



BOX 14114 Mesa, AZ. 85216

*Finding Joint problems  
where they hide most  
- during motion.*

( 855 ) 369-7291

Rev: 06/20

ACCOUNT STATEMENT

**ACCOUNT:**

First Name: \_\_\_\_\_ Last Name \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ can we communicate by text? Yes / No

ACCOUNT # \_\_\_\_\_

DIAGNOSIS: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

Services Provided:

| DOS   | POS | CPT   | MOD | Units | DX  | CHARGE | NPI        |
|-------|-----|-------|-----|-------|-----|--------|------------|
| _____ | 15  | 76499 |     | 1     | 1,2 | 775.00 | 1154612232 |
| _____ | 15  | 76496 | 22  | 1     | 1,2 | 450.00 | 1154612232 |

AMOUNT PAID \_\_\_\_\_ note: \_\_\_\_\_

FEDERAL TAX ID 86-0978472

BALANCE DUE \_\_\_\_\_

\_\_\_\_\_  
(Signature of Patient/Parent or Legal Guardian)

\_\_\_\_\_  
(Date)



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## DOCUMENTATION OF PROCEDURE

### CPT CODE: 76499 "Unlisted Procedure" Roentgenometric Procedure One or More Areas

This code requires a description of procedure to accompany it. This document fulfills this purpose.

The International Chiropractic Association's written policy for this procedure:

*Digital radiographic mensuration (per spinal region)*

Digital radiographic mensuration is a biomechanical analysis technique. Anatomical landmarks from digital dynamic motion x-rays (DMX) or plain film radiographs. Studies are recorded in a computer program for the assessment of the biomechanical components of the vertebral subluxation(s) and spinal distortions. The computer's analysis compares the computerized biomechanical model to the patient's data and generates a report. They have determined 76499 the appropriate code.

Please note that the CPT codes are owned and determined by the American Medical Association. CPT codes are not chiropractic specific and so this interpretation was made so that all payers will understand that this code *best* identifies this procedure. We are not aware of a more appropriate code for this procedure.

The procedure is called Computer-aided Radiographic Mensuration Aalysis (CRMA), also know as X-ray Digitization which includes: The technical component of loading the data into the computer and then the analysis of the data which will produce the CRMA report.

*Technical Component*

CRMA involves the computerized enhancement of DMX images and/or plain film radiographs. The process utilizes a computer with specialized software and requires detailed knowledge of human spinal anatomy by the doctor supervising the operation of that software. Magnification is compensated by the computer locking onto either the right or left identification marker on the films. Points must be placed at specific anatomical landmarks. Multiple positional images are analyzed. The result of this analysis produces an assessment of injury and impairment due to loss of motion segment integrity both for angular and translational integrity. This software demonstrates whether an injury has altered the relationship between spinal structures. Neither the patient nor his/her doctor can manipulate the results. The time required to screen, process the paperwork, perform the CRMA and forward the results is approximately 1 ½ to 2 hours. The CRMA report consists of both the Mensuration report and the biomechanical report.

*CRMA Report*

We are a prescription service providing objective diagnostic testing. The doctor utilizing our services has already established that he or she has medical necessity to employ the testing procedure. As an independent diagnostic testing facility, we cannot be held accountable for the referring doctor's pre- or post notes. The written script along with any medical necessity notes along with the report, accompanies all claims.

The Biomechanical Report is the precise interpretation of the mensuration analysis in a narrative format. A trained doctor performs the digitization process and a Board Certified M.D. Radiologist confirms the results are accurate.

### ABOUT NGC

The National Guideline Clearinghouse (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents. Their mission is to "provide physicians and other health professionals, health care providers, health plans, integrated delivery systems, purchasers, and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use." It was created by the Agency of

Healthcare Research and Quality (AHRQ), U. S. Department of Health and Human Services, in cooperation with the assistance of the A.M.A. and America's Health Insurance Plans (AHIP), a national trade organization representing 1,300 insurance companies who provide medical benefits to over 200 Million Americans. The criteria for inclusion in NGC are very stringent and our service of CRMA is listed in the guidelines as "X-ray Digitization." Therefore it has passed the NGC screening criteria. There is not another higher guideline listing in the USA that supersedes the NGC.

*AMA Guides to the Evaluation of Permanent Impairment*

The American Medical Association, in its *Guides to the Evaluation of Permanent Impairment*, list the following as acceptable means to rate impairment:

- Impairment due to loss of muscle power and motor function,
- Impairment due to abnormal motion of the spine,
- Impairment due to loss of motion segment integrity,
- Impairment due to disc problems,
- Impairment due to pain or sensory deficit, and segmental instability.

