MORNINGSTAR
NEUROPATHY + PAIN
TREATMENT CENTER, LLC

4710 Mexico Rd. St. Peters, MO

NEW PATIENT PAPERWORK

DEMOGRAPHICS:

First Name: _____ Last Name: _____

DOB: _____ Email: _____

Work: _____ SS#_____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ City_____ State_____ Zip_____

Cell Phone: _____ Home Phone: _____

Spouse or Patient's Guardian: _____

Whom may we thank for referring you? (Check Appropriate Box)

☐ Doctor ☐ Facebook ☐ TV Ad ☐ Other_____

Emergency Contact: _____Relationship: _____

Emergency Phone: _____ Email: _____

Responsible Party (complete if different from above)

Name of person responsible for account_____

Relationship to Patient_____

Address_____

Home Phone_____ Cell Phone_____

Driver's License#_____ DOB: _____

Is the person currently a patient at our office? ☐ Yes ☐ No

INSURANCE: Do you have Medical Insurance? (If so, provide a card)

Primary: _____ ID:

_____

Relationship to Policyholder_____ Policyholder's DOB: _____

Secondary_____ ID: _____

Relationship to Policyholder_____ Policyholder's DOB: _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS *A*N APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERIS*A*/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Morningstar Neuropathy and Pain Treatment Center, LLC, Heather Leone FNP, Andrew Morningstar, DC, Joseph Novof,** DO as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare providers') the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Providers for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Providers as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Providers all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPA*CA* governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under m*y/*our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Providers can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PP*ACA* Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due *(*or have been previously paid) to either Healthcare Providers, myself, and/or my family members as a result of services rendered by Health care providers, and to pursue any and all remedies to which *I*/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Providers is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Providers can pursue any and all rights that I*/W*e may have under state and/or federal law regarding m*y/*our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that ha*ve *been previously provided by Healthcare providers.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this_____ day of _____, 20__. X_____

(Patient Signature)

X_____ _____

(Parent or Guardian Signature, if applicable)

Health History

Chief Complaint: _____

History of Chief Complaint:

Location: _____ Quality: _____

(Where is the pain/problem?) (Example: normal vs abnormal color, activity, etc.)

Severity: _____ Duration: _____

(Scale of 1-10, 10 is worst pain) (When did it start? How long?)

Timing: _____ Context: _____

(Does the pain/problem occur at specific times) (What makes the pain worse/better?)

Social History

Do you smoke? ___ Quantity per day_____

Drink Alcohol? ___ Quantity_____

Drug Use? _____

MEDICAL QUESTIONS:

Do you have a pacemaker? _____ Do you have a defibrillator? _____

Are you dependent on either? _____ Any other cardiac devices? _____

Primary Care Physician? _____ Cardiologist? _____

Neurologist? _____Pharmacy? _____

Pharmacy Address? _____

Diabetic History:

Are you a Diabetic? ☐ Yes ☐ No

When Were You Diagnosed? _____ Current Hemoglobin A1C: _____

Are your blood sugars controlled? ☐ Yes ☐ No Fasting Blood Sugars: _____

Does your PCP treat your Diabetes? ☐ Yes ☐ No If not who does? _____

Neuropathy History:

☐ Pain ☐ Numbness ☐ Tingling ☐ Pain with Touch ☐ Shooting Shocks ☐ Aching

Where are these symptoms located? _____

Date diagnosed with neuropathy. _____ Diagnosed by: _____

Do I need to test for PAD?

Peripheral Arterial Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys become narrowed or clogged. It affects over 8 million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Check if any apply:

☐ Foot, calf, buttock, hip, or thigh discomfort when you walk which is relieved by rest

☐ Any pain at rest in you lower legs or feet

☐ Foot or toe pain that often disturbs your sleep

☐ Toes or feet pale discolored or bluish

☐ Skin wounds or ulcers on your feet or toes that are slow to heal

☐ Diagnosed with diminished or absent pedal (foot) pulses

☐ Suffered a severe injury to the leg(s) or feet

☐ Have an infection of the leg(s) or feet that may be gangrenous (black skin tissue)

Do you suffer from any of these conditions?

☐ Currently undergoing external defibrillation.

