
A.K. CHIROPRACTIC CENTER

2061 COLLIER CORPORATE PARKWAY

ST. CHARLES, MO 63303

PH:(636)724-5058 FAX:(636)724-5230

OFFICE AND FINANCIAL POLICY

Our office is committed to your health and well-being. Because of this commitment, we are a medium volume practice. We like to spend the time with you that we feel you need. Our prices therefore reflect the time spent under care. It is our policy to explain all procedures and fees. It is our intention that you are fully educated every step of the way.

Dr. Jeremy Schiermeyer Initial Visit:	\$300.00
1 Hour Visit:	\$220.00
½ Hour Visit:	\$110.00
Acupuncture:	\$95.00

Dr. Chris Welsh Initial Visit:	\$240.00
1 Hour Visit:	\$160.00
½ Hour Visit:	\$80.00
Acupuncture:	\$55.00

Dr. Erin Hogan Initial Visit:	\$160.00
1 Hour Visit:	\$160.00
½ Hour Visit:	\$80.00

Additional Services:

Laser therapy in office:	\$30.00
At Home Laser Therapy	\$65- \$80
Laser Vials:	\$100.00

Heart Graph:	\$25.00
Bio-Health Scans:	\$150.00
SAAT:	\$100.00

Appointment Scheduling:

Our office works by scheduled appointment only. Please try to understand that if you are late to your appointment then our schedule will run late from that point forward. Therefore, please be considerate and arrive a few minutes before your scheduled appointment. We sincerely apologize if our office is running behind schedule. If deemed necessary by the doctor/staff a patient may require to book future appointments at a full hour at the rate listed above.

1st Visit/Appointment:

The times & prices listed above are subject to change. The 1st Time Patient Deposit of \$240.00 will hold the allotted time for your visit, and is designated for **you only**. Please schedule spouse/children/parents/friends their own separate appointments. You will be charged per patient treated/consulted, not per appointment slot time. We do this in order to make sure patients get the full attention and care needed and to keep our office running on time. **Deposit can only be applied to 1st appointment with the doctor**, no other services or products. Charges for visits do not include additional costs of supplements, equipment rentals, laboratory testing, or other therapies. Additional time in the office might also be needed for in office scans, testing, therapies, etc.

As a patient, I understand payment is due at the time of service. We ask that you call our office and notify us as soon as possible if you cannot make an appointment. There is no charge for rescheduling or canceling an appointment as long as it is done at least 48 business hours prior to the appointment time. **Failure to reschedule or cancel your appointment prior to 48 business hours will result in: New Patients losing the full deposit of \$240 or Existing Patients will be charged a missed appointment fee of \$50.00 per 30 minute appointment.**

HIPAA Policy:

At the A.K. Chiropractic Center, we are committed to treating and using protected health information about you responsibly. The Notice of Privacy Practices describes the personal information we collect, and how we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective November 10, 2010, and applies to all protected health information as defined by federal regulators. Should you have questions or require additional information, you may contact the Privacy Officer Patricia Schiermeyer at (636) 724-5058.

A.K. CHIROPRACTIC CENTER
PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____
Address: _____ City: _____
State: _____ Zip: _____ E-Mail: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth Date: _____ Sex: M / F Referred by: _____
Spouse's Or Guardian's (if under 18) First/Last Name: _____

CURRENT HEALTH CONDITION

Purpose of doctor's visit: _____
Other Treatments tried for this condition? _____
When did this condition begin? _____ Has this condition Occurred before? Y / N
Do you adhere to a special diet?: _____
Please list Any & All Health Conditions: _____

Prescriptions/Supplements you take: _____

Major Hospitalization/Surgeries/Procedures /Accidents/Falls: _____

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PAYMENT RESPONSIBILITY / CANCELTION POLICY:

- As a patient, I understand payment is **due at the time of service.** **Patient Initials:** _____
- We ask that you call our office and notify us as soon as possible if you cannot make an appointment. There is no charge for rescheduling or canceling an appointment as long as it is done at least 48 business hours prior to the appointment time. Failure to cancel or reschedule your appointment prior to 48 business hours will result in: New Patients losing \$240.00 deposit, Existing patients will be charged a missed appointment fee of \$50.00.

