Vertebral Motion Analysis
VMA™ Order Form

PATIENT NAME: _____ **DOB:** _____ **PHONE:** _____

MEDICAL NECESSITY: The patient above requires VMA Diagnostic Fluoroscopic Radiological Procedure for _____

_____

ICD-10(s) _____

ORDERED TEST CONFIGURATION (MUST SELECT ONE OR BOTH):

- ☐ **VMA™ Cervical Exam** – Fluoroscopic Two-view Flexion/Extension Series, assisted bending routine.
- ☐ **VMA™ Lumbar Exam** - Fluoroscopic Standard Six-view Flexion/Extension Series, and weight-bearing and non-weightbearing assisted bending routines.
- ☐ **VMA™ Cervical & Lumbar Exam**

_____

PAYMENT COVERAGE

- ☐ ***CASH PAY amount due $*** _____
- ☐ ***WORK COMP ADJUSTER'S NAME*** _____ ***PH*** _____
- ☐ ***ATTORNEY, LAW FIRM NAME:*** _____ ***PH*** _____
- ☐ ***PRIVATE INS RADIOLOGY REVIEW PHONE*** _____ ***CONTACT*** _____
- ☐ ***AUTH PENDING Y / N (CIRCLE ONE) AUTH#*** _____ ***HARD COPY RECEIVED*** _____
- ☐ ***MEDICARE / MEDICAID (circle one or both if applicable)***
- ☐ ***WAIVER SIGNED Y / N (CIRCLE ONE) *Advance Beneficiary Notice or Waiver of Noncoverage must be signed before the procedure if billing insurance in the interim of Third Party Liability cases.***

Referring/Ordering Physician for VMA™ Test

Physician Name: _____ **Physician Signature:** _____**Date:** _____

Preferred VMA Appointment Date: _____ **Physician Follow Up Appointment:** _____

To schedule an appointment please email support@vertebralmotiondiagnostics.com

Phone: 833-773-8VMA Fax: 833-773-8862

Vertebral Motion
DIAGNOSTICS

VMA™ Patient Instructions

Each VMA test takes about 30 minutes.
Please bring a picture ID with you to your appointment.

Clothing:
Please wear loose fitting clothes (sweat pants and t-shirts are ideal). For women please, wear a sports bra or any bra without metal components. If you have long hair, please wear your hair up so that it does not hang down below your neck. Please do not wear belts, jewelry, piercings or anything metal around your waist.

Eating & Drinking:
Do not eat or drink 4-6 hours prior to testing. If you are diabetic, have another medical condition or if fasting for 4-6 hours is not feasible for you, please eat as little as you are comfortable eating and to stick with "BRAT" foods (Banana, Rice, Applesauce, Toast). Also, you may bring juice or a snack with you.

Medication:
If you would normally take medication for lumbar back pain, please take these medications and any other medications as indicated.

The VMA test uses X-ray. If you are pregnant, or if there is a possibility that you may be pregnant, please notify your physician and facility in advance of the test.

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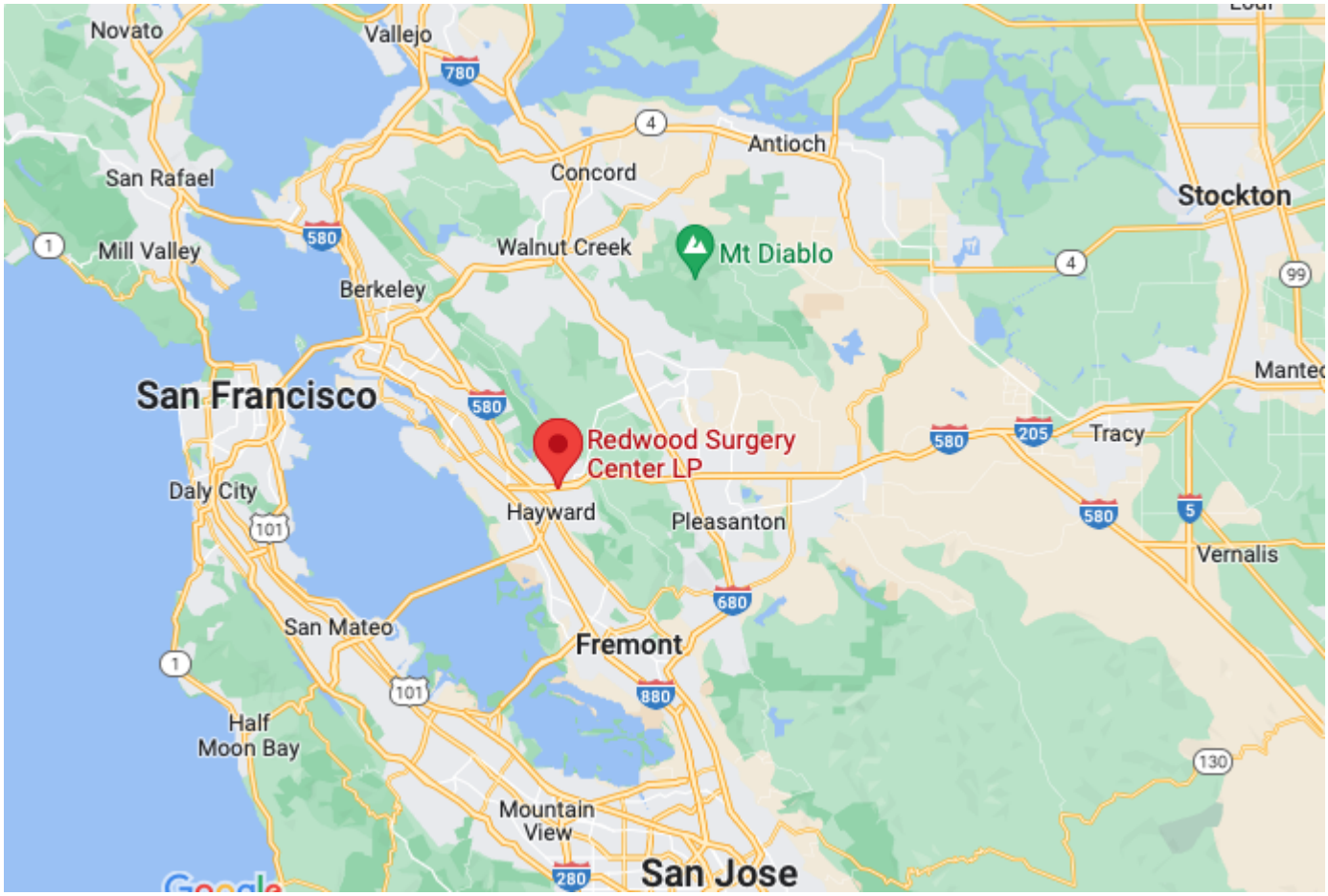
Email: support@vertebralmotiondiagnostics.com

