Precision Spinal Care, LLC

Dear Valued 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 the completed materials 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 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

Directions to Our Office:

Highway 83 from the North: This Hwy turns into one-way streets through town– continue South and keep on S. Jeffers St. When the road widens to 3 lanes, get in the far right lane. You will know you are close when you see the cross streets begin to say W. A Street, then W. B Street and keep on going until you see W. G Street—turn Right. Immediately to the right our office sits on the corner of G and Jeffers. It is a small brick house. Find a place to park and come right in!

Highway 83 from the South: This Hwy turns into one-way streets through town– you will be on the North bound street called Dewey, this is a 3 lane street. After you pass through the intersection of Dewey and Phillip (there will be a Walgreens on the corner) you will need to get in the far left lane. You will see a Dairy Queen and the police/fire station on the left– the very next road is G street. Turn Left onto G street and go to the stop sign. You will be facing our office on the North West corner of G and Jeffers Street, it is a small brick house. Cross over the South bound Hwy (also called Jeffers St) find a place to park and come right in!

From I-80: Exit the interstate at the West North Platte exit #177. Turn to the North, you are now on Hwy 83. This Hwy is one-way streets through the town and is 3 lanes wide and is called Dewey Street. Stay in the center lane as you continue North passing the river, Walmart, The Mall, etc. When you go through the intersection of Dewey and Phillip Street (there is a Walgreens on the corner), get in the far Left lane. You will see Dairy Queen and the police/fire station. The very next road is G Street, make a left on G Street and go to the stop sign. You will be facing our office on the North West corner of G and Jeffers Street, it is a small brick house. Cross over the South bound Hwy (also called Jeffers St) find a place to park and come right in!

OFFICE USE: DR. MATT DR. ALLEN INS COMPANY _____ NO INS SR PLAN PAID _____

DRIVERS LICENSE OR STATE APPROVED ID VERIFIED: YES NO

PLEASE PRINT IN BLUE OR BLACK INK

IF YOUR INJURY IS DUE TO AN AUTO ACCIDENT OR IS WORK RELATED PLEASE SEE THE FRONT DESK FOR ADDITIONAL PAPERWORK

APPOINTMENT DATE:_____

Patient Full Legal Name:

_____Date of Birth:_____

Nickname/Preferred Name:_____ Gender: M F

Patient's Social Security # (***Required for insurance***): _____

Billing Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Cell Phone:_____

Email:_____

Occupation: _____

Marital Status: S M D W Spouse's Name:_____

How did you hear about our office: *(please list only one name & their relationship to you)*

_____

Do you want us to submit your visits to your **Health Insurance Company**?

YES NO

(We must have a legible copy of the front and back of your insurance card on file)

Is the patient the Primary Insurance holder? YES NO

Is the patient 19 years of age or older? YES NO

PLEASE COMPLETE THE FOLLOWING IF YOU ARE NOT THE PRIMARY INSURED OR YOU ARE THE PARENT/GUARDIAN OF MINOR PATIENT (UNDER 19 YEARS OF AGE) :

Your Full Legal Name :_____

Date of Birth:_____ SS# for Insurance:_____

Relationship to Patient: PARENT SPOUSE OTHER:_____

Address, if different from the patient: _____

_____

Please list the names and relationships of anyone you would like to have access to your information: (Each person listed will require a separate release to be signed)

