CENTER FOR FUNCTIONAL MEDICINE

practice guidelines and policies

effective April 1, 2023

A PERSONAL MESSAGE FROM DR LAUREN

Thank you for your interest in pursuing a partnership with me – I know there are a LOT of options and when it comes to your life, health and well-being, this is not a light decision. Here are a few foundational beliefs and expectations I have. If we are in alignment, then we can move forward together.

I believe when a doctor and a patient enter a relationship, a level or trust, dedication and love begins. I can only offer high quality care to a limited number of people. Therefore, the people participating in my practice are expected to make their health a top priority. The results you receive are often a reflection of the amount of energy invested in reaching your goals. I am here to help, support and at times guide, but most of the heavy lifting will be on you.

I believe that quality holistic care should be available to those that are truly interested and dedicated, despite their financial situation. I do offer financial hardship opportunities, opportunities for barter, and other forms of discounts when absolutely necessary. Therefore, if you are someone that can afford care (remembering this is a top priority), I invite you to offer the fair exchange for services. If you are truly someone that cannot, please feel free to make a proposal of what you CAN do.

I believe it is important to fill our "free time" with things we love and that bring us great joy! I am a dedicated mama to my 4 children at home (Noah, Hunter, Kylie and Clara) and I also choose to invest quite a lot of energy into each and every patient at work. Therefore, I ask that you choose a plan of care based on the level of support and energy you will need from me. Please make a list of requests, questions and anything else you think of between visits and try to hold them until your scheduled appointment. I also want you to feel free to contact me and I do appreciate updates on how things are going for you between our visits – because I do care that you are improving and getting the best care for you. Some matters are too much for a text message in which I will ask to shift to a phone call to discuss matters is necessary and there may be charges for this service.

I believe I am not the perfect fit for everyone and hope that all who are seeking answers, find their ideal practitioner. I strongly prefer our practice members to commit to a long term relationship and avoid the "quick-fix" mentality as that is a very difficult expectation to live up to. Obviously, I completely understand that life happens and things can change after you have made "plans", and will not ask you to sign a binding contract … I prefer to work on the "honest man's handshake" here.

By accepting care as my patient, you are agreeing to enter a mutually fair and rewarding relationship that will require work and dedication from both of us in order to reach your goals. I have laid out different options for levels of care and ask that you take some focused, quiet time with yourself to determine the best plan for you moving forward. If at any point the relationship is not mutually fair and rewarding, our agreement can be revisited. But honestly, I'm hoping and praying for miracles … so let's go!

A MAP TO NAVIGATE THIS GUIDE WITH EASE

ADMINISTRATIVE INFORMATION + AUTHORIZATIONS

HOLISTIC CHIROPRACTIC CARE OPTIONS

ADULT CARE PLAN OPTIONS

PEDIATRIC CARE PLAN OPTIONS

LABORATORY FEES + TESTING INFORMATION

INTENT OF TREATMENT

_____ I understand that my body is a self-healing and self-regulating organism, who's natural state is hardwired for health, healing and life. I believe that my body has the ability and potential to heal and this is what I desire for myself. I am seeking the **assistance** of Dr Lauren and/or Center for Functional Medicine to help facilitate this healing. I understand it is not the responsibility of Dr Lauren to "heal me" but to help re-connect me with my innate intelligence God has given me.

_____ I understand that the full intention of Dr Lauren and/or Center for Functional Medicine is to help and heal and never to do harm.

_____ I understand that with any medical procedure and in the practice of health care that negative reactions and/or side effects may occur. If any such reactions occur, I will notify Dr Lauren immediately.

_____ I understand that in order to follow my treatment appropriately, I must follow-up with visits and consultations to evaluate and monitor treatment and make appropriate changes as necessary. Some products and procedures are designed for short term use and others may be long term; and I understand it is my responsibility to keep Dr Lauren informed of my care through routine visits at time periods that we both agree to be appropriate.

_____ I understand that information shared between Dr Lauren, any of her staff and assistants, and myself (and if applicable, my children, spouse or other approved parties) is confidential; if visits or phone calls are recorded, all parties will be notified and offer their approval. Any recordings, treatments plans, and customized recommendations received by me, the patient, will not be shared with others, posted online or to social media or disclosed to other parties without consent from Dr Lauren.

