



NDS METHOD™ APPLICATION FORM

PERSONAL INFORMATION:

Name:					Today's Date:					
Home Phone:			Cell Phone:			Work Phone:				
Address:						City:				
State:		Zip:		Date of Birth: / /		Age:		Gender: M F		Marital Status:
Email Address:				Spouse's Name (if applicable):			Occupation:			
Last 4 of Social Security Number:				Employer Name:						
Best Way to Contact: (circle best) Phone Cell Email			How did you hear about our office?							
Chief Complaint: _____										
Have you had a MRI? NO _____ YES _____ When? _____ Where? _____										
Have you had Spinal Surgery? No _____ Yes _____ If Yes then When? _____										
Have you been recommended to have Spinal Surgery No _____ Yes _____										
Do you have any metal in your body? If Yes where? _____										

PRIMARY INSURANCE:

Insurance Co:			Name of Member:			Member's Date of Birth:		
Member ID:			Group ID:			Phone Number:		

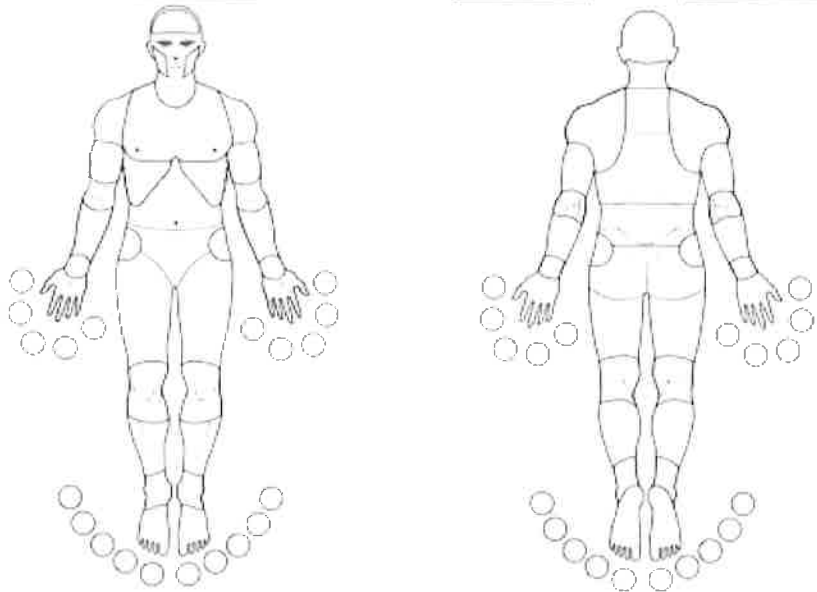
NDS Method™ Patient History Form

Patient Name: _____ Patient DOB: _____ Date: _____

On the diagrams to the right, please mark where you are experiencing any symptoms:

Use the following as a guide:

- P= Pain
- T= Tingling
- N = Numbness
- B = Burning
- W = Weakness



Is the pain constant? YES NO N/A Is the numbness/tingling constant? YES NO N/A

How long have you been suffering with your condition? _____

Have you had any problems like this in the past? _____

Has it been getting worse? YES NO If yes, how long has it been getting worse? _____

How would you describe the pain? Burning Ache Sharp Dull Deep Throbbing _____

How would you rate your pain on a scale of 1 (best) to 10 (worst)?

Currently: 1 2 3 4 5 6 7 8 9 10

At Its Best: 1 2 3 4 5 6 7 8 9 10

On Average: 1 2 3 4 5 6 7 8 9 10

At Its Worst: 1 2 3 4 5 6 7 8 9 10

Did your problem come on gradually or suddenly? Gradual Sudden Not sure

Was there any type of injury that may have caused your problem? _____

What aggravates your problem? Bending Lifting Twisting Turning Sitting Standing Walking

Sitting-to-Standing Laying Down Reading Computer Driving Getting in/out of vehicle