20998 Redwood Rd. Castro Valley, CA 94546



VMA STUDY TAKES 20 - 30 MINUTES

BE SURE TO ARRIVE 15 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME

LATE ARRIVALS WILL BE RESCHEDULED

BRING YOUR PAPERWORK

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Vertebral Motion Diagnostics presents:

Vertebral Motion Analysis (VMA)

A breakthrough imaging technique that has greatly improved the diagnostic accuracy of the standard x-ray. VMA is the first functional test that provides diagnostic assessment of spinal injuries and spinal instability in real-time, providing a more accurate diagnosis of back and neck injuries. The VMA study helps locate the source of pain or discomfort in your spine, allowing your healthcare professional to make more informed decisions about your treatment options. VMA is dynamic, quantitative, functional spine imaging.

VMA PROCESS AND WHAT TO EXPECT:

During the study, the VMA machine will gently guide you through a spine-bending routine of flextion and extension movements. The routine should not cause any discomfort, but there is a "stop" button that can be pressed at any time to halt testing if you do begin to feel pain. Every second, advanced VMA software captures eight pictures of your spine. Images are then uploaded to VMA online servers, where they are processed to produce a report your physician will use to diagnose your condition. VMA's cloud-based system provides access to test results via any internet-connected computer, tablet, or smartphone, allowing results within 48 hours.
Benefits of VMA over traditional x-rays include:

- Provides important information that an x-ray might miss
- Detects spinal motion in real-time
- Less radiation than a standard x-ray
- 500% more sensitive in detecting lumbar radiographic instability

What VMA can uncover:

- Fracture/ Dislocation
- Disc degeneration
- Displaced disc
- Slipped vertebra

If you have been injured or are experiencing back or neck pain, please reach out to our courteous, knowledgeable staff at Vertebral Motion Diagnostics. We offer an array of advanced imaging technology that can assist your healthcare professional in determining a treatment plan that is customized to your needs.

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PATIENT DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION:

First Name: _____ MI: ____ Last Name:_____

Address: _____DOB: _____/_____/_____ AGE: _____
Street Address, City, State, Zip

Home Phone: _____Mobile: _____ SEX [ ]M [ ]F SSN: _____-_____-_____

EMAIL: _____ MARITAL STATUS [] SINGLE [] MARRIED [] DIVORCE [] WIDOWED

Emergency Contact: _____Phone _____

PATIENT'S EMPLOYER INFORMATION:

Employer: _____ Work Phone: _____

Address: _____ Is this visit Accident Related? [ ] Yes [ ] NO
Street Address, City, State, Zip [ ] Work Related [ ] Motor Vehicle Accident

RESPONSIBLE PARTY:

Guarantor Name: _____MI: _____Last Name: _____

Guarantor Address: _____DOB: ___/___/____
Street Address, City, State, Zip

Home Phone: _____ MOBILE: _____ SEX [ ]M [ ]F SSN: _____-_____-_____

INSURANCE INFORMATION:

Primary Insurance Name: _____Phone #_____

Policyholder Name: _____Group#_____ Policy#_____
Type of Plan: [ ]HMO [ ]PPO [ ]POS [ ]WORK COMP [ ]MEDICARE [ ] MEDICAID

Group Name: _____ Relationship to Patient _____

Secondary Insurance Name: _____Phone #_____

Policyholder Name: _____Group#_____ Policy#_____

Group Name: _____ Relationship to Patient _____

I hereby attest that the information provided above is true to the best of my knowledge.