_____ Should I ever feel that I want to offer negative feedback publicly or pursue legal action against Center for Functional Medicine LLC, Dr Lauren or any of her staff/assistants, I promise to notify her/them first to open up a line of communication about my dissatisfaction to see if we can find resolution.

Patient Signature: _____ Date: _____

Signature of Dr Lauren: _____ Date: _____

COMMUNICATION AUTHORIZATION

FOR PRIVATE USE OF EMAIL, PHONE AND TEXT

In order to communicate more efficiently with our patients, the Provider (Lauren Benakovich DC and/or Center for Functional Medicine) may use email, text and/or voicemail regarding our patients for non-urgent messages. These communications may include, but not limited to: appointment confirmations, scheduling, general questions, invoicing and billing information, communications with mutual health care providers, release of medical information and test results.

The Provider offers patients the opportunity to communicate by e-mail, text messages or voicemail. Transmitting patient information by e-mail, text messages or voicemail, however, has a number of risks that patients should consider before using e-mail, text messages or voicemail ("E-Messages"). These include, but are not limited to, the following risks:

- E-Messages can be circulated, forwarded, and stored in paper and electronic files
- E-Messages senders can easily misaddress an e-mail, text messages or voicemail
- E-Messages are easier to falsify than handwritten or signed documents
- Backup copies of E-Messages may exist even after the sender of the recipient has deleted his or her copy
- Employer and on-line services have a right to archive and inspect E-Messages transmitted through their systems
- E-Messages can be intercepted, altered, forwarded, or used without authorization or detection and can be received by many intended and unintended recipients
- E-Messages can be used to introduce viruses into computer systems

The Provider will use reasonable means to protect the security and confidentiality of e-mail, text messages or voicemail ("E-Messages") information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail, text messages or voicemail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of E-Messages for patient information which includes the following conditions:

- All E-Messages to or from the patient concerning diagnosis or treatment may be forwarded internally to Provider's staff as necessary and/or printed and added to the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails or text messages.
- Although Provider will endeavor to read and respond promptly to an E-Message from the patient, Provider cannot guarantee that any particular E-Messages will be read and responded to within any particular period of time. Thus, the patient shall not use E-Messages for medical emergencies or other time-sensitive matters.
- If the patient's E-Messages requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the E-Messages and when the recipient will respond.
- The patient should not use e-mail, text messages or voicemail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, metal health, developmental disability, or substance abuse.
- The patient is responsible for protecting his/her password of other means to access to e-mail, text messages or voicemail. Provider is not liable for breaches of confidentiality caused by the patient or third party.
- Provider shall not engage in e-mail, text messages or voicemail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- It is the patient's responsibility to follow up and/or schedule and appointment if warranted.

Please initial the following choices to indicate your agreement and acceptance:

_____ **E-MAIL :**

I authorize Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC to use electronic mail (e-mail) to contact me and/or other professionals involved in my or my child's care. I am aware that Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC does not use any specialized encrypted email software and cannot guarantee that information transmitted via e-mail will not be intercepted by other parties. By signing this form, I agree to not hold Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC or its employees responsible for any breach of confidentiality that may occur by someone else accessing the information continued in any emails sent to or from Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC regarding my or my child's personal health information. I understand that reasonable means will be used to protect the security and confidentiality of the email. All concerns to and from me regarding my or my child's personal health information will be a part of my or my child's medical record and can be viewed by healthcare and insurance providers and Dr Lauren's office support staff. My email will not be forwarded outside the office without my consent or as required by law.

Authorized email address: _____

Authorized email address: _____

_____ **VOICEMAIL :**

Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC has my permission to leave detailed clinical information on my voicemail or answering machine including but not limited to messages regarding appointments.

☐ Including health information, testing results, or treatment recommendations

_____ **TEXT MESSAGES :**

Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC has my permission to send clinical information to my cell phone including but not limited to messages regarding appointments.

☐ Including health information, testing results, or treatment recommendations

Authorized mobile number(s): _____

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail, text messages or voicemail between Provider and me, and hereby give my authorization to communicate with me, the patient, by e-mail, text messages or voicemail. Any questions I may have had were answered.

