Schoenwalder
Health & Wellness

Advanced Beneficiary Notice (ABN)

Patient Name: _____ DOB _____ MRN#_____

This notice is to inform you that our office is no longer contracted or a participating provider with any medical/health insurance company. Payment for all our services are expected on the date of service. If you are unable to pay in full – we offer financing options thru Care Credit.

Please note that if you choose to seek reimbursement from your insurance company, that it may not pay for the services you receive in our office. It is the responsibility of the patient to check your specific Insurance's *out of network* benefit to determine what services can be considered for reimbursement.

Examples of services that most likely won't be reimbursed by insurance are:

- Shape Reclaimed Program
- Hormone Replacement Therapies: Pellet implants/injections
- Ozone/Prolozone/PRP Therapies
- Vitamin/IV Nutrition

By signing this notice, you agree to take financial responsibility for the costs of supplies or services provided.

Patient Signature: _____ Date Signed: _____

* A copy of this notice will be kept in your patient file. You may request a copy of this notice at any time.

PLEASE note – forms in this packet are on front and back of page. Thank you!

1585 Woodlake Drive, Suite 214 Chesterfield MO 63017 schoenwalderhealth.com
P: (314)721-2140 F: (314)721-2115

Schoenwalder Health & Wellness Patient Registration Form

(Please Print)

Today's date:	Schoenwalder Health and Wellness

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (select one) (select one)

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home: ( ) Cell: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Preferred Form of Communication
☐ Home # ☐ Cell # ☐ Email ☐ Text ☐ Other _____

Is it okay for our office to email you? ☐ Yes ☐ No Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Full Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand this practice will not submit my claim to insurance. I understand that I am financially responsible for any balance. I also authorize Schoenwalder Health & Wellness or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PHARMACY INFORMATION

Pharmacy name:	Zip:	Phone #:

Schoenwalder Health & Wellness

MEDICAL HISTORY QUESTIONAIRRE

Patient Name: _____DOB: _____ Todays Date: _____

Past Medical History - Please list all medical conditions you have been diagnosed:

Past Surgical History:

Allergies (Drug, Food or Plant):

Medications (Please include drug name, dose and frequency):

Vitamins/Supplements/OTC MEDS:

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Preventative Medical Exams (Date of most recent):

Bone Density: _____ Stress test: _____
Colonoscopy: _____ Mammogram: _____
Other: _____

Family History: (Please list any medical conditions for parents/grandparents here– i.e. Heart disease, diabetes, hypertension, etc.)

Mother: _____ Father: _____

Maternal GP: _____ Paternal GP: _____

Social History:

Tobacco: Yes/No: If yes, how often per day: _____ week: _____ month: _____ Date Quit: _____

Alcohol: Yes/No If yes, consumption per day: _____ week: ____month: _____

Caffeine per day: _____

Aerobic Exercise per week: _____

Weight Lifting per week: _____

Marital Status: (select one) _____

Occupation: _____

Environmental Exposures – Work/Home (Second hand smoke, pesticides, mercury fillings, chemicals, etc.):

_____
_____
_____
_____
_____
_____

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Schoenwalder Health & Wellness

Informed Consent

I, _____ (print name), have sought medical care from Michael Schoenwalder, DO, LLC DBA as Schoenwalder Health & Wellness I have chosen to do this of my own free will, because I believe the alternative/integrative, holistic approach to medicine that is practiced by Dr. Michael Schoenwalder or Kristina Plesons, AGNP is more in keeping with my philosophy. I also understand that Dr. Michael Schoenwalder is a Board-Certified Internist, who will employ standard drug therapy for medical management if indicated.

