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

Additional Services:

Heart Graph:	$25.00
Bio-Health Scans:	$150.00
SAAT/Laser Vials:	$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 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 $160 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.

New Patient Intake Form

Dr. Erin Hogan, D.C.
Phone: 636-724-5058
Address: 2061 Collier Corporate Pkwy St. Charles, MO 63303

DATE_____ PHONE_____ EMAIL_____

NAME_____ DOB_____/_____/_____ AGE_____

REFERRED BY_____ MARITAL STATUS M S W D SEX: M F

ADDRESS_____ CITY_____ STATE_____

ZIP_____ OCCUPATION_____

SPOUSE_____ NUMBER OF CHILDREN_____

MINOR INFORMATION

MINOR NAME_____ DOB_____/_____/_____ SEX: M F

AGE_____ YOUR RELATIONSHIP TO MINOR_____

MOTHERS NAME_____

FATHERS NAME_____

I hereby authorize Dr. Erin Hogan to treat the above named minor and acknowledge that I am responsible for all the costs of their treatments. I also swear by my signature that I am the custodial parent or legal guardian of the above named minor.

GUARDIAN SIGNATURE _____ DATE_____

PATIENT NAME_____ D.O.B._____

PRIMARY CONCERN

What problem(s) bring you in today?_____

When did the problem(s) start?_____

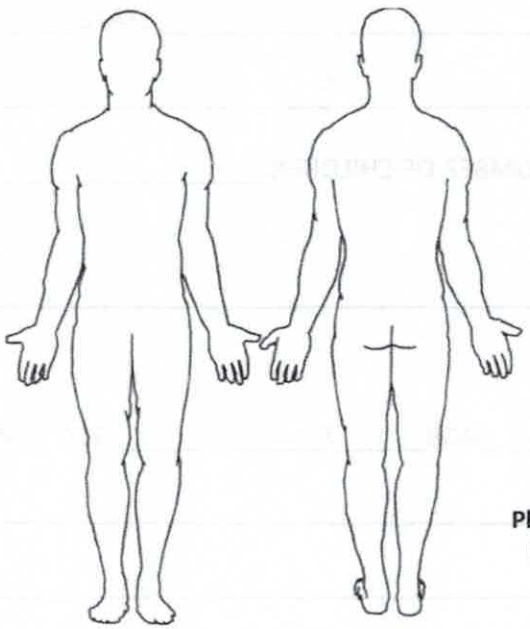
Do you know what caused these problems?_____

Any other problems?_____

Have you seen a chiropractor before?_____What was the nature of the problem?_____

Did you experience relief?_____Approximate date of last visit_____

Mark Area of Complaint Below



Please indicate the factors that affect your problem

	N/A	Better	Worse
Movement			
Sitting			
Standing			
Lying down			
In the morning			
Towards end of day			
During exercise			
While resting			
Before meals			
After meals			

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

Have you **GAINED** or **LOST** weight in the last 5 years? If yes, how much?_____Current weight_____

Are you under the care of another healthcare provider?_____If yes, what for?_____

Have you had X-Rays taken in the past six months?_____If yes, what for?_____

Do you exercise on a regular basis?_____If yes, what type of exercise_____

Family Health History: *Please check all that apply and explain*

_____Cancer_____Heart Disease_____Stroke_____Diabetes_____High Blood Pressure_____Tumors

_____

PATIENT NAME_____D.O.B._____

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_____

_____

List any **prosthetics, implants or hardware**_____

_____

List **any other** health issues, even those NOT pertaining to today's concern_____

_____

*Please list all medications, supplements, vitamins or minerals you are currently taking_____

_____

_____

What did you eat yesterday?

BREAKFAST_____

LUNCH_____

DINNER_____

SNACKS_____

_____

Is this a typical diet for you?_____

If yes, for how long?_____

PLEASE CHECK ANSWER:	Daily	Weekly	Occasionally	Never
Alcohol				
Artificial Sweetener				
Fresh and Homemade Foods				
Soft Drinks				
Dairy				
Energy Products				
Caffeine				
Packaged or Restaurant Food				
Water				
Popcorn/Nuts				
Grains (Bread, pasta, cereal)				

What cooking oil do you use? (Olive, Coconut, Butter)_____

Do you experience indigestion?_____ Gas or bloating?_____ If yes, please explain _____