Patient Name: _____ Date: _____

Signature of Patient, Parent or Legal Guardian: _____

Signature of Witness: _____ Date: _____

RELEASE OF MEDICAL INFORMATION

AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

center for FUNCTIONAL MEDICINE

4375 Georgetown Road | Indianapolis | IN | 46254
tel | 317.617.3542 fax | 317.245.8100
support@drbenakovich.com
www.DrBenakovich.com

Patient Name: _____

Birthdate: _____ Phone: _____

Address: _____

Parent/Guardian Name : _____

I hereby authorize _____
(name of practitioner or facility) *(fax number)*

to take the following action:

ACTION REQUESTED:

- ☐ Provide a copy of **my health information** to me
- ☐ Release **my health information** to:
- ☐ Discuss **my health information** with:
- ☐ Obtain copies of **my health information** from:

CENTER FOR FUNCTIONAL MEDICINE	records@drbenakovich.com	317.647.1007
(name of other person, provider, or entity)	(email)	(fax number)

4375 GEORGETOWN RD	INDIANAPOLIS	IN	46254
street address	city	state	zipcode

For the dates of service from: _____to _____.

(records will be provided for all service dates if left blank)

PATIENT SIGNATURE: (Parent of guardian if applicable)	DATE:

RELEASE OF MEDICAL INFORMATION

AUTHORIZATION FORM

I _____ specifically request that the following individuals be granted access to medical information about myself (or if a minor, my child) without restriction: (i.e. spouse, grandparent, etc)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Pediatric Patients: Names of ALL patient for which this authorization applies: (list all children)

_____ _____

_____ _____

Signature of Patient, Parent or Legal Guardian: _____

Signature of Witness: _____ Date: _____

SCHEDULING GUIDELINES

Life can get busy and things we want to keep at top priority must get scheduled first. Since we ask that your care be a top priority for you, we also ask that you pre-schedule your follow-up appointments in advance so that we can also prioritize YOU.

Upon choosing your level of support and frequency of care, we ask that you have your calendar and schedule available so that we can take the time to schedule your visits together. We do have an online scheduling system that you may also use but have found it much easier to initially schedule these with you because of the number of services and choices we have – it can get overwhelming and confusing doing it on your own!

Follow-up visits must be scheduled in order to maintain an "Active Patient" status; should you need to reschedule, please notify our office within 24 hours of your scheduled appointment. Please review our "Missed Appointment Policy" for our cancellation and no-show procedures.

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

APPT DATE + TIME: _____ **APPT DATE + TIME:** _____

RESCHEDULING

Scheduling in advance is easy and re-scheduling should something more important come up is allowed! In order to avoid any fees or charges for late notices, we ask that you **please contact us AT LEAST 24 HOURS BEFORE your scheduled appointment**.

MISSED APPOINTMENT POLICY (MAP)

This policy is in place as a written understanding between our office and our patients in regards to maintaining a peaceful practice and flow to scheduling. We absolutely understand that LIFE happens and will do our best to accommodate changes as necessary on an individual basis when applicable.

- Any appointment not cancelled and rescheduled within the 24 hours of the scheduled appointment may be subject to a late cancellation or MAP Fee;
- Please notify our office of the need to cancel by telephone at 317-617-3542; you may leave a message or send a text message;
- The MAP Fee may be up to the full cost of your scheduled appointment. If a MAP Fee is charged, here are the general guidelines for charges:
    - First missed appointment may be charged up to 25% of the booked appointment fee
    - Second missed appointment may be charged up to 50% of the booked appointment fee
    - Third missed appointment may be charged up to 75% of the booked appointment fee
    - All continued missed appointments will be charged the full price of the scheduled appointment

By signing your name below, you are stating that you have read and understand our Missed Appointment Policy and promise to do your best in upholding this agreement. Should our office see fit to charge a MAP Fee, we will notify you of the charge and your account will be billed within 7 days of the missed appointment.

Patient Name: _____ Date: _____

Signature of Patient, Parent or Legal Guardian: _____

Signature of Witness: _____ Date: _____

MISSED APPT DATE: _____ CHARGE: _____ DATE CHARGED: _____

MISSED APPT DATE: _____ CHARGE: _____ DATE CHARGED: _____

MISSED APPT DATE: _____ CHARGE: _____ DATE CHARGED: _____

MISSED APPT DATE: _____ CHARGE: _____ DATE CHARGED: _____

FINANCIAL EXPECTATIONS

I believe *that quality holistic care should be available to those that are truly ready and dedicated, despite their financial situation. I do offer financial hardship opportunities, opportunities for barter, and other forms of discounts when absolutely necessary. Therefore, if you are someone that CAN afford care (remembering this is a top priority to you), I ask that you please offer a fair exchange for services. If you are truly someone that cannot, please feel free to make a proposal of what you CAN offer and/or do in order to make the energetic exchange "fair"; please keep in mind we will verify income and request financial documents before approval is finalized.*

Important things we would like to highlight for clarity:

_____ We do offer a sliding scale fee schedule available to all patients that are unable to pay for services in full. We ask that payment for services is **paid before or at the time of services rendered** unless previous arrangements have been made.