_____ _____
Patient Signature Date

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Vertebral Motion
DIAGNOSTICS

CONSENT TO TREAT

I hereby authorize employees / agents of Motion Diagnostics (including physicians, physician assistants, nurse practitioners, and other employees /staff members) to render medical evaluations and care to the patient indicated below. I understand if the patient is a minor that this consent authorizes the foregoing person(s) to consent to medical and surgical procedures. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of medical emergency.

_____	_____	_____
PATIENT NAME (PLEASE PRINT)	SIGNATURE OF PATIENT / LEGAL GUARDIAN	DATE

LEGAL ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE, AUTHORIZATION FOR RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS OF THE HEALTH PLAN FOR PROCESSING & REIMBURSEMENT AS REQUIRED BY FEDERAL AND STATE LAWS

For the medical expenses incurred, I have insurance and/or employee healthcare benefits coverage captioned in the provider's New Employee Registration Form. I hereby assign the above named healthcare provider(s) as my designated Authorized Representative(s) and transfer directly all medical benefits and / or insurance reimbursement, if any, otherwise payable to me for services rendered by this provider and regardless of provider network participation. I understand and agree that I am legally responsible for any and all total charges regardless of any applicable insurance or benefit payments.

I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I authorize any plan administrator or fiduciary, insurer and my attorney to release to this provider any and all plan documents including Summary Plan Description and Master Plan Description, health plan policy and / or claim settlement information upon written request from such provider for the purpose of claiming such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and / or employee health benefit claim submissions.

I hereby transfer to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tort feasor insurer(s), with respect to any and all medical charges legally incurred as a result of the medical services received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to:

(1) obtaining information about the claim to the same extent as the assignor;
(2) submitting evidence;
(3) making statements about facts or law;
(4) making any request, or giving, or receiving any notice about appeal proceedings; and
(5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____	_____	_____
PATIENT NAME (PLEASE PRINT)	SIGNATURE OF PATIENT / LEGAL GUARDIAN	DATE

PREGNANCY QUESTIONAIRE

Patient Name: _____ DOB: _____

As a female of childbearing age, you must be advised that certain radiological procedures may harm an unborn fetus. If you are pregnant, all precautions must be taken to prevent harm to your unborn fetus. This includes not going through any radiological procedures if you are pregnant. In order to prevent any harm, it is required that you provide accurate and truthful information about all pregnancy related information including the following:

[ ] I have not been sexually active

[ ] I am on birth control

[ ] I am pregnant

[ ] I am not pregnant; LMP _____ [ ] Hysterectomy

I attest that all of the information that I have provided to Vertebral Motion Diagnostics, LLC. is truthful and accurate. If any such information is not accurate, I will hold Vertebral Motion Diagnostics, LLC, my physicians and all of their affiliates, harmless and not responsible for any and all claims for damages of any type (this expressly includes all claims of negligence) arising from any alleged harm to an unborn fetus, or any harm to me as a result of miscarriage and/or other harm to the unborn fetus.

I understand that it is my obligation to obtain a pregnancy test before any radiological test performed by Vertebral Motion Diagnostics, LLC.

Date: _____ Time: _____ am / pm (circle one)

_____ _____

Signature of Patient or Legal Guardian Print Name

_____ _____

Witness Name Relationship to Patient

I hereby refuse to submit to pregnancy testing and accordingly. I release and hold harmless Vertebral Motion Diagnostics, LLC, together with their affiliates from any damages or liability which may result from the radiological service at issue, including any claims for negligence or any other claim that I may have in law or in equity.

Date: _____ Time: _____ am / pm (circle one)

_____ _____

Signature of Patient or Legal Guardian Print Name

_____ _____

Witness Name Relationship to Patient

Vertebral Motion
DIAGNOSTICS

Personal Injury Lien Agreement

Patient Name: _____ Date of Injury: _____
Patient Address: _____ Place of Injury: _____
City, State, Zip: _____

Attorney Name: _____ Phone: _____ Fax: _____

I hereby authorize Vertebral Motion Diagnostics to furnish you, my attorney, with a full report of my examination, diagnostic test and report findings, etc. with regards to the date of accident referenced above.

I hereby authorize and direct you, my attorney, to pay Vertebral Motion Diagnostics such sums as may be due and owing for any and all medical services, evaluations, procedures, diagnostic tests rendered to me at any time during the treatment both by reason of this accident and by reason of any other bills that are due to the office and to withhold such sums from any settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Vertebral Motion Diagnostics for all bills submitted by them for services rendered to me and this agreement is made solely for said center additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may essentially recover said fee.

I agree to promptly notify Vertebral Motion Diagnostics of any change in legal representation in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this lien by signing below and returning it to Vertebral Motion Diagnostics. I have been advised that if my attorney does not wish to cooperate in protecting Vertebral Motion Diagnostics' financial interest, the center may declare the entire balance immediately due and payable.

_____ _____
Patient Signature Print Name Date

_____ _____
Treating Physician Signature Date

_____ _____
Representative Name Phone

_____ _____
Patient's Attorney Signature Date

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