☐ Have an implantable pacemaker or cardiac device or insulin pump

☐ Bilateral mastectomy

☐ Dermatological lesions or calluses on bottom of feet

☐ An absence of two or more limbs

☐ Arterial Catheters on arm or leg or an arteriovenous (AV) fistula or shunt

Medical History

Head
- ☐ Trauma

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Glasses/contacts

Ears
- ☐ Hearing aids
- ☐ Nose/Sinuses
- ☐ Allergic Rhinitis
- ☐ Sinus Infections

Mouth
- ☐ Dentures

Cardiovascular
- ☐ Aneurysm
- ☐ Angina
- ☐ Deep Vein Thrombosis
- ☐ Dysrhythmia
- ☐ High Blood Pressure
- ☐ Murmur
- ☐ Heart Attack
- ☐ Other heart disease

Respiratory
- ☐ Bronchitis
- ☐ COPD
- ☐ Pleuritis
- ☐ Pneumonia

Gastrointestinal
- ☐ Cirrhosis
- ☐ GERD
- ☐ Gallbladder Disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ Jaundice
- ☐ Ulcer

Genitourinary
- ☐ Hernia
- ☐ Incontinence
- ☐ Nephrolithiasis
- ☐ Kidney disease
- ☐ STDs
- ☐ UTIs

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ M/S Injury

Skin
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Skin condition(s)
- ☐ Psoriasis

Neurological
- ☐ Epilepsy
- ☐ Seizures
- ☐ Severe headaches, migraines
- ☐ Stroke
- ☐ TIA

Psychiatric
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Hallucinations, Delusions
- ☐ Suicidal Ideation
- ☐ Suicide attempts

Endocrine
- ☐ Goiter
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Thyroiditis
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Heme/One
- ☐ Anemia
- ☐ Cancer

Infections
- ☐ HIV
- ☐ STDs
- ☐ Tuberculosis

IF YOU HAVE HAD ANY SURGERIES, PLEASE LIST THEM HERE:

Procedure	Surgery Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Check all that apply)

	Father	**Mother**	**Brother**	**Sister**
Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Neuropathy	☐	☐	☐	☐
Deceased	☐	☐	☐	☐

If Deceased, please provide age at death _____

Allergy History (Please List All Allergies):

_____

_____

Medication Lists

Medication Name	Dosage/MG

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Reviewing Provider:

_____ _____

Signature of Provider Date

_____

Printed Name of Provider

Neutra Pharmaceutical Vitamin Blend Injection Consent

1) Each patient responds differently to medicine and may respond differently from one treatment to the next. As with all medicines, results are temporary, and regular dosing is necessary. The length of time the injectable medication lasts varies in each patient. No guarantee can be made regarding the results or length of time it lasts.
2) I understand there are some risks with any treatment. The following is a list of possible risks with injection:

- Pain or bruising of the skin injection site
- Small amount of bleeding
- Scarring of the skin (unlikely)
- Possible skin infection, a possibility any time the skin is broken, even with sterile needles and skin cleansing with alcohol swab

3) I have been educated on potential side effects as well as ingredients in the Neutra Pharmaceutical Vitamin Blend injection
4) I verify to the best of my knowledge; I am not pregnant or breastfeeding
5) I verify to the best of my knowledge; I am not allergic to any of the constituents in the Neutra Pharmaceutical Vitamin Blend injection including Sterile Water, Thiamine, Alpha Lipoic Acid, Vitamin B Complex, L-Carnitine, Ascorbic Acid, MultiTrace-4, Pyridoxine, 8.4% Sodium Bicarbonate, 2% Lidocaine, Hydroxocobalamin.
6) The nature and purpose of the injection, possible alternative methods of treatments, risks involved, possible consequences, and the possibility of complications have been explained to me.
7) I have read and understand the ingredients of the injection being administered to me, and I consent to treatment.
8) This consent is good for up to 36 visits of Sanexas and the Neutra Pharmaceutical Vitamin Blend injection including Sterile Water, Thiamine, Vitamin B Complex, L-Carnitine, Ascorbic Acid, MultiTrace-4, 8.4% Sodium Bicarbonate, Pyridoxine, Alpha Lipoic Acid, 2% Lidocaine, Hydroxocobalamin

