Notice of OFFICE POLICIES

Payment Policy: We are not in-network with any health insurance providers. Payment is required at the time of service and may be made via credit/debit card or by personal check. Returned checks will incur a $20 fee. A monthly billing charge of $25 will be added to all accounts 30 days past due. By initialing, you certify that you have read the payment policy and understand that you are financially responsible for the cost of all services rendered. **Initials: _____**

Notice of Medicare Non-Coverage: 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, therapeutic ultrasound, low-level laser therapy, cupping therapy, and manual therapy. Note that chiropractic services performed for the purpose of health maintenance do not meet medicare's definition of medically necessary treatment and will not be covered. Medicare patients seeking reimbursement for chiropractic treatments may expect to receive 80% of the Medicare approved amount. Reimbursement is dependent on Medicare's decision to cover the treatment, and reimbursement is paid directly from Medicare to you. By initialing, you certify that you have read this notice of Medicare non-coverage and understand that you are financially responsible for the cost of all services rendered in accordance with our Payment Policy. **This notice is for MEDICARE PATIENTS ONLY. Initials: _____**

Right to a Good Faith Estimate of Charges: You are entitled to a written estimate of treatment costs. You may request an estimate at any time. Estimates are made in good faith and may differ from the actual cost of treatment. You have the right to dispute costs that are $400 or greater than the original estimate. Estimates are valid for twelve months from the issue date. Disputes must be made within 120 days of the charge date. Additional information is available at www.cms.gov/nosurprises. By initialing, you certify that you understand your right to a good faith estimate of costs. **Do you want to request a written estimate of treatment costs at this time? Please specify "Yes" or "No"_____ Initials: _____**

Missed Appointment Policy: Missed appointments and appointments canceled without 24 hours notice will incur a cancellation fee in the amount of $25. Exceptions for inclement weather, acute illness, or family emergencies will be made to this policy. By initialing, you certify that you have read the missed appointment policy and understand that appointments must be canceled or rescheduled 24 hours prior to the original appointment date. **Initials: _____**

Notice of Privacy Policy: Our privacy notice is available at www.nygrenchiropractic.com/privacy. You may request a printed copy of this notice at any time. By initialing, you certify that you have read and understand our privacy policy and consent to our privacy practices. **Initials: _____ If you would like to grant an individual access to your health information, you may include their name(s) and contact information here:**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Electronic Communications Policy: We provide electronic scheduling and communications services provided by Block, Inc (Square) and Google, LLC. Use of these services requires the electronic storage of your name, email address, phone number, and appointment information. This information is stored in a manner consistent with the security rules established by the Health Insurance Portability and Accountability Act. By initialing, you consent to the use of electronic scheduling and communication technologies and assume responsibility for the security of private information sent to your device and/or communication service provider. **Initials: _____**

Voicemail Policy: Voicemail recordings are stored and managed by your phone service provider, which may not employ security practices consistent with those established by the Health Insurance Portability and Accountability Act. By initialing, you consent to our use of your voice mailbox and certify your understanding of the associated risks. **Initials: _____ If applicable, please specify which number(s) at which we may leave voicemails:** [ ] Cell [ ] Home [ ] Work [ ] Other _____ [ ] None

Consent to Disclosure for the purpose of Insurance Filing: For all medicare patients, and for some patients with private health insurance providers covering chiropractic treatments, we will submit your health insurance claims directly. By initialing, you authorize us, the staff of Nygren Chiropractic & Acupuncture, to disclose any protected health information that is necessary for the completion, submission, or processing of this health insurance claim. This authorization may be revoked at any time. **Initials: _____**

Informed Consent to Manual Evaluation Methods: As part of the initial examination and subsequent reassessments, your chiropractor will perform manual evaluations, which may include orthopedic tests, neurologic tests, clinical muscle tests, and tests specific to the practice of chiropractic and acupuncture techniques. These tests are necessary for making an accurate diagnosis and for ruling out

conditions that may contradinciate conservative therapy. Some tests may involve the reproduction of your symptoms or may otherwise be uncomfortable. You may decline the performance of any physical exam procedure at any time. By initialing, you consent to manual evaluation and certify that you understand the benefits and risks associated with such methods. **Initials: _____**