- Please have your check or card ready for prompt processing if paying at the time of services.
- Patients may keep their card information on file for an easier checkout experience – paid invoices will be emailed!
- Monthly auto-bill patients must have the scheduled "Credit" on their account at their visit or payment will be expected at the time of service.

_____ All patients on a monthly auto bill plan will complete the Auto Bill Authorization Form.

_____ We do accept HSA but it is the responsibility of the patient to confirm with their carrier that all services and charges are acceptable under your individual plan.

_____ If you would like to submit your paid visits to your insurance to apply to your Out-of-Network deductible or for reimbursement, please complete the Superbill Request Form. All paid invoices will be emailed to the address provided on a monthly basis.

What is your preferred method of Payment? _____

Who is the responsible financial party for the patient? _____

Are you seeking financial hardship for your care with our office? _____

AUTO BILL AUTHORIZATION

If you would like to enjoy the convenience of automatic billing, simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

The payment terms and guidelines are still valid and any balances owed at time of canceling the auto-debit program are due within 10 days of cancellation. By signing the below terms, you agree to allow CENTER FOR FUNCTIONAL MEDICINE LLC to auto-debit the remaining balance due on your account to the credit card below if other arrangements have not been made within 10 days of cancellation.

Patient Information

Patient name: _____ Phone: ____-____-____

Payment Information

I authorize Center for Functional Medicine to automatically bill the card listed below as specified:

☐ At the time of services rendered. I authorize Center for Functional Medicine to keep my credit card information on file and bill for any and all services rendered and/or products received.

Amount $_____ Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ One Time

Start billing on: ____/____/____ End billing when:

☐ Contract expires: ____/____/____

☐ Customer provides written cancellation

Credit Card Information

We accept the following credit cards: **Visa, MasterCard, American Express, Discover**

Credit card type:

☐ Visa ☐ MasterCard

☐ Discover ☐ Amer Express

Credit card number: _____

Expires: ____/____

CVV Code _____

Cardholder's name:
(as shown on credit card)

_____

Cardholder's Zip code
(from credit card billing address)

_____

Cardholder's Signature:

_____

Date:

_____

SUPERBILL REQUEST

I would like to have insurance codes added to my PAID invoices for services received by Dr Lauren and/or Center for Functional Medicine LLC. My intent is to submit the "Superbill" to my insurance to apply to my Out-Of-Network Deductible or for possible reimbursement.

I understand this is not a guarantee of coverage or reimbursement. I understand these forms will be sent to the authorized email address via electronic mail (e-mail) and I give my authorization for these communications.

I understand that Dr Lauren and/or Center for Functional Medicine will not submit, verify or offer additional assistance in the filing of my claims outside of providing a copy of the PAID invoice, appropriate diagnostic codes, and a copy of or access to the NPI number.

Authorized email address: _____

Authorized email address: _____

PLEASE KEEP A COPY OF THIS FOR YOUR RECORDS IN CASE YOUR INSURANCE CARRIER REQUESTS THE INFORMATION AGAIN TO PROCESS YOUR REQUEST.

Important information they may ask for or request (please remember this is all included on the Insurance Claims Superbill Letter that is included in this packet and a link to the PDF is included in every invoice that is emailed as well.

NPI # 1144406224

center for FUNCTIONAL MEDICINE

4375 Georgetown Road | Indianapolis | IN | 46254
tel | 317.617.3542 fax | 317.245.8100
support@drbenakovich.com
www.DrBenakovich.com

To whom it may concern,

The enclosed paperwork is being submitted on behalf of our patient for reimbursement of moneys paid out of pocket. Because they value their health and the care they are receiving, they have been paying out-of-pocket at the time services are rendered. They have informed us that you, as their insurance carrier, may cover a portion of their care and would like to receive reimbursement for their investment.

