungs: Observation ☐ IPP ☐ WNL Nails: ☐ Clubbed ☐ WNL

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YOU CAN DO IT!

We're so happy you decided to quit smoking! Thank you for choosing us to help you!

Acupuncture is an effective tool to enable you to quit smoking by minimizing cravings, calming the nervous system and strengthening willpower. Acupuncture can only work, however, if you are truly ready to quit and willing to commit to the process.

What does Acupuncture do? Acupuncture interrupts messages sent by the brain to the body that demand more nicotine, thereby disrupting the addictive process. It can eliminate most cravings, but not the habit. Generally the treatment reduces cravings from 20 plus to only 3 - 5 a day. It is your responsibility to make it through those few cravings, but we have many suggestions to help you through.

What is the treatment program? On the initial visit we will test your meridians with the AcuGraph. This will give us a baseline of where your body needs the most help in addition to the treatment addiction protocol points. During this first treatment you are to refrain from smoking or having any cigarettes in your possession. If you make it through the next 24 hours smoke free, you will have a 90% chance of being successful. It takes 2 weeks for nicotine to leave the system. It is recommended that you continue acupuncture 3 times a week for at least those 2 weeks.

The following instructions are to help you through the program:

Support Person - Ask someone who is available to you in the next few weeks to be able to talk to and provide encouragement when needed.

Affirmation - Create a list of affirmations (positive statements) about not smoking. Repeating affirmations helps not only to remind you why you are no longer smoking but also imprints a new image of health. Examples: I am a non-smoker; I make healthy life choices.

Setting Boundaries - Ask other smokers to refrain from smoking in your presence. This includes spouses. When possible, stay away from smokers until you feel more confident with your nonsmoking health status.

Drink water - Research shows that dryness causes cravings. Sip water frequently throughout the day.

Refrain from drinking coffee - Research shows that coffee causes cravings and dehydrates the body. However, if you are addicted to coffee, just try to cut back a little.

Food choices - Eat a lot of carrots, celery and other vegetables throughout the next few days. Candies upset blood sugar level, which can aggravate smoking withdrawal symptoms, but cinnamon or peppermint Altoids are encouraged. Take 2000mg of vitamin C daily.

Exercise - Walk or do anything for 20 minutes a day to increase your heart rate and respiration.

Managing cravings - Cravings feel like they will last forever but actually fade in two minutes. Plan what you will do during a craving.

If you give in to your craving, abide by the following rules:

- Smoke a different brand than you are used to - preferably non-filter.
- Smoke with nothing over your head except the sky. Therefore, if you are inside (car, house, etc.,), you must go outside. If it is raining or snowing etc., you may not have anything over your head including an umbrella, awning, etc.
- Smoke with two hands. You may not smoke with only one hand.
- Change where you keep your cigarettes. Put them in less convenient places, for example: your basement, the trunk of your car, etc.-Save every cigarette that you smoke in a baggie. When you want to smoke again, open up the baggie and re-light one.

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Dr. Nichole Nygren, DC Dr. Tyler Nygren, DC
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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