The CRMA report provides an *objective* diagnosis that the ordering physician can determine if an impairment is ratable.

It should be further noted that:

- Computer aided digitizing mensuration analysis software has demonstrated accuracy to 0.0023mm. Hand mensuration cannot approach the accuracy attained with advanced computer technology.
- The importance of utilizing CRMA is attested to by the following Supreme Court Ruling: *"If a physician, as an aid to their diagnosis, i.e., their judgment, does not avail themselves (sic) to the scientific means and facilities open to them for the collection of the best factual data upon which to arrive at their diagnosis, the results is not an error in judgment but negligence in failing to secure an adequate factual basis upon which to support their diagnosis or judgment."* The Pennsylvania Supreme Court, Smith vs. Yohe, 412 Pa. 94, at 105 (1963).

### **Benefits of CRMA to the Doctor and Patient**

- Provides the doctor with an unbiased outside opinion of the biomechanical condition of the spine.
- Provides specific information that can be used to modify the existing treatment plan or to further validate the appropriateness of the current established treatment plan.
- Assists in the determination of impairment.
- Provides the doctor with a better understanding of the extensiveness of the patient's condition or injury, so that the doctor can better manage his patient.
- Provides the doctor with an effective baseline, by which any further or past conditions can be measured against in order to more accurately assess between 2 injuries, should an apportionment be requested. This also allows the doctor to better understand a pre-existing condition, an aggravation of a pre-existing condition or a condition which is newly established as a result of the condition or injury.
- Provides a more accurate diagnosis for ligament injury, giving both the location and extent of injury. Spinal ligament injury can cause or contribute to numerous painful conditions for patients including muscle hypertonicity, tenderness, pain with movement, restrictions of movement, muscle weakness, referred pain including radiculopathy, sclerodermal pain and headaches.
- Undiagnosed spinal ligament trauma can lead the doctor to incorrectly believe that the patient has no physical objective findings and is, therefore, symptom amplifying the condition mentally, due to poor coping skills or malingering. This can be especially important when a disc injury is ruled out by MRI since many doctors then incorrectly assume no significant soft tissue injuries are present. A recent study {Saifuddin, a, et al., "Magnetic resonance imaging of the cervical ligaments in the absence of trauma," *Spine*, 2003, Aug. 1;28(15): 1686-91} conclude that with cervical MRIs "...the spinal ligaments

are commonly not visualized.” Since MRIs are unreliable for identifying these injuries, the diagnosis of ligament injury is very often missed in whiplash cases. Therefore if CRMA is not utilized, the patient may receive an incorrect diagnosis of “non-organic pain.”

- Provides a higher degree of safety for the patient who will receive adjustment or physical manipulative therapy as part of their treatment after any form of spinal injury. It shows the doctor the location and extent of the spinal injury.
- When the patient is injured and that injury leads to impairment, this has serious ramifications for the patient. The assessment must therefore be as accurate as possible. CRMA provides the highest level of accuracy currently available.
- When a patient is not responding the way that the doctor expected, the doctor will often want to investigate further to see if there is something that has been missed. DMX and CRMA is an ideal choice in these cases since in the case of cervical acceleration/deceleration injury, the diagnosis that is most often missed is that of ligament injury.

## **Conclusion**

Patients with symptoms or any dysfunction related to the spine want to know that their provider has done everything he or she can in order to be able to treat them in the most efficient, effective and safest manner possible. In this way the patient can be more confident or receiving the most rapid and complete recovery possible. When our company provides DMX and CRMA to its client doctors, it is assisting their patients to achieve those goals.



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## PATIENT AUTHORIZATION, ASSIGNMENT, LIEN, LIABILITY, AND RELEASE

### INSURED'S DIRECTION OF PAYMENT OF BENEFITS AMONG THE DIFFERENT ELEMENTS OF LOSS

I, the undersigned, have been advised by this facility that the preferred method of payment for services rendered is to be paid directly by me upon services rendered.

I hereby agree that if I receive payment directly, that I will immediately forward proceeds to the facility for payment of the incurred charges.

### AUTHORIZATION AND RELEASE

I authorize **Arizona Digital Motion X-ray and their Associates hereafter regarded as AZDMX**, to bill my own liability insurer for testing fees I incur. I authorize this facility to send notice of Assignment & Lien to my own liability insurer, to the liability insurer of the person I claim caused my injuries and to my attorney (if and when I engage one to represent me) for my claim. I further direct and authorize payment to be made directly to this facility for services rendered to me. I also, authorize the release of any medical information necessary to process my claim.