Patient Initials: _____

Metabolic Assessment Form™

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I				Category VI (Cont.)					
Feeling that bowels do not empty completely	0	1	2	3	Nausea and/or vomiting	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Frequent urination	0	1	2	3
Diarrhea	0	1	2	3	Increased thirst and appetite	0	1	2	3
Constipation	0	1	2	3	Category VII				
Hard, dry, or small stool	0	1	2	3	Greasy or high-fat foods cause distress	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3	Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	Burpy, fishy taste after consuming fish oils	0	1	2	3
Use laxatives frequently	0	1	2	3	Difficulty losing weight	0	1	2	3
Category II				Category VIII					
Increasing frequency of food reactions	0	1	2	3	Unexplained itchy skin	0	1	2	3
Unpredictable food reactions	0	1	2	3	Yellowish cast to eyes	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3	Stool color alternates from clay colored to normal brown	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3	Reddened skin, especially palms	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
Category III				Category IX					
Intolerance to smells	0	1	2	3	Crave sweets during the day	0	1	2	3
Intolerance to jewelry	0	1	2	3	Irritable if meals are missed	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3	Depend on coffee to keep going/get started	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3	Get light-headed if meals are missed	0	1	2	3
Constant skin outbreaks	0	1	2	3	Eating relieves fatigue	0	1	2	3
Category IV				Category X					
Excessive belching, burping, or bloating	0	1	2	3	Fatigue after meals	0	1	2	3
Gas immediately following a meal	0	1	2	3	Crave sweets during the day	0	1	2	3
Offensive breath	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Difficult bowel movements	0	1	2	3	Must have sweets after meals	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3	Frequent urination	0	1	2	3
Category V				Category X (Cont.)					
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3	Increased thirst and appetite	0	1	2	3
Use of antacids	0	1	2	3	Difficulty losing weight	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3					
Heartburn when lying down or bending forward	0	1	2	3					
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3					
Digestive problems subside with rest and relaxation	0	1	2	3					
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3					
Category VI									
Roughage and fiber cause constipation	0	1	2	3					
Indigestion and fullness last 2-4 hours after eating	0	1	2	3					
Pain, tenderness, soreness on left side under rib cage	0	1	2	3					
Excessive passage of gas	0	1	2	3					

Category XI			
Cannot stay asleep	0	1	2 3
Crave salt	0	1	2 3
Slow starter in the morning	0	1	2 3
Afternoon fatigue	0	1	2 3
Dizziness when standing up quickly	0	1	2 3
Afternoon headaches	0	1	2 3
Headaches with exertion or stress	0	1	2 3
Weak nails	0	1	2 3
Category XII			
Cannot fall asleep	0	1	2 3
Perspire easily	0	1	2 3
Under a high amount of stress	0	1	2 3
Weight gain when under stress	0	1	2 3
Wake up tired even after 6 or more hours of sleep	0	1	2 3
Excessive perspiration or perspiration with little or no activity	0	1	2 3
Category XIII			
Edema and swelling in ankles and wrists	0	1	2 3
Muscle cramping	0	1	2 3
Poor muscle endurance	0	1	2 3
Frequent urination	0	1	2 3
Frequent thirst	0	1	2 3
Crave salt	0	1	2 3
Abnormal sweating from minimal activity	0	1	2 3
Alteration in bowel regularity	0	1	2 3
Inability to hold breath for long periods	0	1	2 3
Shallow, rapid breathing	0	1	2 3
Category XIV			
Tired/sluggish	0	1	2 3
Feel cold—hands, feet, all over	0	1	2 3
Require excessive amounts of sleep to function properly	0	1	2 3
Increase in weight even with low-calorie diet	0	1	2 3
Gain weight easily	0	1	2 3
Difficult, infrequent bowel movements	0	1	2 3
Depression/lack of motivation	0	1	2 3
Morning headaches that wear off as the day progresses	0	1	2 3
Outer third of eyebrow thins	0	1	2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2 3
Dryness of skin and/or scalp	0	1	2 3
Mental sluggishness	0	1	2 3
Category XV			
Heart palpitations	0	1	2 3
Inward trembling	0	1	2 3
Increased pulse even at rest	0	1	2 3
Nervous and emotional	0	1	2 3
Insomnia	0	1	2 3

