



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO
NY PIP
P O BOX 9507
FREDERICKSBURG VA 22403

PIKA

1 MEDICARE <input type="checkbox"/> Medicare	2 MEDICAID <input type="checkbox"/> Medicaid	3 TRICARE <input type="checkbox"/> (DoD/DoDx)	4 CHAMPVA <input type="checkbox"/> (Member ID#)	5 GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> EOB <input type="checkbox"/> (HMO) <input type="checkbox"/> OTHER <input type="checkbox"/> (HMO)	6 INSURED'S ID NUMBER 0138739400101059 (For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		3 PATIENT'S BIRTH DATE 08/29/1980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE
5 PATIENT'S ADDRESS (No. Street) 56 BEREHAVEN DR LEFT		6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7 INSURED'S ADDRESS (No. Street) 56 BEREHAVEN DR LEFT	
CITY BUFFALO STATE NY ZIP CODE 14228		8 RESERVED FOR NUCC USE		CITY BUFFALO STATE NY ZIP CODE 14228 TELEPHONE (Include Area Code) (716)-536-0951	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N. A.		10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11 INSURED'S POLICY GROUP OR FECA NUMBER N	
b OTHER INSURED'S POLICY OR GROUP NUMBER		b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		b INSURED'S DATE OF BIRTH 08/29/1980 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
c RESERVED FOR NUCC USE		c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c OTHER CLAIM ID (Designated by NUCC)	
d INSURANCE PLAN NAME OR PROGRAM NAME		10d CLAIM CODES (Designated by NUCC)		d INSURANCE PLAN NAME OR PROGRAM NAME	
REREAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM					
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process my claim and payment of medical benefits either to myself or to the entity who accepts assignment below SIGNATURE ON FILE 01/05/2016					
13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below SIGNATURE ON FILE					
SIGNED _____ DATE _____ SIGNED _____					
14 DATES OF CURRENT ILLNESS, INJURY OR PREGNANCY (IPI) MM DD YYYY 01 04 2016		15 OTHER DATE QUAL: _____ NM: _____ DD: _____ YY: _____		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17 NAME OF INSURING PROVINCIAL OR OTHER SOURCE DR. PETER GUZINSKI M.D.		17b NPI: 17-0014188		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____					
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24)) ICD IND: 0 A: _____ B: _____ C: _____ D: _____ E: _____ F: _____ G: _____ H: _____ I: _____ J: _____ K: _____ L: _____					
22 RESUBMISSION CODE _____ ORIGINAL REF. NO. _____					
23 PRIOR AUTHORIZATION NUMBER _____					
24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMB. _____ D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS: _____ E. MODIFIER _____ F. DIAGNOSIS PENTER: _____ G. DAYS H. DATES I. ID J. RENDERING PROVIDER ID #					
25 FEDERAL TAX ID NUMBER 262448643 SSN/ENR 26. PATIENT'S ACCOUNT NO. 88430 27. ACCEPT ASSIGNMENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
28 TOTAL CHARGE \$ 707.11 29. AMOUNT PAID \$ 0.00 30. Rev'd for NUCC Use \$ (716) 839-3333					
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof) ALAM, UZMA, MD 01/06/16					
32 SERVICE FACILITY LOCATION INFORMATION BUFFALO DIAGNOSTIC IMAGING 1925 MAIN STREET AMHERST NY 14226-4081					
33 BILLING PROVIDER INFO & PH# BUFFALO DIAGNOSTIC IMAGING, P. BUFFALO MRI 4925 MAIN ST AMHERST NY 14226-4081 16212620666					

011116

2240995267



02 1P \$ 000.485
0004539306 JAN 06 2016
MAILER FROM ZIP CODE 14226

Buffalo NY 14226
4925 Main Street
Made easy for you!



BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature authorizes that payment be made and authorizes release or any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, hobby, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.2(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE participation cases; the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the fee charged submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured", i.e., items 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by health employee; 2) they must be integral, although incidental part of a covered physician service; 3) they must be of lands commonly furnished in physician's office; and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, other civilian or military (refer to 5 USC 6538). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 434.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OMB to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1662, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1080; 5 USC 8101 et seq; and 30 USC 901 et seq; 30 USC 613 E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies; for the effective administration of Federal programs that require other third parties pay to the primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 03-70-0301, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 127, page 37549, Wed Sept 12, 1990, or as updated and republished.

FOR OVICP CLAIMS: Department of Labor Privacy Act of 1974. "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA 5, ESA-8, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with debt collection claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 9801-9812 provides penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to document fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or omissions, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1107. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to OMB, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21261-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

3 Tesla MRI

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

PETER GUZINSKI, DC
345 DICK RD
DEPEW, NY 14043

Patient: DANIELLE HARWELL
DOB: 8/29/1980
ID: RAM1965183
DOS: 1/4/2016 1:16:16 PM, 1/4/2016
12:55:41 PM

1. CERVICAL MR
2. THORACIC MR

MRI CERVICAL SPINE W/O CONTRAST 30MIN,MRI THORACIC SPINE (DORSAL) W/O CONTRAST 30MIN

REASON FOR STUDY AND CLINICAL INFORMATION: MVA. Neck and back pain.

IMAGING SEQUENCES: Unenhanced multiplanar 3-T MR Imaging of the cervical spine is performed.

FINDINGS: The cervical spine is imaged from the skull base to the T3 vertebral body level.

The height of the cervical vertebral bodies is well-maintained. The cervical cord is homogeneous in signal intensity. There is mild reversal of normal cervical lordosis. No cerebellar tonsillar herniation is seen. No prevertebral soft tissue edema is noted and no edema is seen within the cervical vertebral bodies.

At C2-3 and C3-4, the canal and neural foramina are patent.

At C4-5, there is disc space narrowing and there is a shallow central disc extrusion. The canal and neural foramina still maintain their caliber.

At C5-6, a shallow central disc extrusion is seen which barely flattens the thecal sac. The canal and neural foramina are patent. Mild uncovertebral spurring is noted.

At C6-7 and C7-T1, the canal and neural foramina are patent. No annular bulge is seen.

There is a gentle right sided curvature of the lower cervical spine is noted.

