# BACK TO HEALTH CHIROPRACTIC CENTER, LLC

617 N Jefferson, Lebanon, MO 65536 Tel: 417-532-2986 Fax: 417-532-2271

*Dr. Melani Crocker, DC MCSP*

Patient Name:______________________________________________

Address: ______________________________Apt/Suite: __________

City:_________________________State:____________________

Zip Code:____________Email:______________________________

Social Security #: __________________ Date of Birth: ______________

Age:_______ Home Phone:_________________________________

Cell Phone: ____________ Work Phone: _______________________

Employer: ____________________Occupation: ________________

Spouse's Name: __________________ Spouse's Employer: ____________

Work Phone:______________________________________________

Emergency Contact: _______________________________________

Emergency Contact #: ______________________________________

Who may we thank for referring you to our office? ________________________

Marital Status: Single Married Divorced Widow(er)

Race: White Black/African American American/Alaskan Indian Decline to Answer

Ethnicity: Hispanic/Latino Not Hispanic/Latino

**I am here today for an evaluation & possible treatment.**

______________________________ ______________________

Signature Date

Patient Name: ______________________________ Date: ______________

**Medications**

| Medication | Dose | Qty | Frequency | Form | | | | | | Route | | | | | Condition Treating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Name of Medications, Vitamins, OTC Medications | | | 1x daily, Morning & Evenings, Bedtime | Tablet | Capsule | Solution | Suppository | Topical | Other | Orally | Injection | Topical | Rectal | Other | Medical condition being treated by medication listed below? |
| *Ex. Lisinopril* | *20mg* | *1* | *1x Morning and 1x Bedtime* | *X* | | | | | | *X* | | | | | *High blood pressure* |
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**Allergies**

| Medication | Reaction | Date of Onset |
|---|---|---|
| *Ex. Codeine* | *Hives* | *11/1/2011* |
| | | |
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**Vaccinations:**

| | | | | | Date Received: | |
|---|---|---|---|---|---|---|
| Influenza Shot | Yes | | No | | Date Received: | |
| Pneumonia Shot | Yes | | No | | Date Received: | |

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(417)532-2986

## *Consent to use PHI*

### Acknowledgement for Consent to Use and Disclosure of Protected Health Information

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Back to Health Chiropractic Center, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Please list those whom we may give your information to:**

Name: ______________________________ Phone#: ____________________
Name: ______________________________ Phone#: ____________________
Name: ______________________________ Phone#: ____________________

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have **received** a copy of the Notice of Patient Privacy Policy. ______Patient Initials

**Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice of Treatment in Open or Common Areas**

Note that some of your treatment may be performed in an "open area". Private areas are available upon request to discuss your health information upon request. ______Patient Initials

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

***By my signature below I give my permission to use and disclose my health information.***

______________________________________________ ________________
Patient or Legally Authorized Individual Signature Date

______________________________________________ ________________
Print Patient's Full Name Time

______________________________________________ ________________
Witness Signature Date

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Lebanon, MO 65536
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# CONSENT FOR COMPLEMENTRY AND ALTERNATIVE EVALUATON AND THERAPY

I_____________________________ the undersigned below request and agree to holistic evaluation and treatment through Alternative medicine approaches which may include Homeopathic/Dietary Supplements/Herbal/Acupuncture and other complementary and alternative approaches. I understand that there is a lack of sufficient prior to the alternative medicine evaluation. I understand that a fee for Traditional Medical Consultation is separate from the fee for Holistic Evaluation. I also understand that the fees do not include the cost of and alternative medicine treatment, which includes alternative medicine remedies or approaches. I understand that I will be financially Responsible for all services rendered and products received and /ordered at the time of visit.

Please Initial _______

I consent that I knowingly, intelligently, and voluntarily accept the risk of the treatment provided with due care. I also understand that it is best to combine these approaches with Conventional Medical Treatment. If I choose to abandon Traditional Medical Treatment exclusively in favor of Complementary and Alternative Therapy approaches, I consent that I do so against the advice of Dr. Crocker and take full responsibility for this decision.

I understand that I would continue to monitor my condition through Convention Medical Treatment as well as Complementary and Alternative Medicine. I will do so by Consulting with both Dr. Crocker and my family physician. I Consent that I have been advised by Dr. Crocker not to eliminate or delay my Conventional Medical treatment without consulting with my family doctor.

Signature__________________________

Date______________________________

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**Lebanon, Mo 65536**
**417-532-2986**

# CONSENT FOR COMPLEMENTARY AND ALTERNATIVE THERAPY APPROACH PART 2

**My Physician Dr. Melani Crocker has clearly disused in detail the nature and purpose of the treatment, the expected benefits, potential side effects, and risk of the Complementary and Alternative Medicine. All the risk and benefits of Complementary and Alternative Medicine Versus Conventional Medical Care have been discussed.**

**I consent that I knowingly, intelligently, and voluntarily accept the risk of treatment provide with due care, I also understand that it is best to combine these approaches with Conventional Medical Treatment. If I choose to abandon Traditional Medical Treatment exclusively in favor of Complementary and Alternative Therapy approaches, I consent that I do so against the advice of Dr. Crocker and take full responsibility for this decision.**

**I verify that neither Dr. Crocker nor any of her staff have given me any guarantees or promises with respect to the outcome of the Complementary and Alternative treatment.**

**I also understand that some Acupuncture treatment devices are considered investigative devices.**

**Signature**________________________________

**Date**___________________________________

*Back to Health Chiropractic Center, LLC*

*Dr. Melani Crocker, DC MCS-P*

617 N. Jefferson, Lebanon, MO 65536 www.backtohealthteam.com Ph: 417-532-2986 Fax: 417-532-2271

Patient instructions for SAAT treatment:

. DO NOT wash your ears the day of your treatment.