Category XV (Cont.)			
Night sweats	0	1	2 3
Difficulty gaining weight	0	1	2 3
Category XVI (Males Only)			
Urination difficulty or dribbling	0	1	2 3
Frequent urination	0	1	2 3
Pain inside of legs or heels	0	1	2 3
Feeling of incomplete bowel emptying	0	1	2 3
Leg twitching at night	0	1	2 3
Category XVII (Males Only)			
Decreased libido	0	1	2 3
Decreased number of spontaneous morning erections	0	1	2 3
Decreased fullness of erections	0	1	2 3
Difficulty maintaining morning erections	0	1	2 3
Spells of mental fatigue	0	1	2 3
Inability to concentrate	0	1	2 3
Episodes of depression	0	1	2 3
Muscle soreness	0	1	2 3
Decreased physical stamina	0	1	2 3
Unexplained weight gain	0	1	2 3
Increase in fat distribution around chest and hips	0	1	2 3
Sweating attacks	0	1	2 3
More emotional than in the past	0	1	2 3
Category XVIII (Menstruating Females Only)			
Perimenopausal		Yes	No
Alternating menstrual cycle lengths		Yes	No
Extended menstrual cycle (greater than 32 days)		Yes	No
Shortened menstrual cycle (less than 24 days)		Yes	No
Pain and cramping during periods	0	1	2 3
Scanty blood flow	0	1	2 3
Heavy blood flow	0	1	2 3
Breast pain and swelling during menses	0	1	2 3
Pelvic pain during menses	0	1	2 3
Irritable and depressed during menses	0	1	2 3
Acne	0	1	2 3
Facial hair growth	0	1	2 3
Hair loss/thinning	0	1	2 3
Category XIX (Menopausal Females Only)			
How many years have you been menopausal?			years
Since menopause, do you ever have uterine bleeding?		Yes	No
Hot flashes	0	1	2 3
Mental foginess	0	1	2 3
Disinterest in sex	0	1	2 3
Mood swings	0	1	2 3
Depression	0	1	2 3
Painful intercourse	0	1	2 3
Shrinking breasts	0	1	2 3
Facial hair growth	0	1	2 3
Acne	0	1	2 3
Increased vaginal pain, dryness, or itching	0	1	2 3

PART III

How many alcoholic beverages do you consume per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat fish per week? _____

How many times do you eat out per week? _____

How many times do you work out per week? _____

How many times do you eat raw nuts or seeds per week? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

A K CHIROPRACTIC CENTER
PATIENT INFORMATION

SYMPTOMS

NAME: _____

If you are in pain, please mark the exact location of your pain on the diagram below, using the following letters to indicate the type of pain.