IMPRESSION:

1. SHALLOW DISC EXTRUSIONS ARE NOTED AT C4-5, C5-6. THE CANAL AND NEURAL FORAMINA ARE PATENT THROUGHOUT THE CERVICAL SPINE.
2. THERE IS MILD REVERSAL OF NORMAL CERVICAL LORDOSIS. GENTLE RIGHT SIDED CURVATURE OF THE LOWER CERVICAL SPINE IS PRESENT.
3. THE MRI FINDINGS ARE CONSISTENT WITH PHASE 2 PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEBRAL SUBLUXATION COMPLEX.



Buffalo Diagnostic
Imaging, PLLC

Snyder Place
4925 Main Street
Amherst, NY 14226

P: 716.839.3333
F: 716.839.3338
Toll-free 888.MRI.3939

buffalomri.com

3 Tesla MRI

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

PETER GUZINSKI, DC
345 DICK RD
DEPEW, NY 14043

Patient: DANIELLE HARWELL
DOB: 8/29/1980
ID: RAM1965183
DOS: 1/4/2016 1:16:16 PM, 1/4/2016
12:55:41 PM

MRI THORACIC SPINE (DORSAL) W/O CONTRAST 30MIN**REASON FOR STUDY AND CLINICAL INFORMATION:** MVA. Neck and back pain.**IMAGING SEQUENCES:** Unenhanced multiplanar 3-T MR Imaging of the thoracic spine is performed.**FINDINGS:** The thoracic spine is imaged from T1-2 to the T12-L1 level.

The height of the thoracic vertebral bodies is well-maintained. No suspicious edema is seen within the thoracic vertebral bodies on the STIR images and no suspicious prevertebral soft tissue edema is seen. The height of the thoracic vertebral bodies is well-maintained and the thoracic cord is homogeneous in signal intensity.

From T1-2 to T9-10, the discs are well-hydrated. The canal and neural foramina are patent.

A hemangioma is seen within the T10 vertebral body.

At T10-11, mild facet arthropathy is seen. The canal and neural foramina are patent.

At T11-12 and T12-L1 the discs are well-hydrated. The canal and neural foramina are widely patent.

IMPRESSION:

1. THE CANAL AND NEURAL FORAMINA ARE PATENT THROUGHOUT THE THORACIC SPINE. THE HEIGHT OF THE THORACIC VERTEBRAL BODIES IS WELL-MAINTAINED. NO PREVERTEBRAL SOFT TISSUE EDEMA IS SEEN. A HEMANGIOMA IS NOTED WITHIN THE T10 VERTEBRAL BODY.
2. THE MRI FINDINGS ARE CONSISTENT WITH PHASE 1 PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEBRAL SUBLUXATION COMPLEX.

Thank you very much for referring this patient to us.

Sincerely,

**Buffalo Diagnostic
Imaging, PLLC**

**Snyder Place
4925 Main Street
Amherst, NY 14226**

P: 716.839.3333
F: 716.839.3338
Toll-Free 888.MRI.3939

Signed by UZMA ALAM, MD at 1/5/2016 8:33:15 AM

K K 1/4/2016 2:20:45 PM

buffalomri.com

Lancaster Depew Chiropractic

Jason D. Cichocki, D.C.
Peter J. Guzinski, D.C.
Lisa A. DeMarco, D.C.

FAX TRANSMITTAL

TO: Buffalo MRI

FAX#: 809-3338

PAGES INC. COVER: 4

FROM: Dr. Peter Guzinski

DATE: 12/30/2015

RE:

Danielle Howell - C/S, T/S, H/S MRI

Imaging is indicated but due to insurance regulations a script needs to be written by PCP. Please fax the script to our office at (716) 681-3037 or contact the patient directly.

ATTENTION:
CONFIDENTIAL INFORMATION ENCLOSED IS TO BE
VIEVED BY AUTHORIZED PERSONS ONLY.

IF YOU DO NOT RECEIVE ALL PAGES INDICATED PLEASE CALL OUR OFFICE AT (716) 681-3333

Danielle Harwell #3438 Wednesday December 30, 2015

Danielle Harwell #3438
56 Berehaven Dr, left
Amherst, NY 14228

Start Date : 11/12/2015
Phone - Home : 716-536-0951
Phone - Cell : 716-536-0951
Phone - Other :
Fax :
E-mail :
Social Security# : 055-70-3355
Date of Birth : 08/29/1980
Marital Status : Married
Spouse :
Case # : 1
Case Description : NF DOI: 10/31/15

Doctor : Peter Guzinski, DC (0-2)
Billing Profile : No Fault (ID#: 801)
Daysheet comment : DOI: 10/31/2015 *NP* Dr.James Panzarella
Ins Form Comment :

Effective Date :
Payer# 1 :
GEICO
PO Box 9507
Fredericksburg VA 22403-9526

Contact : 800-841-3000

Guarantor : Danielle Harwell
56 Berehaven Dr, left
Amherst NY 14228

Date of Birth : 08/29/1980
Sex : F
Employer : Kaleida Health
Group Name :
Group# :
ID# : 013873940011059
Rel. To Insured : Self

Diagnosis# : 1
Diagnosis Date : 11/12/2015

First Occurrence : 10/31/2015
Consult Date : 11/12/2015
Prev. Symptoms : No

S13.4XXA Sprain of ligaments of cervical spine, initial encounter
S16.1XXA Strain of muscle, fascia & tendon neck level, initial e

Page 2 Patient Information: Danielle Marwell

S33.5XXA Sprain of ligaments of lumbar spine, initial encounter
 S39.012A Strain of muscle, fascia & tendon lower back, initial e
 S23.3XXA Sprain of Ligaments of thoracic spine, initial encounter
 M54.12 Radiculopathy, cervical region
 M99.01 Segmental and somatic dysfunction of cervical region
 M99.03 Segmental and somatic dysfunction of lumbar region
 M99.02 Segmental and somatic dysfunction of thoracic region
 M99.05 Segmental and somatic dysfunction of pelvic region
 M54.2 Cervicalgia
 M54.5 Low back pain

Bill Payer# : 0
 Accept Assignment? : Yes
 Work Related? : No
 Accident Type : Auto
 Accident State : NY