We have provided individual superbills with CPT and ICD-10 codes that are relevant to their current treating condition. Enclosed you will find a superbill for each visit from Center for Functional Medicine, LLC.

All of our information has been provided below to facilitate the processing of this paperwork and payments.

Should you need any further information from us, please use the contact information listed below. Thank you very much for your timeliness in addressing this matter!

Yours in health,

Lauren Benakovich, DC
NPI # 1144406224
IN License # 08002369A (Lauren Benakovich)
Tax ID # 45-5613904 (Center for Functional Medicine, LLC)

To the patient:
Please enclose a copy of the front and back side of your insurance card when filing claims with your insurance carrier.

HOLISTIC CHIROPRACTIC CARE

For patients seeking a stronger connection to the innate intelligence that fuels life. Our holistic chiropractic adjustments and additional therapies help to remove the interference within your physical body, nervous system, immune system and beyond. Restoring balance, flow and function has far reaching effects beyond pain management! Treatments may include manual and/or instrument chiropractic adjustments , SOT pelvic blocking, Webster technique, cranial work, COX flexion-distraction, cold laser therapy (AKA Low Level Laser Therapy), Graston therapy, percussion, and more ...

CHIROPRACTIC NEW PATIENT VISIT $225 - $375

A history of your concerns and goals for treatment will be gathered at the initial visit. Includes either a brief or comprehensive physical evaluation followed with a discussion for recommended treatment options. Your first treatment is also included in this visit and will be based on medical necessity and with your full agreement. Follow-up recommendations and costs will also be reviewed for care moving forward. If you will be entering a wellness based care program, we have several different options available to our practice members including but not limited to:

- **"DROP-IN" VISITS:**
  - $50 for the more traditional adjustment (aka "the quick crack" 😊)
  - $75 for 15 minute treatment
  - $100 for 20 minute treatment
  - $150 for 30 min treatment

- **MONTHLY VISITS:**
  You have 12 visits to use over 12 months.
  - $840 / Year or $72 / Month → twelve 15 minute treatments
  - $1680 / Year or $145 / Month → twelve 30 minute treatments

- **EVERY 3 WEEK VISITS:**
  You have 17 visits to use over a 12 month period.
  - $1105 / Year or $95 / Month → seventeen 15 minute treatments
  - $2210 / Year or $185 / Month → seventeen 30 minute treatments

- **BI-WEEKLY VISITS:**
  You have 26 visits to use over the course of 12 months.
  - $1560 / Year or $135 / Month → twenty-six 15 minute treatments
  - $3120 / Year or $265 / Month → twenty-six 30 minute treatments

YES WE CAN CREATE A CUSTOM PLAN FOR YOU AND/OR YOUR FAMILY!

ANNUAL CHECK-UP (ACU) $750

YEARLY TRACKING OF YOUR PROGRESSION OR $75/MONTH

An ideal plan for those that are under care with another physician that are seeking a second perspective on how your health is progressing overall and those interested in more comprehensive wellness check-ups with a special interest in gut function and microbiome health.

The Annual Check-Up Plan includes:

- ✓ A **COMPREHENSIVE BLOOD CHEMISTRY PANEL** (outside blood draw required) that includes CHARTING services and an initial brief review with chart notes from Dr Lauren
  - Lab orders will be emailed or mailed to you at least 1 month prior to your appointment and must be completed at least 2 weeks prior to your appointment

- ✓ A **COMPREHENSIVE GUT AND DIGESTIVE STOOL TEST** or different tests through one of our specialty labs
  - Kit will be mailed direct to your home at least 8 weeks prior to scheduled visit and must be completed at least 1 month prior to your appointment

- ✓ Up to a **2-HOUR PHONE CONSULTATION or IN OFFICE VISIT**. This includes:
  - completely customized recommendations based on your goals and results from any lab testing;
  - a 2-point blood pressure evaluation (Ragland's Test);
  - physical exam including tongue, finger nails, toe nails, eyes, and skin;
  - hands-on "gut check" for Hiatal Hernia, Ileocecal Valve Syndrome, and Valve of Houston Dysfunction, cranial rhythms, subluxations, pelvic and sacral dysfunction;
  - pelvic blocking with percussion and distraction to release the pelvis, sacrum and lumbar spine to improve digestive and bowel function (if clinically indicated)
  - hands-on or instrument ADJUSTMENT for overall alignment and better balance and to address any clinically indicated restrictions or imbalances

- ✓ **Laboratory fees are not included** in this plan and will be billed through insurance if possible. Cash pay options are available and are based on current fees for testing charged by the lab and will be billed separately through our office. Cash or checks for these services are preferred and if paying by credit card, a processing fee may be incurred. Additional labs may be ordered for an additional fee.