Other: _____

Do any of these **RELIEVE** the pain? Heat Ice Stretching OTC Pain Meds Rest Nothing Other: ___

Is your problem worse in the: Morning Afternoon Evening At Night During Sleep All the Same

Have you been told exactly what condition you have? _____

Have you tried any of the following?:

Results of treatment: (circle one for each)

Muscle Relaxers (Prescription):	YES	NO	No Relief	Worse	Temporary Relief
Anti-Inflammatory Meds (Prescription):	YES	NO	No Relief	Worse	Temporary Relief
Pain Medications (Prescription):	YES	NO	No Relief	Worse	Temporary Relief
Physical Therapy:	YES	NO	No Relief	Worse	Temporary Relief
Chiropractic:	YES	NO	No Relief	Worse	Temporary Relief
Massage Therapy:	YES	NO	No Relief	Worse	Temporary Relief
Acupuncture:	YES	NO	No Relief	Worse	Temporary Relief
Injections (including epidurals):	YES	NO	No Relief	Worse	Temporary Relief
Spinal Surgery:	YES	NO	No Relief	Worse	Temporary Relief

Have you been told you need an injection? YES NO By whom? _____

Have you been told you need spinal surgery? YES NO By whom? _____

Have you ever had:

A spine fracture? YES NO

Bone cancer? YES NO

Bone infection, disease, or disorder? YES NO

Abdominal aneurism? YES NO

Night cramping? YES NO ----> Hands Fingers Calves Feet Toes Right Left

Swelling? YES NO ----> Hands Fingers Legs Ankles Feet Right Left

Do you have any muscle weakness in the arms or legs yet? YES NO Arms Legs Right Left

Do you have any muscle atrophy (loss of muscle tone) yet? YES NO Arms Legs Right Left

How is this affecting your life? _____

How serious do you consider this? _____

What do you think will happen if left untreated? _____

What other surgeries have you had: _____

Charlotte Spine & Pain Relief Center
NOTICE OF PRIVACY PRACTICES

THIS IS A NOTICE OF PRIVACY PRACTICES WHICH 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 is effective as of January 1st, 2013

Charlotte Spine & Pain Relief Center is required by law to maintain the privacy of protected health information, and must inform you of your privacy practices and legal duties.

Charlotte Spine & Pain Relief Center is required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice of Privacy Practices at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room.

Charlotte Spine & Pain Relief Center has a Privacy Officer to answer any questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer will also take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is Dr. Helmebach. You may contact the Privacy Officer at (704) 573-7161.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

Charlotte Spine & Pain Relief Center may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

Charlotte Spine & Pain Relief Center may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the services should be covered.

Charlotte Spine & Pain Relief Center may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordination with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your rights

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have the right to receive confidential communications from us. If you want to receive bills and other information at an alternative address, please notify our staff.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. The limitations are as follows: 1.) Personal Injury cases 2.) Workers' Compensation cases and 3.) Accounts that have an outstanding balance with our office. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in the notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us by the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are required to make without your permission

In certain circumstances, we are required to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are required to make without your permission

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

Charlotte Spine & Pain Relief Center may assist in health oversight activities, such as investigations of possible health care fraud.

Charlotte Spine & Pain Relief Center may disclose information from your record as authorized by workers' compensation laws.

Charlotte Spine & Pain Relief Center may disclose information from your record as authorized to assist in the investigation of personal injuries and automobile accidents.

Charlotte Spine & Pain Relief Center may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to subpoena or other legal process, even if a court does not order this.

Our office staff may contact you at home or at work to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment. If you require an alternative contact location, please let our staff know.

Charlotte Spine & Pain Relief Center may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

Charlotte Spine & Pain Relief Center may contact you for marketing purposes like a testimonial video/written on website or in office.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Charlotte Spine & Pain Relief Center. (Please initial one of the following options and sign below.)

_____ I **do** wish to receive a paper copy of the Privacy Notice.

_____ I **do not** request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Charlotte Spine & Pain Relief to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Helmendach, about my concerns.

