
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: | \$120.00 |

| | |
|-------------------|----------|
| Heart Graph: | \$25.00 |
| Bio-Health Scans: | \$150.00 |
| SAAT: | \$120.00 |

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 \$160.00 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 hours prior to the appointment time. **Failure to reschedule or cancel your appointment prior to 48 hours will result in: New Patients losing the full deposit of \$160 or Existing Patients will be charged a missed appointment fee of \$50.00.**

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 hours prior to the appointment time. Failure to cancel or reschedule your appointment prior to 48 hours will result in: New Patients losing \$160.00 deposit, Existing patients will be charged a missed appointment fee of \$50.00. **Patient Initials:** _____

A.K. CHIROPRACTIC CENTER
PATIENT CONFIDENTIAL HEALTH HISTORY

Please check if any of these apply to you.

GENERAL

- 1 Fever
 2 Chills
 3 Night Sweats
 4 Loss of Sleep
 5 Fatigue
 6 Nervousness
 7 Weight Loss or Gain
 8 Allergies
 9 Bleeding Problems
 10 Anemia
 11 Diabetes
 12 Cancer
 13 Thyroid Disease/Goiter
 14 Alcoholism
 15 Drug Abuse

EAR, EYE, NOSE, THROAT

- 16 Poor Vision
 17 Pain in Eye(s)
 18 Deafness/Difficulty Hearing
 19 Nosebleeds
 20 Nose Problems
 21 Sinus Trouble
 22 Dental Problems
 23 Hoarseness
 24 Tonsillectomy

GASTROINTESTINAL

- 25 Poor Appetite
 26 Poor Digestion
 27 Difficulty Swallowing
 28 Belching or Gas
 29 Frequent Nausea
 30 Vomiting
 31 Vomiting Blood
 32 Pain over Abdomen
 33 Ulcer
 34 Black or Bloody Stools
 35 Liver Problems
 36 Gall Bladder Problems
 37 Jaundice
 38 Hernia
 39 Diarrhea
 40 Constipation
 41 Hemorrhoids
 42 Appendicitis

MEN ONLY

- 43 Testicular Swelling/Pain
 44 Prostate Problems

RESPIRATORY

- 45 Difficulty in Breathing
 46 Chronic Cough
 47 Spitting Phlegm
 48 Spitting Blood
 49 Wheezing/Asthma
 50 Pneumonia
 51 Tuberculosis

CARDIOVASCULAR

- 52 Irregular Heartbeat
 53 High Blood Pressure
 54 Pain Over Heart
 55 Previous Heart Trouble
 56 Ankle Swelling
 57 Varicose Veins
 58 Rheumatic Fever
 59 Stroke

GENTOURINARY

- 60 Frequent Urination
 61 Painful Urination
 62 Blood in Urine
 63 Kidney Disease
 64 Urinary Infection
 65 Inability to Control Urination
 66 Difficulty Starting Urine Flow
 67 Get Up at Night to Urinate
 68 Breast Lump or Pain
 69 Venereal Infection
 70 Sexual Difficulties

SKIN

- 71 Itching
 72 Bruising Easily
 73 Change in Mole(s)
 74 Skin Cancer
 75 Scars Location

NEUROLOGIC

- 76 Weakness
 77 Twitching
 78 Tremors
 79 Headache
 80 Fainting
 81 Dizziness
 82 Convulsions
 83 Epilepsy/Seizures
 84 Numbing/Tingling
 85 Arm/Leg Pain
 86 Mental Disorder

MUSCULOSKELETAL

- 87 Neck Stiffness/Pain
 88 Pain Between Shoulders
 89 Low Back Pain
 90 Swollen Joints
 91 Painful Joints
 92 Muscle Aches/Soreness
 93 Spinal Curvature
 94 Arthritis

WOMEN ONLY

- 95 Painful Periods
 96 Excessive Flow
 97 Irregular Cycles
 98 Vaginal Burning/Itching
 99 Hot Flashes
 100 Date Last Period Began:
 101 Date of Last Pap Smear:

EXERCISE

- 102 None
 103 1 - 2 times/week
 104 3 - 5 times/week
 105 6 - 7 times/week

HABITS

- 106 Smoking ___ # packs/day
 107 Drinking
 108 Recreational Drug Use
 109 Caffeine

FAMILY HISTORY**DO NOT INCLUDE YOURSELF**

- Include information on brothers, sisters
 parents and grandparents.
- 110 Diabetes
 111 Thyroid Disease/Goiter
 112 Tuberculosis
 113 Kidney Disease
 114 High Blood Pressure
 115 Heart Disease
 116 Cancer
 117 Muscle, Bone or Nerve Disease
 118 Lung Disease
 119 Ulcers
 120 Arthritis
 121 Seizures/-strokes

