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: _____

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

Home Address: _____

Parent Phone: _____ Parent Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Pediatrician: _____ Last Seen: _____

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

Reason for Care

Primary Concern: _____

When did this start? _____

How did this start? _____

What makes this better? _____

What makes this worse? _____

Does this interfere with your child's ability to… [ ] Play [ ] Sleep [ ] Eat [ ] Other: _____

Is this case part of any ongoing litigation? [ ] Yes [ ] No

Additional Information: _____

Prenatal History

Pregnancy Complications: _____

Were medications used during pregnancy? [ ] Yes [ ] No If yes, please specify: _____

Were any of the following used during pregnancy? [ ] Cigarettes [ ] Alcohol Notes: _____

Where was the birth? [ ] Hospital [ ] Home Were there any interventions? [ ] Induced [ ] Forceps [ ] Vacuum Extraction [ ] C-Section

Were any of the following used during delivery? [ ] Pitocin [ ] Epidural [ ] Other: _____

Birth Weight: _____ Did any complications occur during birth? _____

Does your child have any disorders or disabilities? [ ] Yes [ ] No If yes, please specify: _____

Feeding History

Was your child breastfed? [ ] Yes [ ] No If yes, how long? _____

Did your child have difficulty latching on? [ ] Yes [ ] No Notes: _____

Did you use formula? [ ] Yes [ ] No If yes, how long? _____ Type? _____

Does your child have any food intolerances? [ ] Yes [ ] No If yes, specify: _____

Health History

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

_____

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

_____

Please list any health monitors or implanted devices: _____

_____

Does your child have a **family history** of certain diseases or problems? If so, please specify: _____

_____

Mark all health items that apply to your child:

[ ] Acid reflux
[ ] ADHD
[ ] Allergies
[ ] Asthma
[ ] Anxiety
[ ] Bed Wetting
[ ] Bladder Problems
[ ] Colds (Frequent)
[ ] Chronic Sinus Problem
[ ] 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: _____

Mark areas of stress that apply to your child:

[ ] Physical Stress
[ ] Birth Trauma
[ ] Car Accident(s)
[ ] High Contact Sports
[ ] Physical Abuse
[ ] Poor Posture
[ ] Sleep on Stomach
[ ] Heavy Backpack
[ ] Continuous Sitting/Standing
[ ] Surgery
[ ] Other: _____

[ ] Emotional Stress
[ ] Relationships/Siblings
[ ] Children
[ ] Homework
[ ] High Stress
[ ] Hold in Feelings
[ ] Quick Tempered
[ ] Verbal Abuse
[ ] Perfectionist
[ ] Self Esteem
[ ] Other: _____

[ ] Chemical Stress
[ ] Secondhand Smoke
[ ] Poor Diet
[ ] Caffeine
[ ] Excessive Sugar
[ ] Heavily Processed Foods
[ ] Artificial Sweeteners
[ ] Soda
[ ] Antibiotics
[ ] Medications
[ ] Other: _____

Additional Notes:

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

Patient: _____ Date: _____

Parent or Guardian Name: _____ Signature: _____