Signature of Acceptance _____ Date Signed _____

Preferred method of Payment _____ Visit scheduled on _____

QUARTERLY CHECK-IN (QCI) $2200

QUARTERLY TRACKING OF YOUR PROGRESSION OR $220/MONTH

The perfect plan for those that are under care for a chronic condition that requires closer monitoring or for those seeking more answers and guidance on improving their function.

The Quarterly Check-In Plan includes:

- ✓ FOUR (4) **COMPREHENSIVE BLOOD CHEMISTRY PANELS** (outside blood draw required) that includes CHARTING services and an initial brief review with chart notes from Dr Lauren
  - Lab orders will be emailed or mailed to you 1 month prior to your appointment and must be completed 2 weeks prior to your appointment

- ✓ Up to EIGHT (8) "**SPECIALTY LABS**" per year – Please see the list of "specialty labs"
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment

- ✓ FOUR (4) **90-MINUTE PHONE CONSULTATIONS or IN OFFICE VISITS**. This includes:
  - completely customized recommendations based on your goals and results from any lab testing;
  - a 2-point blood pressure evaluation (Ragland's Test);
  - physical exam including tongue, finger nails, toe nails, eyes, and skin;
  - hands-on "gut check" for Hiatal Hernia, Ileocecal Valve Syndrome, and Valve of Houston Dysfunction, cranial rhythms, subluxations, pelvic and sacral dysfunction;
  - pelvic blocking with percussion and distraction to release the pelvis, sacrum and lumbar spine to improve digestive and bowel function (if clinically indicated)
  - hands-on or instrument ADJUSTMENT for overall alignment and better balance and to address any clinically indicated restrictions or imbalances

- ✓ **Laboratory fees are not included** in this plan and will be billed through insurance if possible. Cash pay options are available and are based on current fees for testing charged by the lab and will be billed separately through our office. Cash or checks for these services are preferred and if paying by credit card, a processing fee may be incurred. Additional labs may be ordered for an additional fee.

Signature of Acceptance _____ Date Signed _____

Preferred method of Payment _____ Visit scheduled on _____

MONTHLY PRIORITY VISITS (MPV) $4200

MONTHLY SESSIONS TO MAKE A MASSIVE IMPACT OR $400/MONTH

The perfect fit for those wanting to cross high quality chiropractic care with their functional medicine care or for those seeking care for a chronic condition that desires a very comprehensive approach with extensive testing capabilities.

This Monthly Priority Plan includes:

- ✓ Unlimited **COMPREHENSIVE and/or BASIC BLOOD CHEMISTRY PANELS** (outside blood draw required) that includes CHARTING services and an initial brief review with chart notes from Dr Lauren
  - Lab orders will be emailed or given to you directly at your regularly scheduled visit

- ✓ Unlimited "**SPECIALTY LAB**" orders for the year – Please see the list of "specialty labs"
  - Kit may ne be mailed direct to your home or distributed at your regularly scheduled visit

- ✓ TWELVE (12) **60-MINUTE PHONE CONSULTATIONS or IN OFFICE VISITS**. This includes:
  - completely customized recommendations based on your goals and results from any lab testing;
  - a 2-point blood pressure evaluation (Ragland's Test);
  - physical exam including tongue, finger nails, toe nails, eyes, and skin;
  - hands-on "gut check" for Hiatal Hernia, Ileocecal Valve Syndrome, and Valve of Houston Dysfunction, cranial rhythms, subluxations, pelvic and sacral dysfunction;
  - pelvic blocking with percussion and distraction to release the pelvis, sacrum and lumbar spine to improve digestive and bowel function (if clinically indicated)
  - hands-on or instrument ADJUSTMENT for overall alignment and better balance and to address any clinically indicated restrictions or imbalances

- ✓ **Laboratory fees are not included** in this plan and will be billed through insurance if possible. Cash pay options are available and are based on current fees for testing charged by the lab and will be billed separately through our office. Cash or checks for these services are preferred and if paying by credit card, a processing fee may be incurred. Additional labs may be ordered for an additional fee.