Patient's Name (Print)

Today's Date

Signature of Patient/Guardian

Patient's Date of Birth

Witness (Office Staff)

Date



AUTHORIZATION TO RELEASE INFORMATION

To: _____

I, _____ (print name) hereby authorize and request that you release a copy of my patient records containing protected health information, including any diagnoses, x-rays and other diagnostic imaging, laboratory studies, scans, prognosis, treatment and recommendations, as well as any other data pertinent to my treatment to:

Charlotte Spine & Pain Relief Center
7215 Lebanon Road Suite A
Charlotte, NC 28227
(704) 573-7161 Phone
(704) 573-3799 Fax

Date Signed

Patient's Signature

Expiration Date

Patient's Date of Birth

Witness (Office Staff)

Signature of Legal Guardian (for minor)



OFFICE POLICY

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially to see if their spine is developing abnormally? A spinal check-up is easy and fun for kids.

WE ALSO OFFER:

- Supplements, ice packs, nutritional/exercise counseling, custom orthotics.
Please ask if you have any questions about these services!

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule to allow someone else to use your time.
- Feel free to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care needs to end early.
- If your care is due to an accident, then all information must be obtained at the beginning of care.
- I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. They are here to help you any way they can. We want you to do great! ☺

OFFICE VISITS MAY INCLUDE:

- Specific Chiropractic Adjustments to promote mobility, stimulate soft tissue, improve nerve flow, enhance alignment. This is when the Doctor works on your neck or back, sometimes making a popping sound. **\$50 to \$75**
- Extremity Adjustments to promote mobility, stimulate soft tissue, enhance alignment of extremity joints. **\$45**
- Non-Surgical Decompression to help with disc bulges/herniations or degenerative disc in neck or low back **\$60**
- Infra-red technology to promote circulation for neuropathy in hands or feet. **Cost varies for number of areas**
- Intersegmental / Mechanical traction to relax soft tissues, aid healing and mobility. This is the blue table with the rollers that effectively extend, stretch, and traction the spine. **\$30**
- Cold therapy to reduce swelling, this is the ice pack used on the area of concern. **\$10**
- Cold Laser Therapy to decrease inflammation in the area and promote healing. **\$20**
- Electric Muscle Stim. To control swelling, modulate pain, tone muscles. **\$27**
- Manual Therapy / Manual Traction to modulate pain, increase flexibility, reduce swelling, mobilize soft tissues. This is hands-on work to your spine or other joints, performed by the Doctor. **\$45**
- Therapeutic Exercises to improve spinal flexibility, strength and motion. These are stretches or exercises that you perform or the Doctor administers to you. Excellent for the neck, mid, and lower back. **\$45 per unit**
- Supports/Pillow/Braces if needed and as priced.

Patient: _____ Date _____ Staff _____

Paying for your care is easy here!

Mark and initial which one is you:

- No Insurance:
- Easy! Our Care Plans and simple payment arrangements have helped thousands of people and will work great for you too!
Initial_____
- Health Insurance:
- These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
 - **You pay us. We will send any insurance claims in for you that we can at no charge. We are out of network with all insurance companies so we might have to give you a special form. If they pay anything after your deductible, co-ins and co-pays are met, the money will go directly to you.**
 - Of course you can use your HSA, HRA and Flex dollars here!
 - For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.
Initial_____
- Auto Injury
- Auto related injuries are covered 100%. Even if you were at fault or were a passenger. You can get the care you need and it costs you 0 as long as we have all information.
 - All we need is your claim numbers, insurance company, and attorney info.
Initial_____
- Work Injury
- Work injuries are covered 100% for up to 12 weeks of care.
 - All we need is your claim number and Work Comp ins. info.
Initial_____
- Medicare
- Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
 - After this you will receive a significant Medicare discounts.
 - **Medicare supplements normally don't pay anything.**
Initial_____