It is my understanding there is an alternative approach to medical care practiced by a significant minority group of physicians, who emphasize the importance of nutrition, exercise, heavy metal detoxification, MTHFR, hormonal imbalances, thyroid optimization, adrenal restoration, and chronic inflammatory response syndrome to mold, Lyme disease, viral and parasite infections. Based on these conditions' various herbal/homeopathic, natural/biologic, nutritional (vitamins, minerals, amino acids, ozone and glutathione injections), thyroid, cortisol, and hormone injections will be used as the mainstays for restoring a patient to his/her optimal state of health. I realize that such therapy is frequently not as rapid as drug therapy; that it requires a great deal more effort from me, the patient, that the simple administration of a medicine for each complaint, and some medical authorities consider it to be unproven, ineffective, and even unsafe, but the underlying philosophy seems more realistic to me that the simple relief of symptoms. I understand since every individual case has its own inherent uniqueness, Dr. Michael Schoenwalder/Kristina Plesons AGNP cannot warrant or "guarantee" his treatment programs will always result in an improvement of the disease being treated.

I also understand that many insurance plans have clauses that limit coverage to "usual and customary fees for reasonable and necessary services". I realize that some of the integrative/homeopathic medical services provided by Schoenwalder Health & Wellness will not fall under this description, and I do not hold Schoenwalder Health & Wellness responsible for the possible decision by an insurance company that services provided to me are not covered under a specific insurance contract.

I am consulting with Dr. Michael Schoenwalder/Kristina Plesons, AGNP solely for reasons concerning my own health. I am not consulting Dr. Michael Schoenwalder/Kristina Plesons, AGNP in order to provide any information to any enforcement, regulatory, or investigative agency of any kind.

By my signature below, I certify that I have read and understand the above.

Signature: _____ Date: _____

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Schoenwalder Health & Wellness

Office Policies & Procedures

We are honored you have entrusted Schoenwalder Health & Wellness with your care. We look forward to helping you on your journey to reclaiming your health. Our focus will be on prevention of age-related conditions as well as helping you with chronic conditions that are difficult to manage. The following information is to help keep you informed of our practice policies.

Office Hours: Monday – Thursday 8am – 5:00 pm Friday 8am – Noon.

Telephone Answering Hours: Mon- Thursday 8:30am – 4pm/ Friday 8:30am – NOON.

For Emergency Care after Hours: Call 314-285-4747 (Answering Service) or go directly to an Urgent/Emergency Care facility.

Inclement Weather: In the event of bad weather, someone from our office will contact you the day before or the morning of your appointment to let you know if our office is closing.

Late Arrivals: If you are more than 15 minutes late, you may be asked to reschedule your appointment as this delay not only affects the physician/nurse practitioner, but also other patients that are scheduled after you.

Medication Refills: For all non-narcotic prescriptions please call your pharmacy and request the refills- if additional refills are not available, the pharmacy will contact our office and the request will be responded to within 24 hours.

For all narcotic/controlled substances (i.e. Adderall, Percocet, or Hydrocodone), you must be seen in the office at least ***every 6 months for ADD Medications/ every 3 months for Pain Medications***. ***Our office is not responsbile for lost, misplaced or stolen prescriptions and due to the nature of the medication the prescription will not be replaced.***

***WE NEED 24 HOURS NOTICE TO PREPARE ANY PRESCRIPTION THAT REQUIRES A WRITTEN (HARD COPY) SCRIPT.*

Email: Providing your email address below will give Schoenwalder Health & Wellness permission to send you general office news, promotions and important notifications via an online campaign service; if you prefer to not receive notifications please write "refused" on line below, the service will also allow you to unsubscribe at any time.

Email: _____

Referrals: Although we are not a participating provider, some insurance companies will still accept a referral from our office. If your insurance accepts referrals from an out of network provider note the following:

- **You are required to notify us at least 72 hours in advance of an appointment requiring a referral.** Referrals to other physicians or diagnostic facilities can take up to 72 hours for our office process, failure to obtain a referral in a timely manner can result in making you responsible for all charges incurred at the specialist office.

