Schoenwalder
Health & Wellness

WELCOME!

Thank you for choosing us as a partner to help you reach your health goals! Please review this packet of information closely and let us know if you have any questions!

(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) Mar/ DIV/ SINGLE/ WID

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:

PREFERRED COMMUNICATION
Preferred Form of Communication ❑ Home # ❑ Cell # ❑ Email ❑ Text ❑ Other _____
Is it okay for our office to email you? ❑ Yes ❑ No Email address:

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 #:

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

Schoenwalder Health & Wellness

MEDICAL HISTORY QUESTIONAIRRE

Please answer the questions on this medical history form as thoughtfully as possible. Many of the questions that follow may not seem directly related to your main complaint or reason for seeking care. However, the answers to these questions, as well as the information you provide in the office, will determine the individualized approach taken to begin your treatment. Please consider this an opportunity to write anything you think may be pertinent to your health.

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

_____

_____

_____

Height:_____Weight: _____Usual weight:_____

Allergies (Drug, Food or Plant):

_____

_____

_____

Preventative Medical Exams (Date of most recent):

Bone Density: _____
Colonoscopy: _____
Thermogram: _____
Stress test: _____
Mammogram: _____
Cologuard:_____

Social History:

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

_____
_____
_____
_____
_____
_____

Alcohol: Yes/No If yes, what type of alcohol do you consume?
What is your alcohol consumption per day: _____ week: ____month: _____

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

Caffeine per day: _____

What is your typical exercise or diet regimen:

_____

Past Surgical History:

_____

_____

_____

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

Mother: _____ Father: _____

Maternal GM: _____ Paternal GM: _____

Maternal GF: _____ Paternal GF: _____

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

_____

_____

_____

_____

_____

Vitamins/Supplements/OTC MEDS:

_____

_____

_____

_____

_____

What is the reason for wanting an appointment with our practice? Please include when any problems began?

_____

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1._____

2._____

3._____

When was the last time you felt well?_____

Did something trigger your change in health?_____

What makes you feel worse?_____

What makes you feel better? _____

What have you already tried to improve any health problems?

What are some of your short and long -term goals in working with our practice?

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe contribute to and support your health?

_____

What potential obstacles to making lifestyle changes do see?

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 severe weather, someone from our office will contact you the day before or the morning of your appointment to let you know if we need to switch you to a telehealth appointment.

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: If you are on medications, you will be required to be seen at least every 6 months for prescription 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 responsible for lost, misplaced, or stolen prescriptions and due to the nature of the medication the prescription will not be replaced.***

Prior Authorization Requests – Sometimes your prescription will require a prior authorization process. We will provide this service at no cost, but if your medication requires a second request or Appeal and you wish us to pursue the appeal process there will be a $75 charge.

Medication History Consent: The electronic medical recording software we utilize, offers access to your medical prescription database filled by other physicians. This is a convenient feature to be used only with your consent. Your signature on this form also gives us consent to access your medical prescription history only to be used to update your chart with current medication or for continuation of care. Initial _____

Email: Providing your email address below will give Schoenwalder Health & Wellness permission to send you general office news, laboratory/imaging test orders, appointment reminders, promotions, and important notifications via an online campaign service; Some of the items may contain your Personal Health Information. ***We do use an email service that states it is HIPAA compliant, but as with any electronic data transfer there***

is never anyway to guarantee complete security. If you prefer to not receive notifications please write "refused" online below, the service will also allow you to unsubscribe at any time.

Email: _____

Referrals: Although we are not a participating/in-network provider with any insurance, 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)* . *If you do not have lab testing done prior to the appointment, you may be asked to have a tele-med visit to review the labs*. X_____ (Initial here) Note: 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.

Telemedicine Consultations: As a convenience, our physician/ nurse practitioner offers telephone consultations. The cost of a telemedicine visit is within a range of $100-$220, and the charges applied are based on complexity of visit and at the discretion of the provider. Payment for the consultation is due the date it is scheduled.

Please note: Telemedicine consultations charges will be incurred in the following instances:

1) a provider calls to discuss your lab/imaging results
2) responds to a patient's request for a return call
3) responds to exchange phone call or text request after hours
4) scheduled as a telemedicine visit on their schedule

Disability/FMLA (Family Medical Leave Act) Forms: We have a high volume of patients requesting physician statements/FMLA forms to be completed. 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-$150 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**

No Refund/Return Policy:

Schoenwalder Health & Wellness, LLC has a NO refund/return policy. All office-visit service fees are non - refundable. **All service discount packages/purchases** (IV, HOCATT Sauna, HUGO PEMF, Injections) are non-refundable. If for some reason you are unable to continue the service/therapy - you may apply any credit balance to other services offered. All opened products purchased in office – are not refundable.
X_____(initial here)

Cancellations/No Shows:

Due to the increased number of patient "no shows" and/or last-minute cancellations, effective immediately ***we now require 48 hours' notice if you are unable to keep your*** **appointment.** The notice must be done via text or call to our office or exchange phone: (314) 285-4747. Failure to do so will result in **being charged the full amount of the office visit scheduled 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.*** X_____(Initial here)

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.*

Credit Card on File :

I authorize Michael Schoenwalder DO LLC DBA Schoenwalder Health & Wellness to charge my credit card account. This card will automatically be charged 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 charge for missed appointment fees***. If you supply a credit card to us verbally, it will be assumed you have authorized the use of this card for any outstanding balances.