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR NEUTRA PHARMACEUTICAL VITAMIN BLEND INJECTIONS AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM. I RELEASE MORNINGSTAR NEUROPATHY AND PAIN TREATMENT CENTER, LLC, ALL MEDICAL, STAFF, AND EMPLOYEES FROM THE LIABILITY ASSOCIATED WITH THIS PROCEDURE. I CERTIFY THAT I AM A COMPETENT ADULT OF AT LEAST 18 YEARS OF AGE IF SIGNING AS PATIENT. THIS CONSENT FORM IS FREELY AND VOLUNTARILY EXECUTED

_____ _____

Print Name Date

_____

Signature

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is available through our front office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, text message, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or a provider within the office.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, (name) _____ (date)

do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Morningstar Neuropathy & Pain Treatment Center, LLC Financial Agreement

We share your concerns regarding the increasing cost of health care. We believe that you deserve the best possible care we can provide at a reasonable cost. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thereby prevent any misunderstandings. We hope you will consult with us if you have any questions regarding our service and/or fees.

Free Consultation: Our office offers a no-charge consultation for anyone interested in starting care at Morningstar Neuropathy & Pain Treatment Center, LLC. During this consultation, a Patient Advocate will listen to your health issues and determine if you have a condition in which we have success treating, or if your symptoms are best served by another office/provider.

New Patient Exams: Since the initial exam is a meeting seeking a professional opinion there is a charge for this visit. Patients without insurance or with insurance that we are an Out of Network provider for, are required to pay this charge at the time of service. For those patients with insurance, we will forward a claim to your insurance company.

Patients WITH insurance: Morningstar Neuropathy & Pain Treatment Center, LLC accepts most major health insurances. Our office will do its best to determine eligibility and coverage before rendering any services and communicate any potential costs to the patient. Many people are under the impression that if they have insurance, it is the insurance company that owes the doctor for their services, unfortunately, that is not the case. The insurance contract is between the patient and the insurance company; therefore, the patient is responsible for the bill regardless of insurance coverage. We will file claims to your health insurance company; however, it is the responsibility of the patient (or insured) to provide our office with complete insurance information.

Patients WITHOUT insurance: Financing options are available and facilitated by our financial coordinator. If you choose to forgo these options, charges are required to be paid for in-full at the time of service.

Medicare: Providers at Morningstar Neuropathy & Pain Treatment Center, LLC are IN-NETWORK providers with Medicare. Our office will bill Medicare for services rendered and any secondary policies that you have. Medicare covers 80% of services, and the patient (or secondary insurance) is responsible for the remaining 20% of Medicare's allowable.

Medicaid: Our providers are **NOT** Medicaid providers at this time. Medicaid recipients are considered Patients WITHOUT insurance if you wish to seek care.

Non-Covered Services: Neuropathy & Pain Treatment Center, LLC does provide some services that are considered non-covered services by both Major Medical Health Insurances and Medicare. Those services will be communicated to you before being rendered. All costs of these procedures will be discussed before services are rendered.

Discounts: Our office cannot offer discounts due to be contracted with Medicare and many Major Medical Health Insurance companies.

Credit Card Payments: Our office accepts Visa, Mastercard, American Express, Discover, Health Savings Accounts and bank Debit cards.

Patient Responsibility: Agreements between parents/guardians or denying financial responsibility for services rendered are not recognized by this office. We consider the guardian responsible for payment of services. Adults aged 18 years or older are legally responsible for their accounts unless that individual has a condition requiring him/her to have a custodian/trustee of their financial accounts. If a custodian or trustee is in charge, they are responsible for the patient's account with our office.

Returned Checks: A fee of $35.00 will be charged for check recovery.

Account Balances: The balance on all accounts is due in full within 90 days of receiving a Statement of Balance. If payment for services rendered are not made within this time frame, a financial charge of 1.5% per month will be added to the account (18% per annum).

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. If it becomes necessary to effect collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. I also authorize the clinic to release any information required for this claim.

Cancellation Policy: There is a $50.00 fee for cancelled appointments with less than 24-hour notice.

Signature: _____ Date: