McDonagh Medical Center

Carey K. Wennerstrom, D.O. Charles J. Rudolph, D.O., PhD
Phone: (816) 453-5940 www.mcdonaghmed.com Fax (816) 453-1140
2800 NE Kendallwood Pkwy, Gladstone, MO 64119

Nutrition · Allergies · Family Practice · Degenerative Diseases · Preventative Medicine · Metabolic Disorders · Prolotherapy

To Our New Patients

The art and science of medicine has been undergoing revolutionary changes in the past few years, changes of which most patients are largely unaware. We deal with the vital functions of the body that maintain the health or re-establish good health after illness.

Our goal in preventative medicine is threefold:

A. To help the patient eliminate his chief complaints; and
B. To find, by thorough testing, any disorders of which the patient may be unaware then reverse the decline and enable the patient to maintain good health; and
C. To become acquainted with the patient as a whole person, and to help him understand all the facts he will need to help keep fit.

We want you to understand that our viewpoints are not necessarily shared by the AMA, the FDA, the American Cancer society, the Arthritis Foundation, the American Heart association or other similar agencies. The preventative medicine concept of health care is practiced here. We routinely use numerous vitamins, minerals, enzymes, and sometimes hormones or related medications as a basis for nutritional support to improve metabolism, appetite, one's sense of wellbeing as well as for the relief and remission of pain. However, you must be aware that you may not receive all of these benefits, as they do not occur predictably with every patient and in some cases may not occur at all.

FEES AND COLLECTIONS

This center has a "fee for service" policy. This means that payment is expected from the patient or the family when service is rendered. For your convenience, we accept Mastercard, Visa, Discover, cash or check.

We do not accept assignment of benefits from any government agency-third-party payor. We do provide an itemized receipt of service rendered for your convenience in filing for benefits from your particular insurance provider. The responsibility for health claims is between the patient and the insurance company. This is the contract that you pay premiums for and the insurance company agrees to provide health claim benefits in return. Be sure to include your paid receipts when you file your claim with your insurance company. NOTE: We do not participate in Medicare, you will be required to sign a contract stating that you are aware of this.

We encourage frank and open discussions about the cost of your treatment. Since insurance companies are set up primarily for the treatment of crisis type illness or accidents, our experience has shown that many will not pay for therapy rendered here if we file the insurance claim for you. It has been our experience over the years that the over-regulation of medicine of so many organizations has led to a loss of the overall concept we try to keep upper most here at McDonagh Medical Center, "The patient is a whole person and must be treated as a whole person."

Good health is a responsibility we must bear. Good health depends to a large extent on your wisdom and knowledge in the everyday care of your body. You must make use of the wisdom and knowledge you have and supplement it in areas where your knowledge is inadequate. We look forward to working with you toward the goal of improved physiological function and an improved and happier future.

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A NOTICE TO OUR PATIENTS

The vitamins and mineral supplements that are supplied to you from McDonagh Medical Center are special nutritional supplements formulated to support and augment the chelation therapy. Dosage and combinations may change periodically as your condition improves.

Each patient's chelation program is tailored to his or her particular needs. Therefore, some patient's protocols will vary widely from others. Because of this approach, our program has been highly successful for over 40 years. If you want the best possible results in the shortest possible time it is imperative that you follow our prescribed recommendations.

Your understanding is greatly appreciated.

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COLLECTION POLICY FOR MEDICAL SERVICES

To Our Patients:

Over the past 18 months, supplier companies have accelerated the cost increase for medicines, supplements, equipment and supplies we need to carry on out treatment programs successfully.

In addition, the government (OSHA) has laid down new regulations that significantly add additional costs in order for us to comply.

Also, as you may know, Medicare, and other insurers are adding more delays, more confusion and paperwork and are denying more claims. We are putting forth our best efforts to keeping our prices to patients from escalating or at least slow the process. Therefore, for patients receiving chelation treatments, payment for the week of services must be made the last day of the treatment week. New patients who will be receiving testing must pay the second day they are here, when testing is completed. All other general practice patients must pay when services are rendered.

McDonagh Medical Center does not participate or take assignment with any HMO, PPO, Medicare, Blue Shield, or any private insurance carrier. Payment must be made by cash, check, MasterCard, Visa, American Express or travelers checks. Because we do not have any agreements with your insurance carrier, any contact concerning the amount of payment is between you and your insurance carrier. We will continue, as we have in the past, to assist you in your insured claim procedures.

Please be aware that a service charge of 1½% per month, 18% APR, will be added to all overdue accounts. All overdue accounts are liable for legal and collection fees.

By signing this statement, you are acknowledging that you have read, understand and agree with our payment policy.

_____ _____

Patient Signature Date

_____ _____

Witness Date

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CONSENT TO MEDCIAL TREATMENT

Patient Name_____DOB_____Date_____

1. I hereby voluntarily consent to treatment and procedures by McDonagh Medical Center, his assistants or his designees as is necessary in the judgement of McDonagh Medical Center.
2. Permission is granted for prescriptions for my family to be packaged in containers without child-resistant safety caps.
3. It has been explained to me and I understand that Medicare or other health insurers do not generally cover the vitamin and mineral supplements at the clinic.
4. I agree that if I accept treatment, I shall be responsible for payment of all costs at the time of services.
5. Filing of insurance claims shall be on my own responsibility.
6. I have read and fully understand the information above.

Patient Signature_____Date_____

Patient Print Name_____

If patient is a minor or unable to consent, complete the following:

Patient (is a minor____years of age) or is unable to sign because _____

_____

Signature of legal guardian/power of attorney_____Date_____

Witness_____Date_____

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I,_____, hereby acknowledge by this statement that I have been fully informed that some and perhaps all of the medical services provided at McDonagh Medical Center on or after this date may be "Non-Covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. I realize that my insurance coverage and/or Medicare will deny payment for such services are not medically necessary and/or a non-covered service. I also understand there will be an additional charge for the follow-up appointment with the physician to get results. I will be personally responsible for payment to McDonagh Medical Center for all such services and procedures.
Services include any or all of the following:

X-rays	Hair Analysis
Plethysmography	Cytotoxic Food Testing
Blood test (Labs)	Hyperbaric Oxygen Therapy
Candida Skin/Blood Test	Nebulizers
Reconstructive Injections (Prolotherapy)	EKG
Treadmill (Stress Test)	Spirometry
Allergy Testing	Chelation Therapy
Prolozone Therapy	Ozone 10 Pass
Direct IV	Infrared Sauna
IonCleanse Foot Bath	O3 Insufflation

I have read, understand and agree to the above.

_____ _____
Signature Date

CHELATION THERAPY

I additionally understand that I am embarking on a series of EDTA Chelation Therapy treatments which will be administered on an intermittent basis from the date of signature to the completion of the Chelation Therapy program. During this time, I may also receive certain injectable medicines in conjunction with my treatments, which may include but are not limited to GH-3, Vitamin B12, Lasix, Adenosine and Colchicine.
I also understand that I am fully responsible for any and all expenses incurred by me to McDonagh Medical Center. I hereby understand and agree to the above.

_____ _____
Signature Date

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I,_____have received/read a copy of McDonagh Medical Center's Notice of Privacy Practices with a revised date of September 23, 2013.

Patient's Name_____Date:_____

Patient Signature_____

Witness_____Date:_____

Witness Signature_____

Patient Declined_____Patient Accepted _____Copy of Form

McDonagh Medical Center

2800 NE Kendallwood Parkway
Gladstone, MO 64119

Name _____

Date _____

Referred by: _____

Primary Care Physician: _____

Age: _____ Marital Status: _____

Occupation: _____

What is the main symptom or problem for which you are seeking treatment today?

_____

_____

How long have these symptoms been present?

_____

_____

Operations/Hospitalizations (not including pregnancies)

REASON	YEAR
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Current Medications (please include prescription and non-prescription)

MEDICATION	DOSAGE	SCHEDULE

Medication Allergies: _____

_____

Please check the appropriate box(es):

Medical History	Self	Parents	Siblings
Alcoholism			
Arthritis/Gout			
Asthma			
Bleeding Disorder			
Blood Transfusions			
Cancer			
Colon Trouble			
Depression			
Diabetes			
Dizzy Spells			
Emphysema/Black Lung			
Epilepsy/Seizures			
Gastrointestinal Changes			
Constipation			
Incontinence			
Glaucoma			
HIV/AIDS			
Heart Attack			
Hearing Changes			

Medical History	Self	Parents	Siblings
Hernia			
High Blood Pressure			
High cholesterol			
Jaundice/Liver Disease			
Kidney Disease/Stones			
Kidney/Bladder Infection			
Mental Illness			
Migraine/Headaches			
Pneumonia			
Rheumatic Fever			
Stomach/Duodenal ulcer			
Stroke			
Thyroid Disease			
Tuberculosis			
Urinary Changes			
Urinary Retention			
Incontinence			
Sexual dysfunction			
Visual Changes			

Social History:	N	Y	Freq.
Alcohol			# per week:
Coffee			# per day:
Soda			# per day:
Tea			# per day:
Tobacco			Pack(s) per day:

Which is your predominant hand? (please circle one)

Right Left

☐ Please check here if you are or think you might be currently pregnant