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, please 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 may be charged an additional $75 in 15min 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. Any outstanding balances due will be charged to card on file.

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_____

Fee Schedule

Medical Consultations (In-Office/Telemedicine)

Acute Consultation	$100-$120
Initial Consultation	$385.00
Follow Up Consultation	$165
Comprehensive Exam	$220
Well Woman Exam	$220

Administration Fees

New Patient Appointment Deposit	$195	Letter/Physician statement	$75.00
Missed Appointment Fee	cost of appt	Prior Authorization Appeal	$75
Medical Marijuana Form	$75	Short Form/Letter	$35
Physician Statement/ Letter	$75.00	Returned Check	$30

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

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 group of physicians, who emphasize the importance of nutrition, exercise, drainage, detoxification, MTHFR, hormonal imbalances, thyroid optimization, adrenal restoration, and chronic inflammatory response syndrome to various biotoxins and environmental toxins. Based on these conditions' various herbal/homeopathic, natural/biologic, nutritional (vitamins, minerals, amino acids, ozone, and glutathione injections), thyroid medications, cortisol support, and hormone therapies 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/functional 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: _____

Informed Consent for Telehealth/Telemedicine Services

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine is when you receive a telephone call for a medical consultation in replace an in-office visit with your healthcare provider.

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth-telemedicine. Information obtained during telehealth/telemedicine that identifies you will not be given to anyone without consent except for the purposes of treatment, billing, and healthcare operations. I understand, agree, and expressly consent to Schoenwalder Health & Wellness LLC obtaining, using, storing, and disseminating to necessary third parties, information about me, as necessary to provide the telehealth/ telemedicine services.

As with any tele communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network security protocols to protect the confidentiality of patient identification and texting data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Telehealth/ telemedicine sessions may not always be possible. Disruptions of signals or problems with Internet infrastructure may cause broadcast and reception problems (e.g., poor sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless Schoenwalder Health & Wellness, LLC and all members of my care team from any loss of information due to technical failures with the telehealth/ telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth/ telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment at the time of the my telehealth/ telemedicine visit, and that such professionals may not have access to my full medical record or information held at Schoenwalder Health & Wellness.

I understand that I will be given information about test(s), treatment(s) and procedure(s), as applicable including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/ telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/ telemedicine services at any time and revert back to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine services, it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/ telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become part of my medical record.

Signature: _____ Date: _____

Informed Consent Regarding E-MAIL or the Internet Use of Protected Personal Information

INTRODUCTION:

Schoenwalder Health & Wellness provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

RISKS:

- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email to other recipients with or without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail may exist even after the sender, or recipient has deleted his/her history. motivation
- E-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information ; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their email.

It is the policy of Schoenwalder Health & Wellness that all e-mail messages sent or received, which concern the diagnosis, or treatment of the patient will be a part of the patients' protected personal health information and we will treat such e-mail messages or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Schoenwalder Health & Wellness will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

1) All e-mail to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, Dr. Michael Schoenwalder, other health care practitioners, and health service providers will have access to e-mail messages contained in protected personal health information.
2) Schoenwalder Health & Wellness practitioners my forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the email outside the practice without the consent of the patient as required by law.
3) We at Schoenwalder Health & Wellness will endeavor to read e-mails promptly but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, email must not be used in a medical emergency. It is the responsibility of the sender to determine whether the intended recipient received the email and when the recipient will respond.
4) Because some medical information is so sensitive that unauthorized disclosure can be very damaging, email should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

5) Schoenwalder Health & Wellness cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the email, or internet communication. Furthermore, I understand in regard to the use of email for communication - Dr. Schoenwalder is not liable for improper disclosure of confidential information caused by its employee's gross negligence, or wanton misconduct.
6) If Consent is given for the use of email, it is the responsibility of the patient to inform Schoenwalder Health of any type of information you do not want to be sent by email.
7) It is the responsibility of the patient to protect their password or other means of access to email sent, or received, from Schoenwalder Health, to protect confidentiality. Schoenwalder Health is not liable for breaches of confidentiality caused by the patient. Any further use of email initiated by the patient that discusses diagnosis or treatment, constitutes informed consent to the foregoing. I understand that my consent to the use of email may be withdrawn at any time by email, or written communication to Schoenwalder Health & Wellness at Contactus@schoenwalderhealth.com

I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with the use of email.

CONSENT TO :

1. I have read this consent form.
2. I understand the risks and responsibilities associate with the use of email – and I acknowledge its possible risks and complications.
3. I agree to assume all risks associated with the use of email.
4. I authorize and consent to the use of my email address: _____ as mentioned above.

Signature: _____ Date: _____

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

Permission to Verbally Discuss YOUR Health Information WITH YOUR FAMILY
(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: _____

_____