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 **$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:** _____

Receipts/End of Year Statements: Please note your preference(s) below.
I will need the following: ___Visit Receipts ___ Visit Receipts with diagnosis codes for insurance filing __ I do not need receipts
___ End of Year Billing Record To be ___ emailed ___mailed ___ picked up ___ I do not need my billing record

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 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? Y or N ___home answering machine ___work voicemail ___cell phone voicemail
May we communicate via ____text ___ email, concerning appointment reminders or supplement orders? Y or N

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