

Precision Spinal Care, LLC

Dear Patient:

Welcome to Precision Spinal Care. We appreciate the confidence you have shown in us by making an appointment with one of our doctors. All of us - from doctor to office staff - will do our best to give you the finest spinal corrective care in a friendly and supportive environment. If you have questions at any time about your condition or your treatment, please let us know.

We are providing you with this packet of material to make it easier for you to gather information for your first appointment with us. In this packet are several forms that we ask you to fill out in the comfort of your own home. This information will enable us to prepare your chart quickly once you arrive at our office and will provide your doctor with the information he needs to begin taking care of you.

Please bring this completed material with you to your first appointment. We ask that you arrive at least 10 minutes prior to your scheduled appointment time to allow us time to prepare your chart and have the doctor review your case.

If you are unable to keep your appointment, we ask that you please notify us at least 24 hours in advance.

Please let us know if there is anything else we can do to make your first appointment with us more comfortable for you, or if you have any questions.

Sincerely,
The Precision Spinal Care Staff



Precision Spinal Care, L.L.C.
620 S. Jeffers St., North Platte, NE 69101
308-221-2880 or toll-free 877.484.5600

Patient Full Name _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

S.S.N.: _____ Date of Birth: _____

Marital Status: S M D W Sex: M/F Number of Children: _____

Email: _____ Referred by: _____

(only when you ask for information regarding your case)

Occupation: _____ Work Phone: _____

Employer Address: _____

Spouse / Parent: _____ Date of Their Birth: _____

Their Occupation: _____ Their Work Phone: _____

Their SSN for insurance: _____

Relationship to the Insured: Self Spouse Parent Other: _____

Mark the areas on your body where you feel the sensations described below using the appropriate symbol. Mark the areas of radiation, including all affected areas. Please mark an X on the area where the pain is the worst.

Aching
^ ^ ^ ^ ^

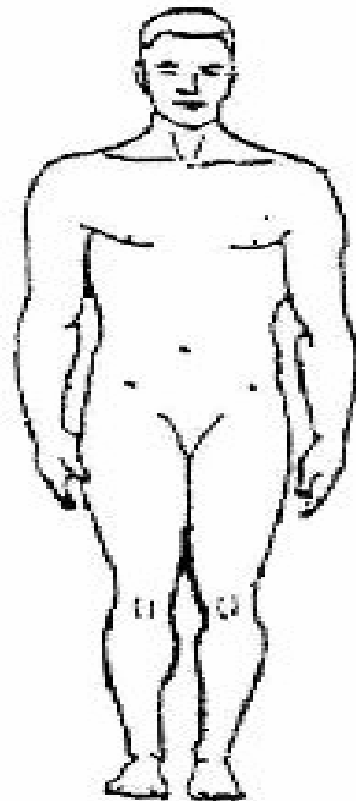
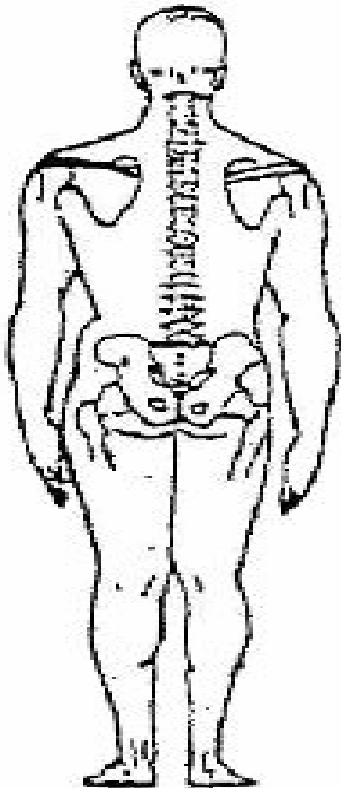
Numbness
=====

Pins & Needles
OOOO

Burning
XXXX

Stabbing
####

Times: Rare (R) less than 1/month Occasional (O) 1 time a week Frequent (F) 3 times a week Constant (C)



On a scale of 1 to 10, circle your pain.