\_\_\_\_\_  
(Name of My Liability Insurer)

\_\_\_\_\_  
(Name of my Attorney)

\_\_\_\_\_  
(Name of Liability Insurer for the Person at Fault)

### HIPPA AUTHORIZATION FORM

I hereby consent and authorize the above mentioned providers to disclose this protected health information, copy of files, DMX, x-ray exams, all reports to be provided to all parties I have given authorization and release mentioned above and any entity required for the purpose of collecting payment for the services rendered by AZDMX.

This authorization shall be in force and effective until my account with AZDMX is paid in full and until my case is settled at which time this authorization to use to disclose this protected health information expires.

I understand that I have the right to revoke this HIPPA authorization in writing, at any time by sending such written notification to the "Privacy Officer" AZDMX at BOX 14114 Mesa, Az. 85216-4114. I understand that a revocation is not effective to the extent that the above mention providers have relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State law. My decision to sign this authorization or not, will in no way affect my treatment provided by this facility.

I understand that I have the right to:

1. Refuse to sign this authorization.
2. Inspect or copy the (PHI) to be used or disclosed as permitted under Federal or State law.

With my consent, this facility may call my home, office or cell phone. They can mail my home or office to carry out TPO such as appointment scheduling, itemized statements, request for additional information unless otherwise noted here:

I have the right to request and restrict how this facility uses or discloses my PHI to carry out TPO. However, they are not required to agree to my request restrictions. But if the facility does, *we are bound by our agreement.*

By signing this authorization I am consenting to this facility to use and disclose of my PHI to carry out TPO. If I decline to sign this consent, this facility may decline to provide testing to myself/child/children. I have been made aware of the company's **"NOTICE OF PRIVACY PRACTICES"** This statement included in this authorization are binding.

## ASSIGNMENT & LIEN

I acknowledge and accept that I am responsible for the full payment for services rendered. Unless other arrangements have been made, I will pay in full at the time of service. In the event that arrangements have been made and a balance is owed following the rendered service, I authorize direct payment of medical benefits from my insurance company, medical payments, the responsible party, any third party payer, and/or my attorney to Dr. Bruce B. Lee, D.C., MUA-C or Arizona Digital Motion X-ray.

In the event payment has not been made resulting in my account being sent to collections, I agree to pay the additional collection agency fees up to 21% of the outstanding balance at the time the account was placed with that agency. Should legal action be necessary to collect the account balance, I agree to pay the attorney's fees and court costs incurred for collection.

If I am going through an attorney, my signature also authorizes my attorney to withhold funds from my settlement in the amount owed for this service and pay directly to Dr. Bruce Lee or Arizona Digital Motion X-ray the balanced owed for services rendered to me. I accept this as a doctor's lien to be issued on my case. I also understand that should my attorney not wish to honor this doctor's lien and protect said doctor's interest, that I will owe immediately the balance in full.

I was involved in an accident in which I was injured for which I have or may have a claim against another person(s) for causing my injuries. In consideration of this agreement made with this facility, they have agreed to accept a down payment of \$550.00 and delay billing me the remainder of \$675.00 personally for the medical testing services rendered until resolution of my claim:

1. I now assign, without any right to later revoke, a part of any proceeds from my claim to fees incurred by me by this facility. I am not assigning any legal cause of action in my claim, but only prospective proceeds. I also assign to the facility my right to enforce the obligation of any insurance company to pay settlement proceeds (to the extent of the facility's fees) for **any** settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of my claim, I understand and permit facility to pursue payment from any source, including PIP benefits/medical payment coverage in an automobile liability policy.
2. **I understand that by signing this lien and any related documents, which I signed in connection with it that I understand the facility's fees. I have not relied on any statements by the facility, technician or my treating physician before entering this agreement. I understand that I remain fully responsible for facility fees not paid out on my claim. If I subsequently die or become totally disabled, this lien is binding on my estate and my personal representative(s).**
3. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant the facility a primary, non-contingent secured interest in all Proceeds to the extent permitted by law for the purpose of securing payment of my Charges.
4. I further agree to and hereby irrevocably waive any present or future right I may have, whether arising under a "Common Fund Doctrine" or other legal basis, to require the facility to reduce its Charges or balance by a proportionate or weighted share of my attorney's fees, cost and other expenses of pursuing collection of my claims, including the Facility Charges.