Problem List

neck pain	Active
low back pain	Active

Allergies

Medication: Keflex
 Medication: codeine
 Medication: biaxin
 Medication: Clindamycin
 Medication: ranidin
 Medication: soma
 Medication: penicillin
 Medication: cipro

Medications (active/current)

pantoprazole 40 MG Delayed Release Oral Delayed Release Oral Tablet since
 CLARITIN Disintegrating Oral Tablet since

Reported Tests

none

Physical exam (vitals)

11/12/2015 Ht: 0' 0" Wt: 0 lbs.
 11/12/2015 Never smoker
 11/12/2015 Temp: 97.6 Resp: 0
 11/12/2015 BP (left): 170/80
 11/12/2015 Pulse (left/resting): 73

Buffalo MRI
High-Field & Open MRI Multi-Slice Spiral CT

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENTS OF BENEFITS FORM)**
(For Accidents Occurring on and After 3/1/02)

I, DANIELLE HARWELL ("Assignor") hereby assign to Buffalo Diagnostic Imaging, PLLC, all the right privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on the behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on , notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the action or conduct of the assignor.

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF THE MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM KNOWLINGLY MAKES OR KNOWLINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, OR DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

PATIENT: DANIELLE HARWELL

11/4/02	Danielle Harwell
Date	Signature of Patient

011116

00 00 0000 10 00

00





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/11

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARRIER -

PIKA										PICA							
1. MEDICARE [Checkmark] (Medicare)		MEDICAID [Checkmark] (Medicaid)		TRICARE [Checkmark] (DOD/DoD)		CHAMPVA [Checkmark] (Member ID)		GROUP HEALTH PLAN [Checkmark] (GHP)		FECA BACKLAW [Checkmark] (B&L)		OTHER [Checkmark] (O)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY				SEX M [] F []			
HARWELL, DAURILLE										8. PATIENT RELATIONSHIP TO INSURED Self [] Spouse [] Child [] Other []		4. INSURED'S LD. NUMBER 013673940-0101-059					
6. PATIENT'S ADDRESS (No., Street) 56 MERRIBEAU DR.										7. INSURED'S ADDRESS (No., Street) 013673940-0101-059							
CITY AMHERST					STATE NY					CITY							
ZIP CODE 14228					TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) [] YES [] NO							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? [] YES [] NO PLACE (State) [] YES [] NO [] (zip)							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? [] YES [] NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d CLAIM CODES (Designated by NUCC)							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below										11. INSURED'S POLICY GROUP OR FECA NUMBER							
SIGNED <u>ON 11-16-16</u>										DATE <u>11-16-2016</u>							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 14-31 2015 QUAL:					15. OTHER DATE MM DD YY 17a 17b NPI					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI							
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LABS \$ CHARGES [] YES [] NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										22. RESURREPTION CODE ORIGINAL REF. NO.							
A <u>M50.22</u>	<u>M51.29</u>	C <u>L599.03</u>	D <u> </u>	E <u>F</u>	G <u>H</u>	I <u>K</u>	J <u>L</u>										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 1 6 16 1 6 16 11 97140										B. TYPE OF SERVICE EMR CPT/HCPCS 2 144462011	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	F. DIAGNOSIS POINTER	G. DATES OR UNITS	H. FREQUENCY Per Day Per Month	I. ID QUAL	J. RENDERING PROVIDER ID # NPI
3 1 6 16 1 6 16 11 97140										ABC10K	55 700 3	NPI					
4 1 6 16 1 6 16 11 97140										ABC10K	55 700 3	NPI					
5 1 6 16 1 6 16 11 97140										ABC10K	55 700 3	NPI					
6 1 6 16 1 6 16 11 97140										ABC10K	55 700 3	NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? For non-items, see box [] YES [] NO	28. TOTAL CHARGE \$ 55.00	29. AMOUNT PAID \$ 0.00	30. Rev'd for NUCC Use 55.00				
099605323										31. SIGNATURE OF PHYSICIAN OR SUPPLIER including DISABILITIES OR CIRCUMSTANCES I declare that the services or supplies are furnished to the patient by me	32. SERVICE FACILITY LOCATION INFORMATION BARBERS, Dr.	33. BILLING PROVIDER INFO & PH# 716 725-0264					

SIGNED DATE 11/4/14

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offence under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

HEICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item B is completed, the patient's signature authorizes release of the information to the health plan or agency named. In addition to Medicare or TRICARE participation cases, the physician agrees to accept his charge determinations of the Medicare carrier or TRICARE as responsible party for the deductible, coinsurance and non-covered services. Co-insurance and the deductible are borne upon the charge determinations of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniform Services, anniversaries of service, or otherwise. In cases non-enrolled in "Inpatient," "In," "Area 1," "2," "6," "7," "8," and "11,"

BLACK LUNG AND RELATED DISEASES

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished any and all applicable law, regulations, and program instructions, which are available from the Medicare coordinator; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim (whether submitted by me or on my behalf) by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment regardless but not limited to the Federal and/or Statewide statute and Physician Self-Referral law under Medicare (as set forth on this form) to make medically necessary and personally furnished by me or were furnished incident to my professional services by my employee under my direct supervision except as otherwise expressly permitted by Medicare or TRICARE; 5) for each service rendered incident to my professional services, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering such service as reported in the designated section for Services to be considered "incident to" a physician's professional services; 6) they must be rendered under the physician's direct supervision by her/his employees; 7) they must be an integral, although incidental part of a covered physician service; 8) they must be of kinds commonly furnished in physician's offices; and 9) the portions of non-physician services must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services, am not an active-duty member of the Uniformed Services or a civilian employee of the United States Government, or a contract employee of the United States Government, or a contractor of the United States Government, either civil or military (relief to 6 USC 3639). For Blue-Loop claims, I further certify also, the services performed were for a Blister Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by section 101, and regulations (42 CFR 424.31).

NOTICE: Any one who misrepresents or omits essential information to receive payment from Federal funds requested by the family may upon conviction be subject to fine and imprisonment under applicable Federal laws.