At its very Worst: 0 1 2 3 4 5 6 7 8 9 10

Now: 0 1 2 3 4 5 6 7 8 9 10

Confidential Patient Case History

O - OCCASIONAL

F - FREQUENT

C - CONSTANT

P - PAST

GENERAL

- _____ Allergy
- _____ Chills
- _____ Convulsions
- _____ Dizziness
- _____ Fainting
- _____ Fatigue
- _____ Migraines
- _____ Headache
- _____ Loss of sleep
- _____ Loss of weight
- _____ Nervousness/depression
- _____ Neuralgia
- _____ Numbness
- _____ Sweats
- _____ Tremors

MUSCLE & JOINT

- _____ Arthritis
- _____ Bursitis
- _____ Foot trouble
- _____ Hernia
- _____ Low back pain
- _____ Lumbago
- _____ Neck pain or stiffness
- _____ Pain between shoulders
- _____ Pain or numbness in:
 - _____ Shoulders
 - _____ Arms
 - _____ Elbows
 - _____ Hands
 - _____ Hips
 - _____ Legs
 - _____ Knees
 - _____ Feet
- _____ Painful tail bone
- _____ Poor posture
- _____ Sciatica
- _____ Spinal curvature
- _____ Swollen joints

GASTRO-INTESTINAL

- _____ Belching or gas
- _____ Colitis
- _____ Colon trouble
- _____ Constipation
- _____ Diarrhea
- _____ Difficult digestion
- _____ Distension of abdomen
- _____ Excessive hunger
- _____ Gall bladder trouble
- _____ Hemorrhoids
- _____ Intestinal worms
- _____ Jaundice
- _____ Liver trouble
- _____ Nausea
- _____ Pain over stomach
- _____ Poor appetite
- _____ Vomiting
- _____ Vomiting of blood

EYES, EARS, NOSE & THROAT

- _____ Asthma
- _____ Colds
- _____ Crossed eyes
- _____ Deafness
- _____ Dental decay
- _____ Earache
- _____ Ear discharge
- _____ Ear noises
- _____ Enlarged glands
- _____ Enlarged thyroid
- _____ Eye pain
- _____ Failing vision
- _____ Far sightedness
- _____ Gum trouble
- _____ Hay fever
- _____ Hoarseness
- _____ Nasal obstruction
- _____ Near sightedness
- _____ Nosebleeds
- _____ Sinus infection
- _____ Sore throat
- _____ Tonsillitis

CARDIO-VASCULAR

- _____ Hardening of arteries
- _____ High blood pressure
- _____ Low blood pressure
- _____ Pain over heart
- _____ Poor circulation
- _____ Rapid heart beat
- _____ Slow heart beat
- _____ Swelling of ankles

RESPIRATORY

- _____ Chest pain
- _____ Chronic cough
- _____ Difficult breathing
- _____ Spitting up blood
- _____ Spitting up phlegm
- _____ Wheezing

SKIN

- _____ Boils
- _____ Bruise easily
- _____ Dryness
- _____ Hives or allergy
- _____ Itching
- _____ Skin eruptions (rash)
- _____ Varicose veins

GENITO-URINARY

- _____ Bed-wetting
- _____ Blood in urine
- _____ Frequent urination
- _____ Inability to control kidneys
- _____ Kidney infection or stones
- _____ Painful urination
- _____ Prostate trouble
- _____ Pus in urine

FOR WOMEN ONLY

- _____ Congested breasts
- _____ Cramps or backache
- _____ Excessive menstrual flow
- _____ Hot flashes
- _____ Irregular cycle
- _____ Menopausal symptoms
- _____ Painful menstruation
- _____ Vaginal Discharge

Yes No Are you pregnant?

