

## 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. You are financially responsible for all services rendered. Any returned checks will incur a **\$30 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:** \_\_\_\_\_

**Documents Requested:** It is our office courtesy to provide the following documents if needed. Please note, (Y) Yes or (N) No, and specify method of delivery, so we can note your file.

1. Insurance Verification Form (for you to call your insurance to check for out of network coverage). Y N
2. Appointment Receipts (for your records upon checkout): Y N Preference for receipts:  Emailed  Printed
3. Diagnosis Codes on your receipts: (Needed only if you are submitting to insurance) Y N
4. End of Year Payment Record: (Each appointment receipt saved to one record). Y N To be  emailed  mailed  picked up

**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. 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 cupping, laser or electrical stimulation. I understand that acupuncture is usually beneficial and seldom causes any problems. I have reviewed 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. **Initials:** \_\_\_\_\_

**Informed Consent To Clinical Muscle Testing, Dietary Suggestions & Supplements:** I have 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? Y or N  home answering machine  work voicemail  cell phone voicemail

Communication concerning appointment reminders or supplement orders:  text  email

**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



**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.

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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.

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Name(s) and Relationship