D = DULL

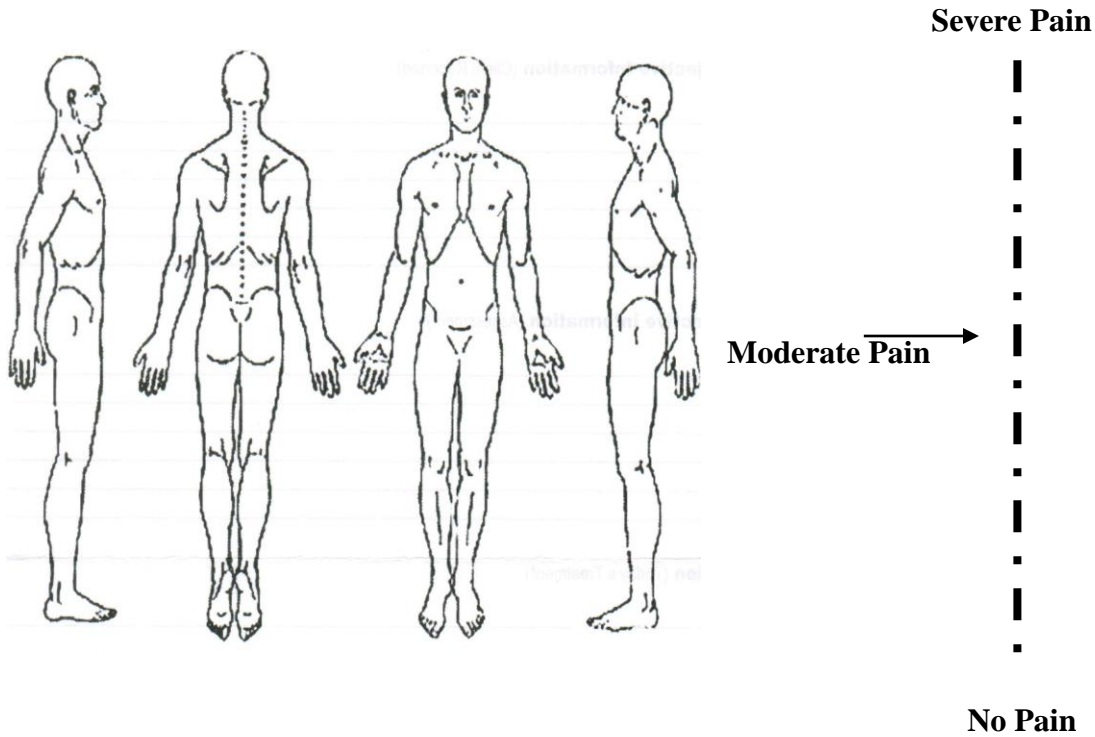
T = TINGLING

B = BURNING

S = SHARP

N = NUMBING

TH = THROBBING



Frequency of pain:

- Constant Frequent Intermittent Occasional

Aggravated by:

- Lying Sitting Standing Bending
 Coughing Movement

Duration:

- Days Weeks Months Years

Comments:

CONSENT TO CHIROPRACTIC TREATMENT

The Material Risk Inherent to Your Treatment

Chiropractic care is a safe and effective approach for many health conditions, however as with any health care procedures, chiropractic treatments present the risks of complication or negative side effects. The list below includes the various treatments available in our clinic and the potential risks associated with these treatments.

Chiropractic Manipulation Therapy

The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and your doctor has done a careful screening for contraindications during the consultation and examination. Another more common side effect associated with chiropractic manipulation therapy is some soreness or stiffness following the treatment.

Soft Tissue Technique

A ceramic instrument is used to strip a muscle or tendon, softening adhesions and promoting healing of the injured or scarred tissue. In some instances, this procedure may cause bruising and some reactive swelling. This may be uncomfortable but is not creating any harm to the patient and this reaction is part of the healing process. Please inform the doctor if you are taking a blood thinner medication or if you bruise easily.

Laboratory Tests

Laboratory tests, including the collection of a blood sample may be ordered to help diagnose your condition. Some patients may faint at the sight of needles or blood. Patients with delicate veins may experience some bruising at the puncture site. In very rare instances, the needle can touch a nerve, causing pain for a few days.

Decompression Therapy

Most patients do not experience any adverse side effects from undergoing Non-Surgical Spinal Decompression Therapy. Occasionally, a few patients experience muscle spasm for a limited time.

Frequency Scans & Therapies:

The risks associated with frequency scans & therapies include increased circulation, irritation and/or itching of electrode pad sites. Patients whom are pregnant, have a pace maker or pump of any kind, those who have heart palpitations/conditions, or epilepsy/seizures are not recommended.

Laser/Light Therapy:

The risks associated with Low Level Light Therapy can include eye damage and therefore protective eyewear must be worn during all Laser frequency/Light Sessions in office.