. Avoid all food and drink 20 minutes Before examination (this includes water).

. Avoid if possible, 2 hours prior to your exam, taking any supplements, homeopathic formulas, herbs, especially mint, chocolate, coffee and herbal teas. These substances could interfere with energetic finding and render evaluation less effective.

. Continue to take conventional Western medication as prescribed by other physicians. However, if possible, avoid taking such medications 2 hours prior to your evaluation.

. Remove all jewelry before treatment.

. Do not wear perfume or cologne.

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## *Dr. Melani Crocker, DC MCSP*

Small semi-permanent needles have been inserted in the skin of your ear for treatment purposes. This is part of a treatment through the specialized ear micro system of acupuncture.

You are advised to do the following for the best results:

- Avoid exposing the treated ear to water as much as possible.
- Needles could be left in the ear for three weeks
- Normally no pain is felt at the site of the need unless the area is touched, you sleep on that side or you apply equipment on the ear such as telephones.
- As soon as you experience any continuous irritation, spontaneous pain or unusual feeling at the site of the needle/needles, or if the area appears red, please remove the involved needle immediately as instructed. It is imperative that you do so immediately as these signs may signal the beginning of an infection or inflammation. Call this office to schedule replacement of the needle.
- Needles for allergy treatment only will be replaced once, free of charge, if they fall out accidentally or spontaneously.
- If possible, try to minimize eating the food items being treated.
- If possible, try to avoid unnecessary exposure to the substance being treated (mold, dust, etc.)
- Needles must be removed if they need to undergo an MRI.
- Do not clean your ear the day of your appointment. If there is adhesive residue from previous treatments, ensure it is adequately removed no less than 24 hours before your appointment.

I hereby, acknowledge receiving and understanding the above instructions. I understand that no guarantees have been stated or implied by the above-named physician, designated assistants, or staff with respect to the outcome of the above listed procedure(s).

______________________________ ________________________

Signature Date

# DO ***NOT*** CLEAN YOUR EAR THE DAY OF YOUR APPOINTMENT!

**If there is adhesive residue from previous treatments, ensure it is adequately removed No Less than *24 hours* before your appointment.**

# Back to Health Chiropractic Center LLC

Dr. Melani Crocker, DC MCSP

- 617 N Jefferson Avenue, Lebanon MO 65536
- (417) 532-2986 Fax (417) 532-2271
- mcrocker@backtohealthteam.com bkoffice@backtohealthteam.com

## Instructions & Acknowledgements

## Following Soliman Auricular Allergy Treatment (SAAT)

Date: ________________ Patient Name: ______________________________

My signature at the bottom of this page acknowledges that all Back to Health Chiropractic Center staff has instructed me to adhere to specific guidelines after receiving SAAT ear acupuncture. I understand and agree that they shall be followed precisely. I acknowledge that I am personally responsible for following them:

1. I will continue to avoid the substances (allergens) to which I have been allergic. I acknowledge that the Back to Health Chiropractic Center has instructed me to NOT intentionally expose myself to allergens for which I have received treatment.
2. I will do my best to carefully maintain the semi-permanent acupuncture needles for the required 3 to 4 weeks. They will be removed at home by a family member, friend, or myself by lifting and peeling off the covering tape with a pair of tweezers.
3. I understand that if lifting the tape does not remove the ear acupuncture needles, they are easily pulled out (by the circular handle) with the tweezers.
4. I acknowledge that no promise or guarantee of results has been suggested by the Back to Health Chiropractic Center. I understand that I may be allergic to many different substances that could trigger similar symptoms.
5. I agree to only contact the Back to Health Chiropractic Center for advisement. I will NOT seek the opinions or advice from unqualified or inexperienced individuals (including other practitioners) via social media or other sources.
6. I understand that if I have received SAAT in support of allergy to foods (such as alpha ga/meat), and choose, on my own accord to try eating that food, I will strictly follow the following guidelines:
   a. I will test eating a portion of the food no larger than the size of a grain of uncooked rice.
   b. I will test eating only pure, plain unseasoned food
   c. I will wait at least 24 hours (with no evidence of allergic reaction) before trying it again.
   d. I will very gradually increase the size of the tested food (grain of rice, then pea size, then marble sized, etc.).
   e. I will NOT test by eating foods with spices, dry rubs, sauces, mixtures, preservatives, additives, natural flavorings, or other ingredients.
   f. I will NOT eat restaurant food (especially fast food) as a test
   g. I will NOT eat vacuum-sealed products as a test
   h. I will be aware of foods and non-food products containing carrageenan (red seaweed extract), as well as gelatin, marshmallows, and other substances derived from mammalian meat.
   i. I understand that if I voluntarily test exposure to an allergen, and it does bother me, I will save a sample of it (in a Ziplock bag stored in the freezer) and call the Back to Health Chiropractic Center immediately to discuss.

I understand and agree to the following the above guidelines. I acknowledge that I am personally responsible for my own choices; the staff of the Back to Health Chiropractic Center has instructed me to avoid intentionally testing the effectiveness of SAAT.

Signature: ______________________________

Printed Name: ______________________________