Height: _____ Weight: _____ Avg. Body Temp _____

Immune System:

Past / Recent Illness: _____

Family History relative to your condition: _____

Are there records with other doctors / MRIs / examinations Relative to this case with another provider / hospital? Y/N

1. How serious is your problem to you: _____
2. How many years have you had each problem/pain: _____
3. How much time do you expect your pain / problem to heal: _____

PLEASE PRINT

List surgical operations and years: _____

Drugs you now take for : Nerve pills Pain killers Muscle relaxers "Pep" pill Tranquilizers Birth control pills

For: example heart _____

Age of mattress: _____ Comfortable Uncomfortable

Describe: _____

Are you wearing: Heal lifts Sole lifts Inner soles Arch supports None

Have you been in an auto accident Past year Past 5 years Ever None

Describe: _____

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:	YES	NO	Describe Briefly
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch, or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured / broken bone (s) ?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

ARE YOU:	YES	NO	Describe Briefly
Which vitamins / supplements are you taking?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Special Notes: If you have something important not found on this form, please use the space below:

HABITS:	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brush Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Are you interested in any further info in the following areas:
1. Nutritional advice? Y / N _____
 2. Air purification? Y / N _____
 3. Other information you may wish: _____

Precision Spinal Care, L.L.C.—Informed Consent Form

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a **rate between one instance per one million to one per two million cervical** spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care at Precision Spinal Care, a health history and physical examination will be completed. These procedures are performed by our doctors and are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a verbal care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary and to the chiropractic care including spinal adjustments, as reported following my assessment.

X

X

Patient Name (printed)

Signature Date

X

X

Patient or legal Guardian

Signature Date

Relationship to patient

Witness Signature (PSC staff)

Date

Questions regarding this form should be directed to the Precision Spinal Care Staff.

Medicare

Precision Spinal Care
620 S. Jeffers St., North Platte, NE 69101
308-221-2880 Toll-free 877.484.5600
Updated 1/3/2012

Only

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) some Chiropractic below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D)some Chiropractic below.

(D) Some Chiropractic Services	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:
Services other than chiropractic		
Office visits - (98940, 98941, 98942), manage, or, re-evaluate, or counsel.	Medicare or Medicare carriers allow a predetermined number of treatments per condition you report as long as progress is being made in the case	By Medicare Fee Schedule
X-rays, laboratory, supplies, vitamins		1 Adjustment - \$26 in CO
Non-spinal manipulation	Medicare doesn't cover the cost of x-rays taken in a chiropractic clinic	1 Adj - \$24 in NE, KS, WY
Maintenance Care - stable and not making improvements		X-rays \$76 / per visit as necessary
98940, 98941, 98942 (CMT) 12-18 visits		History & Exams \$98
		1 exam - \$21 in CO
		1 exam - \$19 in NE, WY, KS

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D)Chiropractic Services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the (D)Chiropractic Services listed above. You may ask to be paid now, but I also I want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the (D)Chiropractic services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

OPTION 3. I don't want the (D)Chiropractic services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Precision Spinal Care, L.L.C.

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Correction: A correction is the specific application of forces to remove a misalignment found in the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.
(Print name)

All questions regarding the Doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

X _____
(Signature)

(Date)

Welcome to our office! When you are done with these forms,
please give them to the front desk staff.

Precision Spinal Care, L.L.C.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your doctor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your doctor or the doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your doctor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **March 23, 2009.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

Directions to Our Office:

Highway 83 from the North: This road will turn into N and S. Jeffers St. Go south and keep on S. Jeffers. You will know you are close when you see cross streets begin to become W A st, then W B street and keep on going until you want to turn right on W G st. On the corner of G and S. Jeffers, is a brick building. Find a place to park and come right on in.

I-80: Near mile marker 177, the west North Platte entrance. We will want you to go north over the bridge (Fort Cody trading post will be on your right—very close to the highway). And go about 1 mile until you have made it past Runza, past the Howard Johnson, past the mall, past Dairy Queen. Then after DQ, you will want to turn left on G street and go one block. Right ahead on the north western corner you will see a brick building and that is our clinic. Find a place to park and come right on in.