**I understand that it is my responsibility to remain aware of my account balance for services rendered. I have received notice of the fees from the facility, or if not, I will request the facility for one.**

5. I understand that this is an expressed contract to pay for the services rendered by this facility. I agree to pay my account balance in full and/or direct its payment from my claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account for services rendered, I agree that my remedy will be to resolve it with a separate action from my claim.
6. NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS THE FACILITY CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES, BUT MED PAY/PIP PROCEEDS PAID OR HELD BY MY ATTORNEY SHALL NOT BE SUBJECT TO DEDUCTIONS OF ATTORNEY FEES.
7. I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE

**ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THE FACILITY HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE FACILITY CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THE FACILITY.**

8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.
9. THIS LIEN SERVICES THE FOLLOWING PROVIDERS WITH BALANCES:  
(Arizona Digital Motion X-ray, Dr. Bruce B. Lee, D.C., and/or its assigns)

## **LIABILITY STATEMENT**

In addition to the I (we), the undersigned, acknowledge and attest that:

- 1) I (we) have chosen and give permission to have a digital motion x-ray performed on our person or persons to whom I (we) have legal guardianship over and that I (we) understand that the image will not be sent for interpretation until the minimum deposit has cleared from my account.
- 2) I (we) understand that if my deposit is declined for any reason, the interpretation of the digital motion x-ray will not be performed until at least the minimum is paid along with any associated fees from the decline.
- 3) I (we) will be responsible for the entire bill plus any additional fees should any litigation/collections be required regardless of receiving the interpretation and the outcome of that interpretation.
- 4) I (we) understand that should Arizona Digital Motion X-Ray and or Dr. Bruce Lee be paid for the x-ray services by a 3<sup>rd</sup> party (insurance company, Attorney, e.t.c.) any amount will be applied to the balance owed. If there is a credit on my account, Cedar Health Center/Arizona Digital Motion X-ray will refund that amount to me.
- 5) I (we) understand that, at the discretion of Arizona Digital Motion X-ray and or its assigns, may sell your account to another party. Should this occur, Arizona Digital Motion X-ray will no longer have any recourse for your account. Any and all agreements made regarding your account will transfer to the new servicer/owner of your account. In addition, any settlement arrangements, discounts, or write offs, not previously agreed to in writing, must be made by the new servicer/owner of your account.

I (we), the undersigned also confirm:

- 1) That I, the undersigned, am of legal age to sign this document either for myself if I am the one receiving this study or I am the legal guardian of the patient receiving the aforementioned study.
- 2) That the one receiving the Digital Motion X-ray does not have any contraindications for receiving this study such as pregnancy.
- 3) That I, the undersigned in behalf of myself or of who I have legal guardianship, hold harmless any injuries or financial burdens sustained resulting from this study as a result of negligence or non-disclosure on my part or that of my ordering physician.
- 4) That, although digital motion x-rays are of the lowest forms of radiographic diagnostic imaging, radiation is still being emitted and can cause damage to my health or birth defects in unborn children. I fully accept this responsibility of continuing with this study.

**By signing below, you are signing in full agreement for all terms and conditions set forth in all 3 pages of the PATIENT AUTHORIZATION, ASSIGNMENT, LIEN, LIABILITY, AND RELEASE.** ANY EXCEPTIONS MUST BE NOTED HERE PRIOR TO SIGNING:

☐ I AM IN FULL AGREEMENT AS SET FORTH

☐ I ACCEPT THE TERMS AND CONDITIONS SET FORTH WITH EXCEPTION OF:

\_\_\_\_\_  
Name of the legal guardian or patient

\_\_\_\_\_  
Name of the Patient receiving the study  
If different from the legal guardian

\_\_\_\_\_  
Signature of the legal guardian or  
Patient

\_\_\_\_\_  
Date signed

Patient's Attorney acknowledgement to honor the lien against this patient's case, by Arizona Digital Motion X-ray, as contained in these documents.

\_\_\_\_\_  
Attorney signature

\_\_\_\_\_  
Date of signature





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### MEDIA RELEASE FORM

I \_\_\_\_\_ Authorize the release of information, testimonials and pictures and video regarding my digital motion x-ray evaluation for the purposes of advertising and public education by Arizona digital motion x-ray, Cedar Health Center and its companies agents or assigns. I offer this release of information without gain or prejudice and hold harmless Arizona digital motion x-ray, Cedar Health Center and its companies agents or assigns as any result of exposure of this information.

I also understand that no personal identifying information such as my name or date of birth and address will be given, however, it is possible that someone may identify me from the information presented.

**X** \_\_\_\_\_

**Date** \_\_\_\_\_