Acupuncture:

Acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to regulate bodily dysfunction, to modify pain perception, and to normalize the body's physiological functions. Side effects may include, but are not limited to: minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Do Not Sign Until You Have Read And Understand The Above.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the A.K. Chiropractic Doctors or Staff and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or, in the case of minor, in the best interest of the patient) to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name

Patient's Signature Or Guardian/Parent Signature if minor

Neuro Emotional Technique Informed Consent:

NET is a mind-body technique that uses a methodology of finding and removing neurological imbalances related to the physiology of unresolved stress patterns. These patterns are called Neuro Emotional Complexes (NECs).

Emotional responses are naturally “hard wired” in the body. A stimulus happens, we respond, and then the body should return to normal. Occasionally, however, emotional trauma in the presence of a neurological or meridian deficit can cause a physio-pathological pattern in the body or an NEC that does not resolve itself. NET seeks to normalize this pattern by a physiological change; a result of a physical intervention that is made through cutaneous or spinal accesses to the nervous system.

The effect of emotions on health is well documented in scientific literature and for over 100 years, Chiropractors (since 1895) have attributed emotions to being one of the three causes of a misaligned vertebra (a vertebral subluxation). Neuro Emotional Technique (NET) was developed in 1988 to treat vertebra that misaligned/subluxated in an acquired reflex to unresolved emotional triggers.

NET is an interactive process that requires the Patient’s participation. The Chiropractor is merely a facilitator. The NET process establishes the stuck (unresolved) emotion relating to an original event or experience, by determining weakness in the Patient’s acupuncture meridian system and the body’s response to particular words.

To release the unresolved emotion, the Chiropractor will contact, or ask the Patient to contact, particular body points while the Patient pictures the original event or experience. Needles are NOT used.

NET does not deal with “REALITY” but with “EMOTIONAL REALITY (perceived reality)”. Any conceivable life experience may be the subject of an unresolved emotion. Such experiences may include but are not limited to those appearing at the top of the next page. **NET does not predict the future, and it does not tell people what their plan or action may be for the future.**

The Patient is in complete control and can discontinue the treatment if any topic arises which the Patient does not wish to discuss. Occasionally, Patients may become emotional during or after an NET treatment. This is perfectly normal and can be likened to the purging effect of coughing or sneezing.

NET is a highly specialized technique requiring significant training. It is used by healthcare practitioners from many disciplines. **It is not psychology or psychiatry, and it does not involve any type of psychotherapy or “talk it out” therapy. If there is a psychological aspect present, this should be addressed by an appropriate healthcare professional, such as a psychologist, psychiatrist, etc.**

Topics that may arise during an NET treatment:

Any conceivable life experience may be the subject of an NET treatment. Topics may include but are not limited to the following:

Abortion	Eating Disorders	Mortality	Sexual Experiences
Abuse of any kind	Enemies	Obesity	Sexual Preferences
Adultery	Ethnicity	Personal Inadequacies	Sexuality
Addictions	Family Dynamics	Phobias	Spirituality
Animal Cruelty	Failure	Politics	Success
Authority Figures	Genetic Flaws	Public Figures	Terrorism
Belief in Past Lives	Injustice	Rape	The Supernatural
Control Issues	Intimacy	Religion	Traumatic Events
Death	Love	Self-Image	Violence
Divorce	Money	Self-Worth	War

I give my consent for Student Doctor Chris Welsh and/or any other qualified Practitioner to use the skills necessary to examine and care for me each time I consult him/her using NET.

SIGNED BY PATIENT, PARENT OR
GUARDIAN:

PRINT NAME HERE:

DATE: _____

CHIROPRACTOR'S SIGNATURE:

DATE: _____

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PAYMENT RESPONSIBILITY

Patient Information:

As a 'cash/self' patient, I understand I will be provided with superbills or detailed statements indicating the diagnosis and procedure codes and receipts for services rendered. I understand the physician will not bill any third party payers on my behalf. I accept any and all responsibilities and liabilities of submitting my own documentation and claims for reimbursement from any and all insurance companies or third party complications that may arise in my attempts to receive compensation from any third party payer.

I fully understand that I am directly and *fully responsible* to A.K. Chiropractic Center P.C. for all medical bills submitted for services rendered. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover fees.

Patient's signature _____ Date _____

Print Patient's name _____ DOB: _____