_____

_____

_____

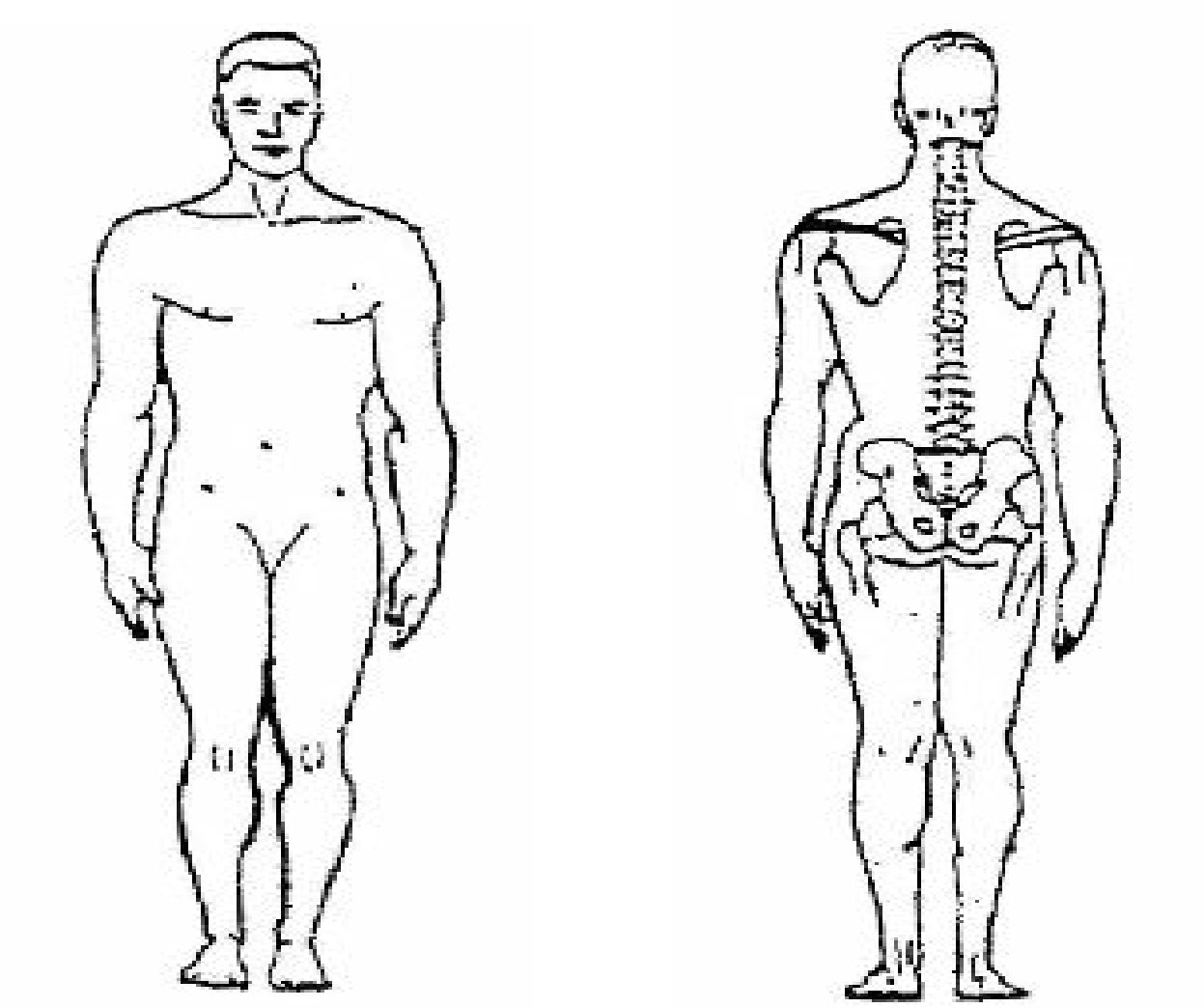
OFFICE USE: RELEASE(S) SIGNED: YES NO NUMBER OF RELEASES SIGNED: _____ STAFF INITIAL:_____

PLEASE PRINT

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**	**Burning**	**Stabbing**
^^^^^^	=====	OOOO	XXXX	####

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

What is your Primary Reason for the visit today: _____

HOW MANY YEARS HAVE YOU HAD EACH PROBLEM/ PAIN?_____
HOW LONG DO YOU EXPECT FOR EACH PROBLEM/ PAIN TO HEAL?_____
HOW SERIOUS ARE THESE PROBLEMS TO YOU?_____

PLEASE PRINT

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
BEEN KNOCKED UNCONSCIOUS?			
USED A CANE/ CRUTCH/ OTHER SUPPORT?			
BEEN TREATED FOR A SPINE OR NERVE DISORDER?			
HAD A FRACTURE/ BROKEN BONE?			
BEEN HOSPITALIZED FOR SOMETHING OTHER THAN SURGERY?			

