



Benjamin J. Visger, D.O. & Paul S. Dyball, D.O.

Board-Certified Specialists in Neuromusculoskeletal
Medicine & Osteopathic Manipulative Medicine

162 N. Causeway | N. Muskegon, MI 49445

231-981-0150 (p) | 231-242-8229 (f)

Welcome to Dr. Visger & Dr. Dyball's office!

Both Dr. Visger and Dr. Dyball specialize in conservative management for problems with nerves, muscles, and bones using careful manual medicine to help relieve pain and restore mobility in the body. It is our goal to get you back to feeling like your old self!

- Please bring your *ID card, insurance card, and completed paperwork!*
- Please arrive 10 minutes before your scheduled appointment time.
- We suggest that you wear comfortable, flexible clothes.
- If you need to reschedule, we ask for a 48 hour notice so patients on our wait list can come in.

If you cannot give us 48 hours, please give us as much notice as you can.

- *If you miss an appointment without calling to cancel, you will be charged a \$50 missed appointment fee.*

Please feel free to call us at 231-981-0150 if you have any questions!

We look forward to seeing you soon!



Initial Medical Evaluation

Please complete this form.

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PATIENT NAME

DATE OF BIRTH

Who referred you to our office? If no one referred you, please share how you found us!

What medical conditions or problems do you have (or have you had)?

What surgeries or medical procedures have you had?

What medications do you currently take? (Or give us a copy of a medication list.)

What allergies do you have?

What medical problems are common in your family? You may write "none" or "unknown."

What jobs do you have now or have done in the past? Are you retired or disabled?

PATIENT SIGNATURE

DATE

Our Practice Policies

Please review this carefully.

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General – You consent to be treated by one or more of our physicians. We are committed to providing excellent care, but there is no guarantee of results. We are not liable for the results of noncompliance. Our physicians may determine that osteopathic manipulative treatment (OMT) is necessary which can temporarily increase pain.

You are expected to arrive on-time for each appointment. We respect our patients' times by booking exclusive times for their appointments, and we often have patients trying to get in sooner. If you need to cancel, we ask for 48 business hours of notice out of respect for our other patients.

Missing an appointment will result in a \$50 charge that you are responsible to pay. "Missing" means not arriving for an appointment without calling ahead to cancel or reschedule. Significant trouble with late arrivals, missed appointments, and short-notice schedule changes may result in termination from our practice.

Payments – **You are responsible for all charges that you incur at this practice.** If you have insurance, you assign and give authorization to us for billing and reimbursement for these charges on your behalf as well as limited power of attorney to represent you in matters related to insurance claims generated here.

Your insurance determines your out-of-pocket expenses. We will do our best to estimate them, but you are responsible based on what your insurance plan is. If your insurance does not cover the full cost of any service, you are responsible for the balance. Your bill may include separate charges for an office visit and manipulative treatment. If you have more than one insurance, you must provide us with complete information for each at the time of service. If you do not, you will be responsible for the uncovered portion.

Payment is due at time of service. This typically includes copayment, deductible, coinsurance, and any existing charges. If additional payments are required, you agree to pay them before the due date on the bill or be charged a late fee.

Other – You authorize us to communicate with you using any of the contact information you have given us. This may include sensitive health information. You authorize us to notify the person who referred you, regardless of whether that person is a medical provider, of your appointment. You agree to and waive us of the responsibility for maintaining the privacy and security of your side of these communications, including your communication accounts and devices. Of course, you are responsible for own communication charges. You agree to inform us promptly when any of your contact information changes. We are not responsible for your lost, stolen, or damaged possessions. You have a right to: restrict the use of your personal information except when necessary for normal business operations; choose someone to make healthcare decisions for you; receive a copy of your medical record or an account of all information disclosures, for a reasonable fee; a copy of this privacy notice; and file a complaint to us or the U.S. Department of Health and Human Services Office for Civil Rights at 200 Independence Avenue S.W., Washington, D.C. 20201, 1-877-696-6775. We will not retaliate against you for filing a complaint. You authorize us to share your health information for legal action, governmental regulations, emergencies, research involving anonymous information, and any other purpose to which you consent.

PATIENT NAME

DATE OF BIRTH

I, the undersigned, understand and agree to the policies above.

PATIENT OR GUARDIAN SIGNATURE

DATE

OFFICE SIGNATURE

DATE