- **Referrals will not be done after hours or on weekends.**

Test Results: Please have your labs drawn at least 2 weeks prior to your appointment so you may review labs with provider in office. Should you have laboratory or other diagnostic testing ordered through our practice, you will be notified of the results as soon as they are available *(please allow 10 business days from test date)* All results must first be reviewed by the ordering provider. You will receive a call or email from the doctor's assistant. You are ultimately responsible for your results – if you do not receive a call within the time frame listed above, please call the office.

Telephone Consults: As a convenience, our physicians/ practitioners offer telephone consultations. You must already be an established patient. Payment for the consultation is due the date it is scheduled, if payment is not received prior to appointment time then the consult will be cancelled, and you will have to contact the office to reschedule.

Disability/FMLA (Family Medical Leave Act) Forms: We have a high volume of patients requesting disability and/or FMLA forms to be filled out. We require all forms to be submitted with patients' signature as early as possible to ensure we have enough time to complete them. There is a **$75 fee** for each set of forms needing to be filled out. Please allow 2 weeks (14 days) for forms to be completed.

Medical Records Request: We require 2 weeks to respond to all medical records request. There is a $26.06 retrieval fee plus $0.55 per page for all requests. Requests from specialist or consulting physician office will be supplied at no charge. **HIPAA:** Since the HIPAA (Health Portability & Accountability Act of 1996) has been passed by the government, it is designed to protect the patient and their privacy as it relates to their medical information, *our office now mandates that **NO** information will be released to any individual, school, business, family member or friend unless the patient, or legal guardian of the patient has signed a HIPAA release form listing them as recipients for this information*. **NO EXCEPTIONS**

Cancellations/No Shows:

Due to the increased number of patient "no shows" and/or last-minute cancellations, effective immediately ***we now require 24 hours' notice if you are unable to keep your* appointment.** The notice must be done via email to our office to: ContactUs@schoenwalderhealth.com (or use the 'Contact us' feature on our website). Failure to do so will result in **$60 fee for each appointment missed.** Three missed appointments without the courtesy of notification will result in termination of patient care at this practice. ***Please note** the appointment reminder calls/texts from our office are a courtesy to you. It is still your responsibility to keep track of your appointment date and time. Not receiving a reminder call/email will not excuse you from the no show fee.*

We understand that sometimes emergencies will interfere with schedules, but please make every effort to contact us promptly. Please consider *a missed appointment is valuable time that could have been utilized for other patient care needs.*

Until Further notice, I authorize Michael Schoenwalder DO LLC DBA Schoenwalder Health & Wellness to charge my credit card account. This card will automatically be charged $60 when you miss your appointment

without prior cancellation via email. Please note that once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. Our system is registered with PayPal and is a certified PCI compliant provider. ***Refusal to provide credit card information will not exempt you from receiving a bill/statement for missed appointment fees***.

X Signature authorizing credit card use: _____

Additional Financial Policy information: We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship, we request you review the following closely.

Note: Each appointment is set for an allotted amount of time. If you use additional time over the allotted time scheduled, you will be charged an additional $75 in 15 minute increments as they are utilized.

Payment is Due at the Time of Service. We accept cash, checks, debit, HSA (with Visa or Mastercard Logo), all major credit cards and CareCredit. All past due balances and fees of service are due at the time of service unless you have made payment arrangements in advance of your appointment.

Returned Checks: There is a *$30 fee for each returned check*. You are required to pay our returned check processing fee plus the amount of the check that was written by cash or money order within 15 days of notification from us. Failure to do so may result in our office contacting a collection agency for further review. If we receive two (2) returned checks from a patient, we will no longer accept another check from that patient. Cash or money orders will need to be the method of payment.

Proof of Insurance: Please provide proof of insurance cards and valid photo ID with you at each visit. It is your responsibility to notify the office of changes in your health insurance. ***Insurance cards*** will be checked at ***EVERY visit*** so please have your most current insurance card available for verification. ***We do not bill your insurance, but in the event, we order laboratory testing or tests from another facility we are required to supply this information.***

You will be financially responsible for charges and the filing to any insurance carrier.