DRUGS YOU NOW TAKE FOR: □ NERVES □ PAIN KILLERS □ MUSCLE RELAXERS
□ "PEP" PILLS □ TRANQUILIZERS □ BIRTH CONTROL PILLS
LIST MEDICATIONS: _____
_____
_____

VITAMINS/SUPPLEMENTS: _____
_____
_____

LIST SURGICAL OPERATIONS/YEARS: _____
_____
_____

DO YOU WEAR: □ HEAL LIFTS □ SOLE LIFTS □ INNER SOLES □ ARCH SUPPORTS
□ NONE

HAVE YOU BEEN IN AN AUTO ACCIDENT: □ PAST YEAR □ PAST 5 YRS □ EVER
□ NONE
IF YES,
DESCRIBE:_____

HAVE YOU EVER HAD A MENTAL OR EMOTIONAL DISORDER: □ YES □ NO
WHEN/
DESCRIBE:_____
OTHER FAMILY MEMBERS WITH DISORDER: : □ YES □ NO
WHEN/
DESCRIBE:_____
ANY PAST/RECENT
ILLNESS:_____
FAMILY HISTORY RELATED TO YOUR CONDITION:_____
_____

ARE THERE RECORDS WITH OTHER DRS/ XRAYS/ MRI'S/ TEST RESULTS...RELATED TO YOUR CONDITION? □ YES □ NO DESCRIBE_____
_____

HABITS:	HEAVY	MODERATE	LIGHT	NONE
ALCOHOL	□	□	□	□
COFFEE	□	□	□	□
TOBACCO	□	□	□	□
BRUSH TEETH	□	□	□	□
EXERCISE	□	□	□	□
SLEEP	□	□	□	□
APPETITE	□	□	□	□

MARK THE FOLLOWING:
0– OCCASIONAL
F– FREQUENT
C– CONSTANT
P– PAST

	GENERAL
	ALLERGIES
	CHILLS
	CONVULSIONS
	DIZZINESS
	FAINTING
	FATIGUE
	MIGRAINES
	HEADACHES
	LOSS OF SLEEP
	LOSS OF WEIGHT
	NERVOUSNESS
	DEPRESSION
	NEURALGIA
	NUMBNESS
	SWEATS
	TREMORS

	MUSCLE & JOINTS
	ARTHRITIS
	BURSITIS
	FOOT TROUBLE
	HERNIA
	LOW BACK PAIN
	LUMBAGO
	NECK PAIN/ STIFF-NESS
	PAIN BETWEEN SHOULDERS
	PAINFUL TAIL BONE
	POOR POSTURE
	SCIATICA
	SPINAL CURVATURE
	SWOLLEN JOINTS

	PAIN/ NUMBNESS IN:
	SHOULDERS
	ARMS
	ELBOWS
	HANDS
	HIPS
	LEGS
	KNEES
	FEET

	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 BLOOD

	RESPIRATORY
	CHEST PAIN
	CHRONIC COUGH
	DIFFICULT BREATHING
	SPITTING UP BLOOD
	SPITTING UP PHLEGM
	WHEEZING

	EYES/ EARS/ NOSE/ THROAT
	ASTHMA
	COLDS
	CROSSED EYES
	DEAFNESS
	DENTAL DECAY
	EARACHE
	EAR DISCHARGE
	EAR NOISES
	ENLARGED GLANDS
	ENLARGED THYROID
	EYE PAIN
	FAILING VISION
	FARSIGHTEDNESS
	NEARSIGHTEDNESS
	GUM TROUBLE
	HAY FEVER
	HOARSENESS
	NASAL OBSTRUCTION
	NOSE BLEEDS
	SINUS INFECTIONS
	SORE THROAT
	TONSILLITIS

	GENITO-URINARY
	BED WETTING
	BLOOD IN URINE
	FREQUENT URINATION
	INABILITY TO CONTROL BLADDER
	KIDNEY INFECTION OR STONES
	PAINFUL URINATION
	PROSTATE TROUBLE
	PUS IN URINE

	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

	SKIN
	BOILS
	BRUISE EASILY
	DRYNESS
	HIVES OR ALLERGIES
	ITCHING
	SKIN RASH
	VARICOSE VEINS
	ACNE

	FOR WOMEN
	CONGESTED BREASTS
	CRAMPS OR BACK-ACHE
	EXCESSIVE MENSTRUAL FLOW
	HOT FLASHES
	IRREGULAR CYCLE
	MENOPAUSAL SYMP-TOMS
	PAINFUL MENSTRUATION
	VAGINAL DISCHARGE

ARE YOU PREGNANT? Y / N

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.