Informed Consent to Needle Acupuncture and Dry Needling Treatments: Acupuncture is a traditional Chinese medicine used to reduce pain and promote overall health. Dry needling is a modern therapy that uses acupuncture needles to relax tight muscles. Mild discomfort can be expected during treatment. Soreness, bruising, and light bleeding are common side effects of both treatments. Some conditions, such as bleeding disorders, may contraindicate the use of acupuncture or dry needling treatments. It is your responsibility to report any known defects, deformities, or pathologies that may make acupuncture unsafe. While many conditions respond well to acupuncture and dry needling, your problem may not improve with treatment. You have the right to decline treatment at any time. By initialing, you consent to receive needle acupuncture and/or dry needling and certify that you are aware of their benefits and risks. **Initials: _____**

Informed Consent to Chiropractic Treatment: Chiropractic treatments reduce pain, improve range of motion, and promote overall health. Mild to moderate soreness is common after treatment and usually resolves within 24 hours. Dizziness and nausea are less common side effects. In very rare cases, cervical manipulation has been associated with stroke resulting from vertebrobasilar artery dissection. It is your responsibility to report any known defects, deformities, or pathologies that may make chiropractic adjustments unsafe. Conditions that may contraindicate chiropractic treatments include vertebrobasilar insufficiency, osteoporosis, hemophilia, malignant tumors, and osteomyelitis. While many conditions respond well to chiropractic treatments, your problem may not improve with treatment. You have the right to decline treatment at any time. By initialing, you consent to receive chiropractic treatments and certify that you are aware of the benefits and risks of such treatments. **Initials: _____**

Informed Consent to Manual Treatment Methods: Chiropractors may recommend additional therapies that reduce pain, improve range of motion, and promote overall health. These include cupping therapy, instrument assisted soft tissue mobilization, post isometric relaxation techniques, and manual traction techniques. You may experience mild soreness or bruising after any of these treatments. By initialing, you consent to the use of manual treatment methods and that you understand their benefits and risks. **Initials: _____**

Informed Consent to Physical Therapy Modalities: Chiropractors may recommend additional physical therapy modalities that reduce pain, improve range of motion, and promote overall health. These include low-level laser, also called cold laser, and therapeutic ultrasound. Cold laser is a therapy that uses specific wavelengths of light to accelerate healing. It has no known side effects. Therapeutic ultrasound is a therapy that uses sound waves to heat and relax tissues. It has no known side effects. By initialing, you consent to the use of physical therapy modalities. **Initials: _____**

Informed Consent to Nutritional Recommendations including Dietary Supplements: Chiropractors may recommend certain diets or foods for the purpose of supporting overall health. They may also recommend certain dietary supplements. Dietary supplements can help to provide nutrients that aren't part of your normal diet. They are also helpful for patients that have difficulty absorbing nutrients. It is important to recognize that supplements are not intended to diagnose or treat disease. By initialing, you certify that you consent to receive nutritional recommendations from your chiropractor and certify that you understand that these recommendations do not constitute treatment. You maintain the right to decline any supplements recommended by your chiropractor. **Initials: _____**

PLEASE SIGN to certify that you have read and understand the above terms and policies.

Name: _____ Signature: _____ Date: _____

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 _____ , certify that I have read and understand the above terms and policies and hereby grant permission for the above named to receive care from Dr. Nygren.

Signature: _____ 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 attend the patient's treatment visit, to make decisions on mine and the patient's behalf, and to communicate the patient's protected health information.