Please be aware that some or all the services you receive may be non-covered or not considered medically necessary by your insurer. You must pay for these services in full. Since each insurance plan/group policies can vary greatly, you are responsible for knowing your insurance benefits.

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

I hereby authorize Michael Schoenwalder, DO LLC DBA Schoenwalder Health & Wellness (facility) to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

a. Any person or entity responsible for payment for the medical services rendered to me at the facility, including third party payers, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me at by employees of the facility or any person providing services at the facility.

b. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.

c. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.

This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received. Initial x_____

FINANCIAL RESPONSIBILITY: It is understood that payment for services rendered by Michael Schoenwalder, DO LLC; DBA as Schoenwalder Health & Wellness is my responsibility.

A copy of this form shall have the same force and effect as the original.

The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

Your signature below indicates you have read and understand the information noted above and office policies and procedures document.

X_____ _____

Patient/Guardian Signature Date

Authorization to Release Health Information

_____ Patient's Full Name	_____ Patient's Social Security Number/Medical Record Number
_____ Address	_____ Patient's Date of Birth
_____ City, State, Zip Code	_____ Patient's Telephone Number

I hereby authorize use or disclose of protected health information about me described below.

The following physician/medical facility/specific person or class of person is authorized to use or disclose information about me:

_____

The following physician/medical facility/person (or class of persons) may receive disclosure of protected health information about me:
Dr. Michael Schoenwalder DO/Kristina Plesons NP
1585 Woodlake Drive Suite 214
Chesterfield, MO 63017

The specific information that should be disclosed is (please give dates of service if possible)

_____
_____

Unless you sign here, **NO INFORMATION** ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION*_____

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying _____in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- My purpose/use of the information is _____.
- This authorization expires on_____,20__, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:_____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies may be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

_____ **Signature of Patient***	_____ **Date of Patient's Signature**	_____ **Date of Birth or Social Security Number**
_____ **Signature of Guardian* or Personal Representative of Patient's Estate**	_____ **Date of Guardian's/Personal Representative's Signature**	_____ **Description of Authority to Act for the Patient**

OFFICIAL USE ONLY

_____ **Received by**	_____ **Processed by**	_____ **Date**

Schoenwalder Health & Wellness

Acknowledgement of Receipt

NOTICE OF PRIVACY PRACTICES

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received Schoenwalder Health & Wellness LLC Notice of Privacy Practices.

Schoenwalder Health & Wellness LLC Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for Michael Schoenwalder, DO. DBA SCHOENWALDER HEALTH AND WELLNESS LLC.

_____ _____

Patient Signature/Parent/guardian Date

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schoenwalderhealth.com

Permission to Verbally Discuss Your Health Information with Family/Others

(Completion of this form is optional)

I. I request Schoenwalder Health & Wellness to VERBALLY discuss the following health information: (check the applicable box below)

- ☐ Scheduling/Appointment Information
- ☐ Medical information, including my symptoms, diagnosis, and treatment plan
- ☐ Billing and payment information
- ☐ Other (describe): _____

II. I authorize my information, as described above, to be verbally discussed with the following recipient(s):

Name: _____

Street Address: _____

City, State, Zip: _____

Home phone: _____ Work phone: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Home phone: _____ Work phone: _____

III. I understand that this authorization will remain in effect:

- ☐ From the date of this authorization until the _____ day of _____, 20____.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs: _____

IV. I understand Schoenwalder Health & Wellness cannot guarantee that the recipient will not redisclose this information to a third party.

V. I understand that I have the right to revoke my permission at any time except where Schoenwalder Health & Wellness has already made disclosures in reliance upon this request.

- I understand that I must notify Schoenwalder Health & Wellness in writing if I want to revoke my permission.

_____ _____

Patient Name Birthdate

_____ _____

Signature of Patient/Authorized Representative Date

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign: _____

_____