_____

(Patient Name– PRINT) **(Patient Signature)** **(Date)**

_____

(Parent or Legal Guardian– PRINT) (Relationship to Patient) (Parent or Legal Guardian– Signature) (Date)

_____

Witness Signature (PSC staff) Date

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

CONSENT FOR TREATMENT AND AUTHORIZATION OF XRAYS

I have been informed by Precision Spinal Care that x-rays are advisable in my case, so that a complete analysis can be made of my present musculoskeletal problem (or illness).

I authorize Precision Spinal Care to perform the necessary radiographic examinations and to analyze and administer the proper care as is deemed necessary to treat my problem (or illness).

SIGNATURE :_____ DATE:_____

FEMALES ONLY: To the best of my knowledge, I an NOT pregnant at this time. Precision Spinal Care has permission to x-ray me for obtaining the information necessary to my case. INITIALS:_____

I am _____weeks pregnant and having been advised of the possible exposure due to the radiographic examination needed to properly treat my problem (or illness). INITIALS:_____

CONSENT FOR CARE OF MINOR CHILD

I_____(parent/ guardian), authorize Precision Spinal Care to adjust my child _____(child's name) and perform necessary tests to determine the condition of his/ her spine.

_____

(PARENT/ GUARDIAN) **PRINTED**

_____ DATE:_____

(PARENT/ GUARDIAN) **SIGNATURE**

Precision Spinal Care, L.L.C Financial Policy

The doctor/patient relationship is a partnership based on mutual trust and confidence. Following is our financial policy. We hope this clarifies the terms of our financial relationship with you. Should you have any questions, please don't hesitate to speak with a business representative.

We are committed to providing you with the best possible care. If you have Chiropractic coverage in your insurance policy, we will try to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy. You:

- Should assist in the follow-up with your insurance company, if requested.
- **Payment for service is due at the time of service**. We accept Cash, Checks, Visa, Master Card and Discover.
- Must meet all payment plan requirements should such a plan be authorized and implemented. Failure to do so will result in immediate action, including, but not limited to reporting your actions with a collection agency. *(this will be our last, not first, resort to settle account balances)*
- If your primary insurance is Medicare and you are 65 or older, we will be happy to offer you the Senior Discount Plan because **we do NOT bill to Medicare**. Because we will not bill to Medicare we can not bill to a secondary insurance plan.
- Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. We will provide you with a completed insurance form printed upon request. As a courtesy, we will file it with your primary insurance company. Our office does not bill secondary insurance companies.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
- Will be charged a $25.00 charge on returned checks for insufficient funds. If you have more than one returned check, your account will be placed on a cash or credit card only policy.
- **I understand that the charges in this office are my responsibility**. In the event that this account is turned over to an attorney or another agency for collection, the patient or guardian agrees to pay reasonable attorneys fee, all lawful pre and post judgment charges and necessary court costs.
- Regardless of any other provision in these terms, fee structures, and conditions, Precision Spinal Care (PSC) may change prices and any other terms and conditions at any time. Notice of such changes may be sent to customers at customer's billing address or online. If PSC does not exercise one of its rights in these Terms and Conditions, this does not mean it would not exercise it in the future. Neither the course of conduct between parties nor trade practice will modify any Term or Condition of this Agreement.

By Signing below, I agree that:

- I have read, understand and agree to the terms of the above policy statement.
- I understand that I am financially responsible to Precision Spinal Care for any charges.
- I authorize Precision Spinal Care to release any medical information necessary to process my chiropractic insurance claims. Furthermore, I hereby assign all money for which I am entitled for services to Precision Spinal Care if I have or keep a balance with the before mentioned group.

Patient Signature: _____ Date: _____

FEES FOR SERVICES RENDERED

There is no fee for consulting with the doctor. Fees begin when a spinal or spine related problem is found and you decide you want us to take care of you.

Establishing a New Patient:		**Rate for age 65 yrs and older :** (NO INURANCE FILED)
History & Report of Findings & Examination Cervical X-rays & X-ray analysis (Pre & Post) Initial Spinal Adjustment **TOTAL**	**$450.00**	**$250.00**
Routine Office Visits Spinal Examination and Spinal Correction	$ 60.00	$35

-There will be a charge for re-x-rays. If re-x-rays are necessary, they will be charged at $50.00 per film to a maximum of $100.00 per day. Services other than those provided on routine office visits may be charged separately. Fees are payable when service is rendered unless other arrangements have been made in advance. All prices are subject to change without notice.

I am responsible for payment of all charges.

_____ _____

(Signature) (Date)

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)

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

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

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.

(over)

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:_____