Hello, and welcome to OSTEOPATHIC MEDICINE!

We are a small (but growing) organization, started by Dr. Benjamin J. Visger, whose creativity and passion for helping our community led him to start this independent practice. We now have five providers across Muskegon, Holland, and Grand Rapids who each bring unique skills and techniques for hands-on treatment!

Because of the progress and success with our patients, we are constantly accepting **new** patients! We are happy to join you on your journey of physical recovery, to help you reach your goals and live a more satisfying life with less pain and increased mobility! It is our goal to get you back to feeling like your old self!

Please visit our website at drvisger.org! Click on *About Us* at the top then select *About OMM* and *FAQ* to learn more! You can also find us on Facebook as Osteopathic Medicine with Dr. Visger and Friends!

For your first appointment…

- Please arrive 10 minutes before your scheduled appointment time.
- Please bring your *ID*, *insurance card*, and *completed paperwork*!
- Please bring your preferred form of payment. You can keep a card on file with us if you wish—useful if you use a HSA card!
- Please wear comfortable, modest clothing.
- If you need to cancel or reschedule, please give us 48 business hours of notice. If you miss an appointment without calling before your appointment time, you will be charged a $50 missed appointment fee.

Again, we are so happy to be involved in your treatment, and thank you for choosing our office! We are looking forward to assisting you in reaching your goals! Please call us with any questions or concerns:

- 231-981-0150 (Muskegon, our headquarters—when in doubt, call here!)
- 616-251-1815 (Holland)
- 616-258-2407 (Grand Rapids)

Sincerely,
Staff of Dr. Visger & the Osteopathic Medicine Team

Initial Medical Evaluation

Please complete this form.

Osteopathic Medicine
Board-Certified Physician Specialists
231-981-0150 (p) | office@drvisger.org

PATIENT NAME _____ DATE OF BIRTH _____

Who referred you to our office? How did you find us? _____

What are you hoping the doctor can help you with? _____

What medical conditions, procedures, and surgeries have you had? _____

What medications do you currently take? (You can give us a medication list instead.)

What allergies do you have? _____

Please circle any of the following symptoms you are having or have had lately.

fatigue | *light sensitivity* | *sound sensitivity* | *heart issues* | *trouble breathing* | *painful breathing*
constipation | *diarrhea* | *pelvic pain* | *muscle cramps* | *rash* | *numbness* | *weakness* | *tingling* | *anxiety*
depression | *thyroid problems* | *weight gain* | *weight loss* | *clotting or bleeding problems* | *food allergies*

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

What jobs do you have now or have had in the past? Please also include retirement and disability.

PATIENT SIGNATURE _____ DATE _____

Our Practice Policies

Please review this carefully.

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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 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, you must call us 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. Missing appointments, especially your first appointment, or other disrespect for these policies may result in your termination from our practice.

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 protected 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.

If you would like us to be able to contact you by email, please enter your email address.

_____

_____ _____

PATIENT NAME DATE OF BIRTH

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

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

Credit Card Authorization Form

Osteopathic Medicine
Board-Certified Physician Specialists
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If you would like to leave a card on file, please review and complete this form!

By signing this form, you are authorizing us to charge your card for any balance due including but not limited to copay, coinsurance, deductible, and administrative fees. You also agree to notify us of any changes to your credit card or contact information.

You also acknowledge the following:

- **We do not determine your out-of-pocket expenses. Your insurance company does.** Any disputes of these charges are between you and your insurance company.
- For security, we will protect your credit card information on a dual password-protected, 256-bit encrypted computer. We will retain no printed copy of this information.

If you would like to receive a receipt when we charge your card, please enter your email address.

_____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Zip Code _____

I agree to the terms above and acknowledge all of the information on this policy.

_____ _____

NAME DATE OF BIRTH

_____ _____

SIGNATURE DATE