MISCELLANEOUS

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

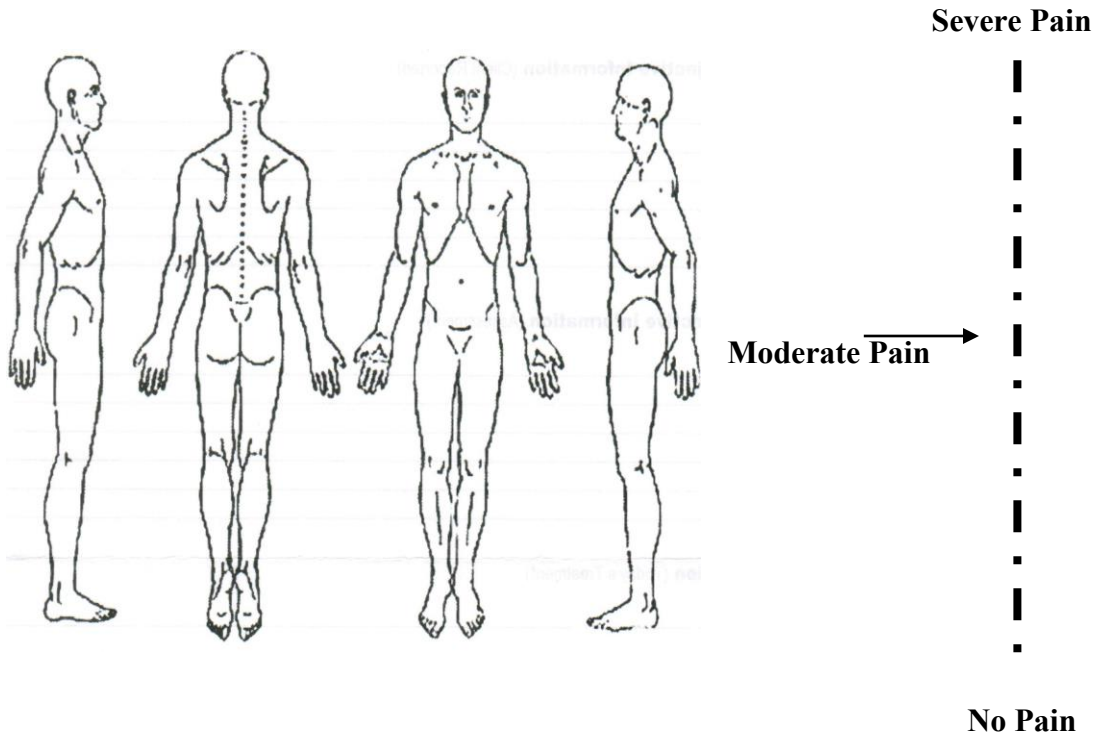
T = TINGLING

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

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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: _____

Authorization for Verbal Communication and/or to Leave Voice Mail Messages and/or Email Correspondence.

Authorization for Disclosure of Protected Health Information: This does not authorize release of copies of medical records.

1. Patient Information:

| | | |
|------------------------|--------------|--------------|
| Name – Last, First, MI | | |
| Street Address: | | |
| Date of Birth: | Cell Phone#: | Home Phone#: |

2. Information to be Disclosed: Verbal communication only re: patient's care – no copies of medical records.

| |
|--|
| VERBAL Communication Between: A.K. CHIROPRACTIC CENTER AND: Patient Name: _____ |
| VOICE MAIL MESSAGES: <input type="checkbox"/> I authorize A.K. Chiropractic Center to send my personal health information via VOICE MAIL Messages to the Phone Number(s) listed above. |
| TEXT MESSAGES: <input type="checkbox"/> I authorize the AK CHIROPRACTIC CENTER to contact me, send appointment reminders and/or send personal health information via TEXT MESSAGE . I understand standard charges/rates may apply. |
| AND/OR: Leave MESSAGE WITH AN INDIVIDUAL who answers the phone at the number provided above. <input type="checkbox"/> Anyone <input type="checkbox"/> Names of authorized individual(s): _____ |

3. Most popular email services (Hotmail, Gmail, Yahoo, centurytel, etc) do not use encrypted email. In accordance with HIPAA act's guidance on email see Page 5634 on the US Dept of Health & Human Services website (<http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>). The guidelines state that if a patient has been made aware of the risks of unencrypted email and consents to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

| |
|---|
| <input type="checkbox"/> Option 1 – ALLOW UNENCRYPTED EMAIL: I understand the risks of unencrypted email and do hereby give permission to the A.K. Chiropractic Center to send my personal health information via unencrypted email. Email address: _____ |
| <input type="checkbox"/> Option 2 – DO NOT ALLOW UNENCRYPTED EMAIL: I do not wish to receive personal health information via email. |

5. This authorization will not expire unless otherwise indicated below and can be revoked in writing at anytime.

In accordance with the conditions listed above, I authorize the use and/or disclosure of my medical information. This authorization includes disclosure of information regarding therapies, treatments, supplements & test results unless I limit the disclosure in writing.

Signature of Patient/Representative/guardian: _____

Date: _____ (mm/dd/yyyy)

New Patient Intake Form

NAME _____ DOB _____ / _____ / _____ AGE _____

OCCUPATION _____ REFERRED BY _____

PRIMARY CONCERN

What problem(s) bring you in today? _____

When did the problem(s) start? _____

Any other problems? _____

Have you seen a chiropractor before? _____ Did you experience relief? _____

What was the nature of the problem? _____

List any other health issues. Even those **not** pertaining to today's concern _____

Please place a single vertical line through the scale below at the point that best describes your pain. (0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|..... 5|.....|.....|.....|.....10

List any major **accidents, car accidents, or injuries** with dates _____

List any **diseases** with dates _____

List any **surgeries** with dates _____

List any **hospitalizations** with dates _____

List any **dental** work with dates _____

What did you eat yesterday?

BREAKFAST _____

LUNCH _____

DINNER _____

SNACKS _____

Is this a typical diet for you? _____

If yes, for how long? _____

Do you crave any foods? _____

Do you experience indigestion? _____

| HOW OFTEN DO YOU HAVE: | Daily | Weekly | Occasionally | Never |
|-------------------------------|-------|--------|--------------|-------|
| Alcohol | | | | |
| Caffeine | | | | |
| Dairy | | | | |
| Grains (Bread, pasta, cereal) | | | | |
| Homemade Foods | | | | |
| Popcorn/Nuts | | | | |
| Soft Drinks | | | | |
| Water | | | | |