MONTELE VO PROBLEMS? ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PEGA, AND BLACK LUNG INFORMATION (PRIVACY ACT ST-101-101)

We are authorized by CMS TRICARE and QWCP to ask you for information needed in the administration of its Medicare, TRICARE, PBCA, and Black Lung programs. Authority to collect information is in section 205(l), 1029, 1032 and 107 of the Social Security Act as amended, 42 CFR 411.24(j), and 424 Stat. (b), and 44 USC 3101 et seq; 44 CFR 10, et seq; and 10 USC 1070 et seq; 5 USC 8101 et seq; and 30 USC 901 et seq; 48 USC 619; E.O. 12857.

This information may be used to determine your eligibility for other programs and services you receive.

The information may also be given to other providers of services, cameras, intermediaries, medical record boards, health plans, and other organizations or Federal agencies, for the disclosure or administration of Federal provisions that require other third parties to pay primary to Federal programs and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 08-70-0501, titled, "Centex Medicare Claims Record," published in the Federal Register, Vol. 53 No. 177, page 37649, Wed. Sept. 12, 1990, as amended and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records" Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-6, ESA-6, ESA-12, ESA-13, ESA-80, or as updated and republished.

FOR TRIDARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and

ROUTINE USE(S). Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation.

concerning their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims; and to Congressional Offices in response to inquiries made at the request of the congressional offices.

DISCLOSURES: Voluntary; however failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment.

Under the proposed amendment, if a company fails to provide timely information, such as financial results, timely payment of the CRA's liability to provide financial information under PEPCA could be deemed an obstruction.

for withholding this information.

ing and Privacy Protection Act of 1988, permits the government

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible,

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by _____.

NOTICE This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that:

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 0595-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-06-08, Baltimore, Maryland 21244-2381. This notice is for comment purposes only. Response to this survey is voluntary.



Patient Name: Danielle Harwell

DOB: 08/29/80

Massage Therapy frequency of treatment: 1x per week for 8 weeks

- No Fault
- Workers' Compensation

Current Diagnosis:

M50.22, M51.26, M51.27, M54.12,
M23.3XXA, M99.01, M99.03, M99.02, M99.05,
M54.2, M54.5, M54.6

If you have any questions, please don't hesitate to contact our office at (716) 681-3333.
 Thank you for your time.

Sincerely,

Date: 01/06/2016

- Jason D. Cichocki, DC
- Peter J. Guzinski, DC
- Lisa A. DeMarco, DC

01 14 16

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(For accidents occurring on or after 03/01/02)**

I, Danielle Harwell, ("Assignor"/Patient's name - print), hereby assign to Colleen Marx, L.M.T., ("Assignee"/Print hospital or health care provider's name) all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51, (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on 10/31/15 (print date), notwithstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLES OR STATED CLAIM FOR EACH VIOLATION.

Patient/Client Information:

Danielle Harwell

(Print Name of Patient)

Danielle Harwell

(Signature of Patient)

56 Berehaven Dr.

11/11/16

(Date of Signature)

Amherst, NY 14220

(Full Address of Patient/Client on the 2 Lines Above)

Provider Information:

Colleen Marx, L.M.T.

Great Lakes Therapeutic Massage
& Bodywork Practitioners
375 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Marx



Colleen Marx
11/11/16

01 14 16

Needs notes
DAP

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Clark Rd Depew, NY 14204

Office: (716) 725-0204

Fax: (716) 725-0265

Client Name: Danielle Hanell Date: 1/16/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliges ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Cervical (posterior) Lumbar (PSIS)

Designating items by the end of the day, Lumbars to shoulders

Says into BLE's L > R, Client has numerous adhesions

Action's Applied: (Check All that Apply) in all cervical musculature.

- Heat Packs Cold Packs Sombra/Biofreeze Hypertonic through Light Pressure Massage Mod Pressure Massage Joint scapular
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretchies Co't Meds Ice / Heat

Therapist: Danielle Hanell

011416

Great Lakes Therapeutic Massage
& Bodywork Practitioners
375 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Marx

BUFFALO NY 142

11 JAN 2016 PM 2 L



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

2240352607





013873940-0101-059

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA													
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDC SEX/LING	OTHER	1a. INSURED'S ID NUMBER (For Program in Item 1)						
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	013873940-0101-059						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							3. PATIENT'S BIRTH DATE MM DD YY					4. INSURED'S NAME (Last Name, First Name, Middle Initial) <u>HARRELL, SEAN</u>	
							SEX M F					- OR - file -	
5. PATIENT'S ADDRESS (No., Street) <u>56 BEREHEAVEN DR</u>							6. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					7. INSURED'S ADDRESS (No., Street)	
CITY <u>AMHERST</u>			STATE <u>NY</u>		8. RESERVED FOR NUCC USE <u>X</u>					CITY			
ZIP CODE <u>14228</u>			TELEPHONE (Include Area Code) <u>(716) 604-7208</u>							STATE <u>()</u>			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FEDC NUMBER	
							b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>NY</u>					a. INSURED'S DATE OF BIRTH MM DD YY <u>M 01 01</u> SEX <input type="checkbox"/> M <input type="checkbox"/> F	
							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME							d. INSURANCE PLAN NAME OR PROGRAM NAME					e. INSURANCE PLAN NAME OR PROGRAM NAME	
							10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9e, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.							SIGNED <u>ON FILE</u>					SIGNED <u>ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) <u>1-1-2011</u>							15. OTHER DATE QUAL <u>17a</u>					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <u>Gershinski, Peter, DC</u>							17b. DATE <u>17b NPI</u>					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					21. CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))							22. SUBMISSION CODE ORIGINAL REF NO						
A <u>S13.4XXX-S</u>	B <u>S16.1XXA</u>	C <u>M99-03</u>	D <u>L</u>	E <u>6</u>	F <u>K</u>	G <u>M54.5 J</u>	H <u>L</u>	I <u>J</u>	J <u>K</u>	K <u>M23.3XXA</u>	L <u>NPI</u>		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. RACE OF SERVICE C. C. E. MODIFIER EMR							D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Usual Circumstances) CPT/HCPCS E. DIAGNOSIS CODE POINTERS					F. G. H. I. J. \$ CHARGES OR UNITS U. PAYMENT PER UNIT I. ID QUAL. J. RENDERING PROVIDER ID.#	
1 1-6 16 1-6 16 21 2 3 4 5 6	37240												
25. FEDERAL TAX ID NUMBER	SSN ENI	26. PATIENT'S ACCOUNT NO.	27. ADJUST ASSESSMENT FEDC LINE OR PHA <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. RECD FOR NUCC USE							
<u>099606323</u>	<u>X</u>	<u>HARRELL, S</u>	<u>55.00</u>	<u>55.00</u>	<u>0.00</u>	<u>55.00</u>	<u>3144962011</u>						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <u>COLLEEN MARX, LMT</u>							32. SERVICE FACILITY LOCATION INFORMATION <u>375 DICK RD</u>					33. BILLING PROVIDER INFO & PHA <u>716 725-0264</u>	
							<u>COLLEEN MARX, LMT</u>					<u>COLLEEN MARX, LMT</u>	
							<u>375 DICK RD</u>					<u>375 DICK RD</u>	
							<u>DEPWA, NY 14043</u>					<u>DEPWA, NY 14043</u>	
COLLEEN MARX, LMT 1-6-2016 SIGNED DATE <u>1344463011</u>							<u>1344463011</u>						