Signature of Acceptance _____ Date Signed _____

Preferred method of Payment _____ Visit scheduled on _____

ANNUAL PEDIATRIC (AP) $750

YEARLY TRACKING OF YOUR CHILD'S HEALTH STATUS OR $75/MONTH

This once-a-year check-up is the perfect addition to your child's regular medical care or for those parents that have opted to keep their child vaccine-free that are seeking different avenues to keeping their child at their full potential.

The Annual Pediatric Check-Up Plan includes:

- ✓ A **2-HOUR IN OFFICE VISIT** with consultation, evaluation and treatment if indicated. This includes:
  - completely customized recommendations based on results and current health status;
  - hands-on "gut check" for Hiatal Hernia, Ileocecal Valve Syndrome, and Valve of Houston Dysfunction;
  - hands-on or instrument ADJUSTMENT for overall alignment and better balance with cranial care, digestive work, or other hands-on soft tissue / organ support if indicated
- ✓ A **COMPREHENSIVE GUT AND DIGESTIVE STOOL TEST** through one of our specialty labs
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ The **OPTIMAL NUTRITION EVALUATION or METABOLOMIX** through Genova Diagnostics (No Blood Draw Required and completed at home)
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ A **FOOD INTOLERANCE / DIETARY ANTIGEN TESTS** through one of our specialty labs
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ **ONE (1) 15-MINUTE PHONE "CHAT" OR ONE (1) EMAIL MESSAGES** per year between visits to answer any questions or concerns that may arise.

- ✓ **Laboratory fees are not included** in this plan and will be billed through insurance if possible. Cash pay options are available and are based on current fees for testing charged by the lab and will be billed separately through our office. Cash or checks for these services are preferred and if paying by credit card, a processing fee may be incurred. Additional labs may be ordered for an additional fee.

Signature of Acceptance _____ Date Signed _____

Preferred method of Payment _____ Visit scheduled on _____

QUARTERLY PEDIATRIC (QP) $2200

QUARTERLY TRACKING OF PROGRESSION + FURTHER INVESTIGATION OR $220/MONTH

This seasonal evaluation is great for those kiddos dealing with any kind of health challenge or for those parents seeking a holistic approach to evaluating and tracking their child's nutritional status to keep them at their peak function.

- ✓ FOUR (4) **90-MINUTE IN OFFICE VISITS** with consultation, evaluation and/or treatment. This includes:
  - completely customized recommendations based on results and current health status;
  - hands-on "gut check" for Hiatal Hernia, Ileocecal Valve Syndrome, and Valve of Houston Dysfunction;
  - hands-on or instrument ADJUSTMENT for overall alignment and better balance with cranial care, digestive work, or other hands-on soft tissue / organ support if indicated
- ✓ Up to TWO (2) **COMPREHENSIVE GUT AND DIGESTIVE STOOL TEST** through one of our specialty labs
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ Up to FOUR (4) **OPTIMAL NUTRITION EVALUATION or METABOLOMIX** through Genova Diagnostics (No Blood Draw Required and completed at home)
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ Up to FOUR (4) **FOOD INTOLERANCE / DIETARY ANTIGEN TESTS** through one of our specialty labs
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ Up to FOUR (4) **15-MINUTE PHONE CONSULTATIONS OR FOUR (4) EMAIL MESSAGES** per year between visits to answer any questions or concerns that may arise.

- ✓ **Laboratory fees are not included** in this plan and will be billed through insurance if possible. Cash pay options are available and are based on current fees for testing charged by the lab and will be billed separately through our office. Cash or checks for these services are preferred and if paying by credit card, a processing fee may be incurred. Additional labs may be ordered for an additional fee.

Signature of Acceptance _____ Date Signed _____

Preferred method of Payment _____ Visit scheduled on _____

MONTHLY PEDIATRIC (MP) $4200

MONTHLY VISITS FOR HIGH PRIORITY CARE OF YOUR CHILD OR $400/MONTH

The perfect fit for those wanting a deep dive into functional medicine, nutrition, and holistic hands-on care to facilitate deep homeostasis, peak performance, and/or optimal growth for their child. If your child has been previously diagnosed with a more complicated health condition or has a more challenging past health history that you are seeking resolution and restoration from, this comprehensive plan give us the time, tools, and resources to make massive shifts.

