Dr. Scott Mullenmeister
Chiropractic Neurologist
Dr. Melanie Mullenmeister
Chiropractor
Dr. Cole Koons
Chiropractor

******PLEASE NOTIFY OUR STAFF IF YOUR HEALTH INSURANCE HAS CHANGED******

Today's Date ________________

First Name ______________________________ **Middle Initial** ____ **Last Name** ____________________________________

Suffix (Jr. Sr. III) ______ **Preferred Name** ______________________________________

Address ____ **City** ____________________ **State** ______ **Zip** _____________

Primary Phone __________________ **Work Phone** __________________ **Mobile Phone** ____________________

Best Contact Method: ___ **Primary Phone** ___ **Work Phone** ___ **Mobile Phone**

EMAIL: ____ **Place of Employment** _______________________________

DOB: ______________________________ **Age** ______ **Marital Status** (check one) ____ **Single** ____ **Married** ____ **Other**

Emergency Contact's Name __________________________ **Relationship** ________________ **Phone** _________________

****PLEASE NOTIFY STAFF IF THIS COMPLAINT IS FROM AN AUTO ACCIDENT OR IT HAPPENED AT YOUR WORKPLACE****

What is your main complaint today that you wish to seek treatment for? ____

When did your symptoms start? ____

Is this a **NEW** complaint? ☐ Yes ☐ No If a **NEW** complaint, please explain the incident: ______________________________

____

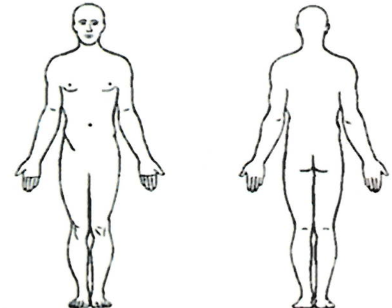
Are your symptoms interfering with your: Work___ Daily routine___ Sleep___ All___

What activities worsen your symptoms? ____

What activities improve your symptoms? ____

Are your symptoms getting progressively worse? Yes____ No ____

Mark an X on the diagram where you are experiencing your symptoms:



If your complaint involves pain, please characterize type:
☐Constant ☐Intermittent ☐ Ache ☐ Sharp ☐ Radiating ☐ Numbness/Tingling

Please rate the amount of pain you are generally experiencing (circle one):
Minor 1 2 3 4 5 6 7 8 9 10 *Severe*

Have you received any previous treatment for your complaint? Yes___ No___

Do you prefer: ☐ Manual Adjustments ☐ Thumper/Activator

Have you had any changes to your health history since your last visit? ☐ Yes ☐ No

If yes, please explain: ____

Have you been diagnosed with osteoporosis or osteopenia? ☐ Yes ☐ No

Have you had any changes in your **medications,** including **dosages and/or frequencies?** ☐ Yes ☐ No

If yes, please describe: ____

Are you currently taking Birth Control? ☐ Yes ☐ No If yes, What Type? (Pill, Injection, Etc.) ________________________

Are you pregnant? ☐ Yes ☐ No

Are you currently taking any Antibiotics? ☐ Yes ☐ No If yes, what is the name of the Antibiotic? ____________________

Is there a history of heart attack? ☐ Yes ☐ No **If yes, Year:**______ Is there a history of stroke? ☐ Yes ☐ No **If yes, Year:**____

Is there a history of seizures? ☐ Yes ☐ No **If yes, Year:**________ Do you have a pacemaker? ☐ Yes ☐ No

CHIROPRACTIC CENTER FOR HEALTHY LIVING PRIVACY NOTICE

1415 WEST HAVENS SUITE 3

MITCHELL SD, 57301

605-996-1160

I, ____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and accreditation

Printed Name: ____

Signature: ____

Date: ____

Chiropractic Center for Healthy Living Financial Policy

Please read and initial at each bullet point below. Ask if you have any questions!

- Payment is due at time of service. If you have a deductible that has not been met, we ask that you pay at least 50% of your visit today. We will bill you for the remaining amount after we hear back from your insurance.
- A co-pay may or may not cover all of your visit here. Some plans will cover only the actual chiropractic spinal adjustment. If you have a therapy/stretches/rehab these charges may be applied to your deductible in addition to your co-pay. It just depends upon your specific plan. We encourage you to be proactive and look into what your health insurance covers for chiropractic services – keeping in mind that chiropractic may be covered differently than medical.
- If you are here for a nutritional consult or a neurologic exam and treatment, this is not billable to your insurance and we will collect in full on the day of your treatment.
- We ask that you be aware that your insurance may have an annual limit to the number of chiropractic visits. While we do our best to keep track of this, only you are fully aware of how many visits you may have had throughout the calendar year – especially if you have been to other chiropractors. The best way to track this is to look up your specific plan on your insurance company's website. We will also ask that you sign a waiver in regards to this. If a visit gets submitted to your insurance AFTER you have reached your maximum number of visits, we reserve the right to collect for this visit in full if your insurance then denies coverage.

Insurance Waiver:

I, the undersigned, understand and have had it explained to me that my insurance may only cover up to a certain number of visits per calendar year. I am responsible to know how many visits I have through my policy and how many I have used. This will include any other chiropractic visits that I may have had at another facility. I also understand that the Chiropractic Center for Healthy Living may bill me for these items and services if they are not covered by my insurance policy, and/or I run out of chiropractic visits. I agree to be financially responsible for these services. These services may include: chiropractic adjustments, acupuncture, exams, extremity adjustments, rehab exercises, rehab stretching, IST table, electric stimulation therapy and ultrasound therapy.

Patient name: (Printed)____

Patient Signature:____Date:______________

Financial Policy waiver:

I understand that I am ultimately responsible for all charges on my account. I have read the above financial policy and understand and accept the terms as they are stated. I also assign directly to the Chiropractic Center for Healthy Living all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature:____Date:______________

(If minor, Parent or Policyholder signature)

Informed Consent Form

Patient Name: ______________________________ **Date:** ____________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel a sense of movement.

Analysis/Examination/Treatment

- Spinal manipulative therapy
- Range of motion testing
- Muscle strength testing
- Ultrasound
- Orthopedic testing
- Postural analysis
- Hot/cold therapy
- Mechanical traction
- Vital signs
- Basic neurological testing
- Acupuncture
- Electric stimulation
- Laser Therapy
- Nutrition Counseling
- Palpation

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during the examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Availability and Nature of Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter pain medications
- Prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.
I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Melanie Mullenmeister/Dr. Scott Mullenmeister/Dr. Cole Koons and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: ______________

____
Patients Name (Print)

____
Patient Signature

____
Signature of Parent/Guardian

Date: ______________

Melanie Puetz Mullenmeister, D.C.
Doctor's Signature

Scott Mullenmeister DC
Doctor's Signature

Cole Koons, D.C.
____
Doctor's Signature