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS COVER-AGENCY AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who fraudulently files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PAYMENTS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authority released of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and related the person has employer group health insurance, liability, no-deductible, worker's compensation or other insurance which is responsible in full or in part for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient agrees to authorize release of all information to his/her health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary at the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain VA facilities and the Uniformed Services. Information on the patient's sponsor should be provided in these items captioned "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amounts paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-fraud statute and Physician Self-Referral law (commonly known as Stark Law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SBN) of the primary individual rendering such service is reported in the designated section. For services to be considered "incident to" a physician's professional service, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I for any employee whose rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military under 5 USC 3338. For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 423.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds, indicated by this form may upon conviction be subject to loss and/or imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCW to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2051(i), 1622, 1672 and 1674 of the Social Security Act as amended, 42 CFR 411.27(a) and 124(a)(6), and 44 USC 3101, 41 CFR 101 et seq. and 10 USC 1079 and 1085; 5 USC 3101 et seq. and 30 USC 901 et seq.; 58 USC 813, E.O. 13697.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if no services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used in a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0601, titled, "Computer Matching Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37549, Wed Sept. 12, 1990, or as updated and republished.

FOR OWCW CLAIMS: Department of Labor, Privacy Act of 1974, "Reputation of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb. 28, 1990, See ESA 5, ESA-6, ESA-12, ESA-19, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE E PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made re. the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(R): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1138B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to account, in payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER) I certify that the services listed above were medically indicated and necessary in the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS 7500 Security Boulevard, Attn: PRA Reports, Clearance Office, Mail Stop C4-26-03, Baltimore, Maryland 21244-1830. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

VMM

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Deyer, NY 14048

Office: (716) 725-0604

Fax: (716) 725-0665

Client Name: Sean French Date: 1-16-16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/constrains pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Lower back, shoulder & L8 discomfort.
on/off. Most discomfort in P.M.

Action/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist: D. French



Patient Name: Sean Harwell

DOB: 02/03/74

Massage Therapy frequency of treatment: 1x per week for 8 weeks

- No Fault
- Workers' Compensation

Current Diagnosis: S13.4XXA, S116.1XXA, S33.5XXA, S39.01AA,
S23.3XXA, S33.6XXA, m99.01, m99.03, m99.05, m99.02,
m54.2, m54.5

If you have any questions, please don't hesitate to contact our office at (716) 681-3333.
Thank you for your time.

Sincerely,

Date: 01/06/16

- Jason D. Cichocki, DC
- Peter J. Guzinski, DC
- Lisa A. DeMarco, DC

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(For accidents occurring on or after 03/01/02)**

I, Sean Harwell, ("Assignor"/Patient's name - print), hereby assign to Colleen Marx, L.M.T., ("Assignee"/Print hospital or health care provider's name) all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51, (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on 10/31/15 (print date), notwithstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLES OR STATED CLAIM FOR EACH VIOLATION.

Patient/Client Information:

Sean Harwell
(Print Name of Patient)

Sean Harwell
(Signature of Patient)

56 Berehaven Dr.

11/6/15

(Date of Signature)

Amherst NY 14228
(Full Address of Patient/Cient on the 2 Lines Above)

Provider Information:

Colleen Marx, L.M.T.

Great Lakes Therapeutic Massage
& Bodywork Practitioners
375 Dick Road, Suite #2
Depew, NY 14204
Attn: C. Marx

Colleen Marx
11/6/2015

011416

Great Lakes Therapeutic Massage

& Bodywork Practitioners

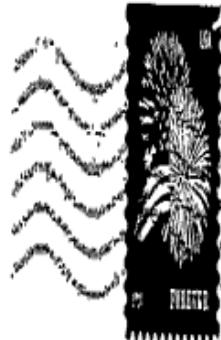
375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

BUFFALO NY 142

21 JAN 2016 PM 11



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403652607



21 Jan 2016



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
NY PIP
P O BOX 9507
FREDERICKSBURG VA 22403

NUCC PICA

PICA

1 MEDICARE (Medigap)	2 MEDICAID (Medicaid)	3 TRICARE (DA/DOD)	4 CHAMPVA (Member/DI)	5 GROUP HEALTH PLAN (DIA)	6 FECA EXCLUDED (DW)	7 OTHER (DW)	8a INSURED'S ID NUMBER 0138739400101059 (For Program Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		3 PATIENT'S BIRTH DATE 08/29/1980		4 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		5 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE	
6 PATIENT ADDRESS (No., Street) 56 BEREHAVEN DR LEFT		7 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		8 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT			
CITY BUFFALO		STATE NY		CITY BUFFALO		STATE NY	
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N.A.		10 IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER M			
b. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURED'S DATE OF BIRTH 08/29/1980		d. OTHER CLAIM ID (Designated by NUCC) <input type="checkbox"/> M <input checked="" type="checkbox"/> P	
c. RESERVED FOR NUCC USE		d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		e. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10e CLAIM CODES (Designated by NUCC)		f. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		g. YES, complete items 9, 9a, and 9d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM
 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. Upon request payment of government benefits either to myself or to the agency which made my assignment before
SIGNATURE ON FILE **01/11/2016**