The Monthly Pediatric Plan includes:

- ✓ TWELVE (12) **60-MINUTE IN OFFICE VISITS** with consultation, evaluation and/or treatment. This includes:
  - completely customized recommendations based on results and current health status;
  - hands-on "gut check" for Hiatal Hernia, Ileocecal Valve Syndrome, and Valve of Houston Dysfunction;
  - hands-on or instrument ADJUSTMENT for overall alignment and better balance with cranial care, digestive work, or other hands-on soft tissue / organ support if indicated
- ✓ Unlimited **COMPREHENSIVE GUT AND DIGESTIVE STOOL TEST** through one of our specialty labs
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ Unlimited **OPTIMAL NUTRITION EVALUATION or METABOLOMIX** through Genova Diagnostics (No Blood Draw Required and completed at home)
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ Unlimited **FOOD INTOLERANCE / DIETARY ANTIGEN TESTS** through one of our specialty labs
  - Kit will be mailed direct to your home 2 months prior to scheduled visit and must be completed 1 month prior to your appointment
- ✓ Unlimited "**SPECIATLY LAB**" orders for the year – Please see the list of "specialty labs"
  - Kit may ne be mailed direct to your home or distributed at your regularly scheduled visit
- ✓ Up to FOUR (4) **15-MINUTE PHONE CONSULTATIONS OR FOUR (4) EMAIL MESSAGES** per year between visits to answer any questions or concerns that may arise.

- ✓ **Laboratory fees are not included** in this plan and will be billed through insurance if possible. Cash pay options are available and are based on current fees for testing charged by the lab and will be billed separately through our office. Cash or checks for these services are preferred and if paying by credit card, a processing fee may be incurred. Additional labs may be ordered for an additional fee.

Signature of Acceptance _____ Date Signed _____

Preferred method of Payment _____ Visit scheduled on _____

THE COMPREHENSIVE BLOOD CHEMISTRY PANEL OPTIONS

ORDERED THROUGH MID AMERICA CLINICAL LABORATORIES

This gives a pretty comprehensive look at the **general** picture of the status of your internal biochemistry and to offer a **general** health check. **WHY DO WE REQUIRE LABS TO BE CHARTED?** It streamlines the review process and makes it easy to see **TRENDS** of what is happening from past to present so we can make better recommendations for your future health. It can allow us to detect pending problems that may be happening before something more serious arises.

- **CBC (complete blood count) with DIFFERENTIAL**
  - Platelet count
  - White blood cell count + differential: Neutrophils, Lymphocytes, Monocytes, Eosinophils, Basophils
  - Red blood cell + Hemoglobin + Hematocrit
  - MCV, MCH, MCHC, RDW, MPV
- **CMP (comprehensive metabolic panel)**
  - Glucose
  - Calcium
  - Sodium, Potassium, CO_2, Chloride
  - Total bilirubin
  - Total Protein, Albumin, Globulin
  - Alkaline phosphatase (ALP), Aspartate aminotransferase (AST), alanine aminotransferase (ALT)
- **IRON, TIBC w/ % Saturation and FERRITIN**
- **CERULOPLASMIN**
- **KIDNEY panel** (BUN, Creatinine, GFR) with **URIC ACID**
- Additional Metabolic markers: **Phosphorus, Magnesium** (Serum or RBC)
- Additional **LIVER ENZYMES**: Gamma-glutamyl transferase (GGT) and Lactate dehydrogenase (LDH)
- Additional Blood Sugar markers: **HGA1C and INSULIN**
- Adrenal Hormones (serum): **Cortisol and DHEA**
- **Complete THYROID panel with ANTIBODIES**
  - TSH, Total T_4 and Total T_3, Free T_4 and Free T_3, Anti-TPO and Anti-TGB, Reverse T_3, TBG
- Inflammatory / Cardiovascular Markers: **C-Reactive Protein, Homocysteine, Fibrinogen**
- **Lipid Panel**: Total cholesterol, Triglycerides, HDL, LDL
- **Vitamin D_3**
- **Candida Albicans Screen**

When submitting testing through your insurance, we will only order testing that is clinically relevant to your case and will comply with the guidelines of medical necessity and proper diagnosis codes. There is no guarantee that your insurance provider will cover all of the testing and is up to the patient to verify coverage and benefits prior to services being rendered.

For more information and locations of the lab please visit https://www.questdiagnostics.com/