Name(s) and Relationship: _____

Name: _____ DOB: _____ Age: _____ Sex: M F Marital Status: M D W S

Address: _____

Phone: _____ Email: _____

Occupation: _____ Hobbies: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Last Seen: _____

Ob/Gyn: _____ Last Seen: _____

Fertility Specialist: _____ Last Seen: _____

Previous Chiropractor(s), Acupuncturist(s), or Massage Therapist(s): _____

Menses Information

1. What day of your menstrual cycle are you currently on? _____

2. Average cycle duration? _____ Do you use products like pads or tampons? Please specify: _____

3. Average days of flow? _____ Please describe your flow: _____

4. What birth control have you used in the past? _____ How long did you use this? _____

5. Have you received any of the following? [ ] Giardisil Vaccine

6. Do you experience PMS symptoms? [ ] Yes [ ] No If yes, please list: _____

7. When do you have PMS symptoms during your cycle? _____

8. Have you had issues with any of the following? [ ] Excessive Body Hair [ ] Frequent Yeast Infections [ ] Sexually Transmitted Disease

If you checked any of the issues in question #8, please specify: _____

9. On a scale of 0 to 10 with 10 being the worst, how would you rate your: a) stress ___ / 10 b) fatigue ___ / 10 c) sex-drive ___ / 10

Fertility Tracking

10. Do you use an app to track ovulation? [ ] Yes [ ] No Notes: _____

11. Do you take your basal temperature? [ ] Yes [ ] No Notes: _____

12. Do you check your cervical mucus? [ ] Yes [ ] No Notes: _____

13. Do you check your cervix position? [ ] Yes [ ] No Notes: _____

14. Do you use ovulation kits? [ ] Yes [ ] No Notes: _____

15. How long have you been trying to conceive? _____

16. Do you have a history of miscarriages? _____

17. Have you tried any fertility treatments? [ ] Yes [ ] No If yes, please specify: _____

18. Have you had any tests done? [ ] Yes [ ] No If yes, please specify: _____

Partner Information

19. Has your partner had any tests done? [ ] Yes [ ] No If yes, please specify: _____

20. Describe the general health status of your partner: _____

Health Habis

21. How would you describe your current level of physical activity? [ ] Good [ ] Fair [ ] Poor

22. How would you describe your diet? [ ] Good [ ] Fair [ ] Poor

23. Do you have any dietary restrictions? [ ] Yes [ ] No

24. What is a typical breakfast for you? _____

25. What is a typical lunch for you? _____

26. What is a typical dinner for you? _____

27. Are you taking any supplements? _____

28. Have you had any cravings? [ ] Yes [ ] No If yes, please specify: _____

29. Do you use caffeine or other drugs? [ ] Yes [ ] No If yes, please specify: _____

30. Are you aware of any household/environmental toxin exposure, such as cleaning products, detergents, and scents? [ ] Yes [ ] No

If you answered yes to #30, please specify which toxins you encounter most: _____

Health History

31. Please list all past major injuries, medical procedures, and health problems: _____

_____

32. Please list all current medications and what they are for : _____

_____

33. If you wear health monitors, or have implanted devices such as a pacemaker, please list those here: _____

_____

34. Do you have a **family history** of certain diseases or problems? If so, please specify: _____

_____

35. Any recent changes in…

[ ] Weight
[ ] Sleep
[ ] Appetite
[ ] Energy
[ ] Sight
[ ] Smell
[ ] Taste
[ ] Strength
[ ] Digestion
[ ] Urination

36. Any recent bouts of…

[ ] Sickness
[ ] Headaches
[ ] Ringing of the Ears
[ ] Chest Pain
[ ] Shortness of Breath
[ ] Dizziness/Fainting
[ ] Abdominal Discomfort
[ ] Constipation/Diarrhea
[ ] Cramping
[ ] Joint Stiffness

37. Were you diagnosed with…

[ ] Heart disease
[ ] Stroke
[ ] Cancer
[ ] Depression
[ ] Diabetes
[ ] Arthritis
[ ] Osteoporosis
[ ] Asthma
[ ] Lung Disease
[ ] Kidney Disease

38. Do you have problems with…

[ ] Eyes
[ ] Ears, Nose, & Throat
[ ] Heart, Arteries, & Veins
[ ] Lungs
[ ] Kidneys
[ ] Liver & Gallbladder
[ ] Stomach & Intestines
[ ] Pancreas
[ ] Skin
[ ] Other: _____

By signing below, you certify that you have completed this form to the best of your knowledge.

Patient: _____ Signature: _____ Date: _____