SIGNED _____

DATE _____

SIGNED _____

14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 10/01/2015	15 OTHER DATE CUAL	MM	DD	YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER GUZINSKI MD	17a CUAL	7-1-00141-88			18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A/L to service line below (24)) M5126 M5127 M4806 M4807					22 RESUBMISSION CODE 0								
A M546	B. L. 	C 	D 	E 	F. G. H. I. J. ORIGINAL REF NO 								
F. L. 	G. L. 	H. L. 	I. L. 	J. L. 									
24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 10 04 16 : 11 04 16					B. PLACE OF SERVICE BMSG 	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 72148	D. MODIFIER 	E. DIAGNOSIS POINTERS ABCD	F. CHARGES 733.04	G. DAYS IN HOSP & OUT PAT 1	H. AMOUNT PAID 1504.35	I. ID CUAL NPI	J. RENDERING PROVIDER ID # 15281-73747- NPI

201 04 16 : 11 04 16	21 04 16 : 11 04 16	22 04 16 : 11 04 16	23 04 16 : 11 04 16	24 04 16 : 11 04 16	25 04 16 : 11 04 16	26 04 16 : 11 04 16	27 04 16 : 11 04 16	28 04 16 : 11 04 16	29 04 16 : 11 04 16	30 04 16 : 11 04 16
3	4	5	6	7	8	9	10	11	12	13
102 04 16 : 11 04 16	103 04 16 : 11 04 16	104 04 16 : 11 04 16	105 04 16 : 11 04 16	106 04 16 : 11 04 16	107 04 16 : 11 04 16	108 04 16 : 11 04 16	109 04 16 : 11 04 16	110 04 16 : 11 04 16	111 04 16 : 11 04 16	112 04 16 : 11 04 16
102 04 16 : 11 04 16	103 04 16 : 11 04 16	104 04 16 : 11 04 16	105 04 16 : 11 04 16	106 04 16 : 11 04 16	107 04 16 : 11 04 16	108 04 16 : 11 04 16	109 04 16 : 11 04 16	110 04 16 : 11 04 16	111 04 16 : 11 04 16	112 04 16 : 11 04 16

26 FEDERAL TAX ID NUMBER 262448643	27 SSN EN X	28 PATIENT'S ACCOUNT NO 88430	29 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	30 TOTAL CHARGE 1504.35	31 AMOUNT PAID 0.00	32 Rcv'd for NUCC Use (716) 839-3333
33 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) ALAM, UZMA, MD		34 SERVICE FACILITY LOCATION INFORMATION BUFFALO DIAGNOSTIC IMAGING 1925 MAIN STREET AMHERST NY 14226-4081		35 BILLING PROVIDER INFO & P.R.# BUFFALO DIAGNOSTIC IMAGING, P BUFFALO MRI 4925 MAIN ST AMHERST NY 14226-4081 18212628666		

SIGNED _____ DATE _____

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR051653 APPROVED OMB 0938-1197 FORM 1500 (02-12)

011516

224088EE26 BEG

224088EE26 BEG



Made easy for you
4925 Main Street
Amherst, NY 14226

BUFFALO MRI

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim or claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal and punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer or group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR §11.24(f). If item 9 is completed, the patient's signature authorizes releases of the information to the health plan or agency whom In healthcare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the healthcare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if the loss is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured" - i.e., Items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide such information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Part B and Part C statutes and Physician Self-Referral laws (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI) license #, or SSN of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims: I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to USC 5336). For Black Lung claims, I further certify that the services performed were for a Black Lung-related decedent.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 421.28).

NOTICE: Any one who misrepresents or fabricates covered information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(e), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(b)(6), and 44 USC 3101-31 CFR 101 et seq and 10 USC 1079 and 1085, 5 USC 8101 et seq and 30 USC 901 et seq 38 USC 812, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, claims intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37519. Wed Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service; private collection agencies and consumer reporting agencies in connection with recompence claims; and to Congressional Offices in response to inquiries made of the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and oral and written liaison related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, could delay payment of the claim. Failure to provide medical information under PEA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988 - permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to decide fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicare program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment and similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and adjudication of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0738-1197. The time required to complete the information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Rm. PRA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21244-1860. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

3 Tesla MRI

1 Tesla Open MRI

128 Slice CT

PETER GUZINSKI, DC
345 DICK RD
DEPEW, NY 14043

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 1/4/2016 1:43:52 PM

MRI LUMBAR SPINE W/O CONTRAST 25MIN

REASON FOR STUDY AND CLINICAL INFORMATION: Non-radiating low back pain status post MVA two months ago.

IMAGING SEQUENCES: Unenhanced multiplanar 3-T MR Imaging of the lumbar spine is performed.

FINDINGS: The lumbar spine is imaged from T11-12 to the L5-S1 level. L5-S1 is the last labeled level for the purpose of the study.

The conus terminates at the level of the T12 vertebral body.

At T11-12, T12-L1, the discs are well-hydrated. The canal and neural foramina are patent.

At L1-2, there is a shallow annular bulge. The canal and neural foramina are widely patent.

At L2-3, the disc is well-hydrated. The canal and neural foramina maintain their caliber.

At L3-4, there is desiccated disc and disc space narrowing with facet arthropathy and there is a shallow annular bulge. These changes result in mild canal narrowing. The neural foramina are patent.

At L4-5, a desiccated disc is seen and there is a central disc protrusion (herniation) with annular tear which impresses upon the thecal sac. There is ligamentum flavum prominence as well and these changes do result in mild canal stenosis. Bilaterally the facet arthropathy and underlying annular bulge do result in mild bilateral recess and neural foraminal narrowing as well.

At L5-S1, hypertrophic facet changes are noted. There is desiccated disc with a central to left paracentral disc protrusion (herniation) and annular tear. The disc protrusion measures 0.5 cm in AP diameter. These changes result in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing. Centrally the canal maintains its caliber.

IMPRESSION:

1. AT L5-S1 THERE IS A CENTRAL TO LEFT PARACENTRAL DISC PROTRUSION (HERNINATION) WITH FACET ARTHROPATHY RESULTING IN BILATERAL NEURAL FORAMINAL AND RECESS NARROWING LEFT GREATER THAN RIGHT.
2. AT L4-5 THERE IS A CENTRAL DISC PROTRUSION (HERNINATION) WITH ANNULAR TEAR WITH MILD FACET ARTHROPATHY AND LIGAMENTUM FLAVUM PROMINENCE ARE ALSO SEEN AND THESE CHANGES RESULT IN MILD BILATERAL NEURAL FORAMINAL NARROWING AND MILD CANAL STENOSIS.