Any food cravings?_____Any food allergies?_____If yes, please explain_____

PATIENT NAME_____D.O.B._____

Please circle below if you have had or if you currently have:

Allergies	CVA (Stroke/TIA)	Kidney Infection/Stones	Spine injury
Alcoholism	Dementia	Liver Disease/Cirrhosis	Shortness of Breath
Alzheimer's Disease	Depression	Loss of Balance	Sinus problems
Anemia	Diabetes	Loss of Memory	Sleep problems/Insomnia
Aneurysm	Digestion Problems	Loss of Smell	Sneezing w/ Temp Change
Asthma	Dizzy Spells	Loss of Taste	Skin Problems/Sensitive
Autoimmune Disease	Epilepsy	Low Blood Pressure	Smoking
Back Pain	Fatigue	Lung Disease	Spinal Curvatures
Bleeding Disorder	Fertility concerns	Macular Degeneration	Swelling of limbs/ankle
Breast Lump	Frequent urination	Meningitis	Swollen joints
Bronchitis	Gallbladder Disease/Stone	Menstrual problems	Thyroid condition
Bruise Easily	Glaucoma	Neuritis	Tuberculosis
Bypass Surgery	Gout	Nosebleeds	Tumors
Cancer	Headaches	Osteoporosis	Ulcers
Cataracts	Heart Disease	Pacemaker	Varicose Veins
Chest Pain	Hemorrhoids	Parkinson's	
Cold Extremities	High Blood Pressure	Prostate Trouble	Other_____
Constipation	Hives	Reflux	_____
Coronary Artery Disease	Hot Flashes	Retinal Disease	_____
COPD/Emphysema	High Cholesterol	Sciatica	_____
Cramps	IBS	Seizures	

What are your goals for this treatment? Pain Relief - Lifestyle Changes - Other

_____

Please add anything else the doctor should know_____

_____

I certify that I have read and understand the above information to the best of my ability. I acknowledge that the above questions were answered correctly, and I understand that giving false information can be dangerous to my health.

SIGNATURE_____DATE_____

NEW PATIENT INTAKE FORM

Child's History

Dr. Erin Hogan, D.C.
2061 Collier Corporate Pkwy St. Charles, MO 63303 I 636-724-5058

Child's Name_____ **Date of Birth**_____

Mother's History: Prenatal

Did you exercise?_____If yes, please explain_____

Did you drink alcohol?_____If yes, please explain_____

Did you take drugs?_____If yes, please explain_____

Did you have any pain during pregnancy?_____If yes, please explain_____

Labor

How long was labor?_____Was labor artificially induced?_____

Did you have an epidural? _____Was pitocin administered?_____Were forceps used?_____

How would you describe labor? EASY / HARD / VERY HARD Did labor ever "stall"?_____

Did you notice if the doctor grasped/pulled the child's head?_____if the doctor twisted?_____

Any complications or injuries?_____

Child's History

Did the child have a problem gaining weight?_____Did the child pass the hearing test?_____

Was the child breastfed?_____If yes, for how long?_____

Was there any problem feeding or latching? Explain_____

Did they have any strange habits or behaviors as a newborn?_____

Any colic?_____Fussy?_____Alert?_____Any babbling?_____

Any immunizations (shots)?_____If so, which schedule was followed?_____

Did the child crawl?_____Beginning at what age?_____For how long?_____

Was the child in a walker?_____Did they use a Boppy seat?_____

When did the child begin to walk?_____Would you say they fell a lot?_____

Any hard falls or injuries?_____

Ear infections?_____Colds?_____Mucous/Sinus issues?_____Mouth breather?_____

Please explain:_____

_____

SIGNATURE OF LEGAL GUARDIAN_____DATE_____

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 ___ Veneral 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

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:
☐ 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:
☐ **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.
☐ Anyone ☐ 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.

☐ **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: _____

☐ **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)

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 by 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

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:_____

_____

HIPAA Policy:

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PAYMENT RESPONSIBILITY / CANCELATION 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 $190.00 deposit, Existing patients will be charged a missed appointment fee of $50.00. **Patient Initials:** _____

A.K. CHIROPRACTIC CENTER

2061 COLLIER CORPORATE PKWY
ST.CHARLES, MO 63303
(636)724-5058 FAX(636)724-5230

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:_____