Buffalo Diagnostic
Imaging, PLLC

Snyder Place
4925 Main Street
Amherst, NY 14226

P: 716.839.3333
F: 716.839.3338
Toll-Free 888.MRI.3939

buffalomri.com

01 15 16

3 Tesla MRI

1 Tesla Open MRI

128 Slice CT

PETER GUZINSKI, DC
345 DICK RD
DEPEW, NY 14043

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 1/4/2016 1:43:52 PM

3. AT L3-4, THERE IS MILD CANAL STENOSIS.
4. THE MRI FINDINGS ARE CONSISTENT WITH PHASE 2 _PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEBRAL SUBLUXATION COMPLEX.

Thank you very much for referring this patient to us.

Sincerely,

Signed by UZMA ALAM, MD at 1/5/2016 1:46:15 PM

K K 1/5/2016 1:43:52 PM



Buffalo Diagnostic
Imaging, PLLC

Snyder Place
4925 Main Street
Amherst, NY 14226

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3 Tesla MRI

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PETER GUZINSKI, DC
345 DICK RD
DEPEW, NY 14043

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X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

1. CERVICAL MR
2. THORACIC MR

Patient: DANIELLE HARWELL
DOB: 8/29/1980
ID: RAM1965183
DOS: 1/4/2016 1:16:16 PM, 1/4/2016
12:55:41 PM

MRI CERVICAL SPINE W/O CONTRAST 30MIN,MRI THORACIC SPINE (DORSAL) W/O CONTRAST 30MIN

REASON FOR STUDY AND CLINICAL INFORMATION: MVA, Neck and back pain.

IMAGING SEQUENCES: Unenhanced multiplanar 3-T MR Imaging of the cervical spine is performed.

FINDINGS: The cervical spine is imaged from the skull base to the T3 vertebral body level.

The height of the cervical vertebral bodies is well-maintained. The cervical cord is homogeneous in signal intensity. There is mild reversal of normal cervical lordosis. No cerebellar tonsillar herniation is seen. No prevertebral soft tissue edema is noted and no edema is seen within the cervical vertebral bodies.



At C2-3 and C3-4, the canal and neural foramina are patent.

At C4-5, there is disc space narrowing and there is a shallow central disc extrusion. The canal and neural foramina still maintain their caliber.

At C5-6, a shallow central disc extrusion is seen which barely flattens the thecal sac. The canal and neural foramina are patent. Mild uncovertebral spurring is noted.

At C6-7 and C7-T1, the canal and neural foramina are patent. No annular bulge is seen.

There is a gentle right sided curvature of the lower cervical spine is noted.

IMPRESSION:

1. SHALLOW DISC EXTRUSIONS ARE NOTED AT C4-5, C5-6. THE CANAL AND NEURAL FORAMINA ARE PATENT THROUGHOUT THE CERVICAL SPINE.
2. THERE IS MILD REVERSAL OF NORMAL CERVICAL LORDOSIS. GENTLE RIGHT SIDED CURVATURE OF THE LOWER CERVICAL SPINE IS PRESENT.
3. THE MRI FINDINGS ARE CONSISTENT WITH PHASE 2 PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEBRAL SUBLUXATION COMPLEX.

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Imaging, PLLC

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P: 716.839.3333
P: 716.839.3338
Toll-free 888.MRI.3939

buffalomri.com

3 Tesla MRI

1 Tesla Open MRI

128 Slice CT

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345 DICK RD
DEPEW, NY 14043

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 1/4/2016 1:16:16 PM, 1/4/2016

12:55:41 PM

MRI THORACIC SPINE (DORSAL) W/O CONTRAST 30MIN**REASON FOR STUDY AND CLINICAL INFORMATION:** MVA, Neck and back pain.**IMAGING SEQUENCES:** Unenhanced multiplanar 3-T MR Imaging of the thoracic spine is performed.**FINDINGS:** The thoracic spine is imaged from T1-2 to the T12-L1 level.

The height of the thoracic vertebral bodies is well-maintained. No suspicious edema is seen within the thoracic vertebral bodies on the STIR images and no suspicious prevertebral soft tissue edema is seen. The height of the thoracic vertebral bodies is well-maintained and the thoracic cord is homogeneous in signal intensity.

From T1-2 to T9-10, the discs are well-hydrated. The canal and neural foramina are patent.

A hemangioma is seen within the T10 vertebral body.

At T10-11, mild facet arthropathy is seen. The canal and neural foramina are patent.

At T11-12 and T12-L1 the discs are well-hydrated. The canal and neural foramina are widely patent.

IMPRESSION:

1. THE CANAL AND NEURAL FORAMINA ARE PATENT THROUGHOUT THE THORACIC SPINE. THE HEIGHT OF THE THORACIC VERTEBRAL BODIES IS WELL-MAINTAINED. NO PREVERTEBRAL SOFT TISSUE EDEMA IS SEEN. A HEMANGIOMA IS NOTED WITHIN THE T10 VERTEBRAL BODY.
2. THE MRI FINDINGS ARE CONSISTENT WITH PHASE 1 PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEBRAL SUBLUXATION COMPLEX.

Thank you very much for referring this patient to us.

Sincerely,

**Buffalo Diagnostic
Imaging, PLLC**

**Snyder Place
4925 Main Street
Amherst, NY 14226**

P: 716.839.3333
F: 716.839.3338
Toll-Free 888.MRI.3939

Signed by UZMA ALAM, MD at 1/5/2016 8:33:15 AM

KK 1/4/2016 2:20:45 PM

buffalomri.com

Lancaster Depew Chiropractic

Jason D. Cichocki, D.C.
Peter J. Guzinski, D.C.
Lisa A. DeMarco, D.C.

FAX TRANSMITTAL

TO: Buffalo MRI

FAX#: 809-3338

PAGES INC. COVER: 4

FROM: Dr. Peter Guzinski

DATE: 12/30/2015

RE: Danielle Howell - C/S, T/S, L/S MRI

Imaging is indicated but due to insurance regulations a script needs to be written by PCP. Please fax the script to our office at (716) 681-3037 or contact the patient directly.

ATTENTION:
CONFIDENTIAL INFORMATION ENCLOSED IS TO BE
VIEWED BY AUTHORIZED PERSONS ONLY.

IF YOU DO NOT RECEIVE ALL PAGES INDICATED PLEASE CALL OUR OFFICE AT (716) 681-3338

Buffalo MRI
High-Field & Open MRI Multi-Slice Spiral CT

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENTS OF BENEFITS FORM)**
(For Accidents Occurring on and After 3/1/02)

I, DANIELLE HARWELL ("Assignor") hereby assign to Buffalo Diagnostic Imaging, PLLC, all the right privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on the behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the action or conduct of the assignor.

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF THE MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM KNOWLINGLY MAKES OR KNOWLINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, OR DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

PATIENT: DANIELLE HARWELL

11/4/11	Danielle Harwell
Date	Signature of Patient

011516

2

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

NUCC

PIKA

1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TICARE <input type="checkbox"/> TICARE	CHAMPVA <input type="checkbox"/> CHAMPVA	GROUP HEALTH PLAN <input type="checkbox"/> Group <input type="checkbox"/> DPA	FCA EXCLUDING DPA <input type="checkbox"/> DPA	OTHER <input checked="" type="checkbox"/> DPA	1a. INSURED'S ID. NUMBER 0138739400101059 (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY 08 29 80		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 56 BEERHAVEN DR. LEFT	
6. RESERVED FOR NUCC USE CITY AMHERST ZIP CODE 14228 TELEPHONE (Include Area Code) ()		8. RESERVED FOR NUCC USE CITY AMHERST ZIP CODE 14228 TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FCA NUMBER 0138739400101059			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 08 29 80		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. INSURANCE PLAN NAME OR PROGRAM NAME Geico			
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM NUMBER (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, complete Items 9, 9c, and 9d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature On File

1/20/2016

SIGNED	DATE	SIGNED	Signature On File
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 15		15. OTHER DATE QUAL 454 01 19 16	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER GUZINSKI DC		17a. NPI 1710014186	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19a. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY* Relate A-H to service line below (24E) ICD IND. O	22. RESUBMISSION CODE	ORIGINAL REF. NO.	
A S13.4XXA	B S16.1XXA	C S43.422A	D M79.609
E G56.01	F I 956.02	G	H
I J	K L		

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE ENG	C. D. PROCEDURES, SERVICES, OR SUPPLIES (List Unusual Circumstances)	D. CPT/HCPCS	E. MODIFIER	F. DIAGNOSIS POINTER	\$ CHARGES	G. DAYS ON UNITS	H. CHARGE PER UNIT	I. ID QUAN	J. RENDERING PROVIDER ID #
01 19 16	01 19 16 11	95903			ABCD	349	84	4	OB	007938
01 19 16	01 19 16 11	95904			ABCD	335	64	6	OB	007938
01 19 16	01 19 16 11	95936			ABCD	126	10	2	OB	007938
01 19 16	01 19 16 11	95860			ABCD	97	59	1	OB	007938
01 19 16	01 19 16 11	99203			ABCD	42	05	1	OB	007938
									NPI	1942397245
									NPI	1942397245
									NPI	1942397245
									NPI	1942397245

25. FEDERAL TAX ID NUMBER 22-3830040	SSN BIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 531621X1	27. ACCEPT ASSIGNMENT? FOR Govt. Employees Only <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 951.22	29. AMOUNT PAID \$ 0.00	30. Rev'd for NUCC Use 1
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Gary R. Smith	32. SERVICE FACILITY LOCATION INFORMATION General Diagnostic Associates 5660 Clinton Street Suite 4 Elma, NY 14059	33. BILLING PROVIDER INFO & PH# (716) 686-0868 General Diagnostic Associates 5660 Clinton Street Suite 4 Elma, NY 14059	
SIGNED 1/20/2016	DATE	DATE	
a. 0	b. 007938	a. 0	b.



01/19/2016

LETTER OF MEDICAL NECESSITY

Name of Patient: Danielle Harwell #3438
 Patient's Date of Birth: 08/29/1980
 Injury/Accident Date: 10/31/2015
 Claim Number: 013873940011059

PATIENT'S SUBJECTIVE COMPLAINTS AND/OR SYMPTOMS:

1. Arm/Hand numbness and tingling, pain, and/or weakness
2. Neck, Shoulder, Arm and Back pain
3. Painful neck lateral bending, extension, and flexion
4. Spasm and twitching of area musculature.

BRIEF SUMMARY OF PERTINENT OBJECTIVE/PHYSICAL FINDINGS:

1. Limited cervical spine range of motion
2. Palpable cervical paraspinal myospasms
3. Positive orthopedic testing: see exam notes
4. Cervical MRI report enclosed.

DIAGNOSIS CODES:

1. Differential Diagnoses: Cervical Radiculopathy versus CTS versus Ulnar Neuropathy
2. Cervical Sprain/Strain with Cervical Disc Derangement/Bulge/Herniation
3. Limb pain and numbness
4. Myospasms

DIAGNOSTIC TESTING ORDERED/PLANNED:

1. Bilateral Upper Extremity NCV/EMG Studies

IT IS THE PROFESSIONAL OPINIONS OF THE DOCTORS IN THIS OFFICE THAT FURTHER EVALUATION OF THIS PATIENT'S CONDITION WARRANTED REFERRAL FOR BILATERAL UPPER EXTREMITY NCV/EMG STUDIES IN ORDER TO FURTHER DETERMINE THE EXTENT OF THIS PATIENT'S INJURIES. THE RESULTS PROVIDED BY SAID DIAGNOSTIC STUDIES OFFER INFORMATION THAT WOULD OTHERWISE BE UNAVAILABLE. THIS INFORMATION IS VALUABLE IN DETERMINING APPROPRIATE PATIENT TREATMENT AND THE ULTIMATE EXTENT OF THE PATIENT'S INJURIES AND PROGNOSIS.

FOR SPECIFIC DETAILS AND CLINICAL DATA INCLUDING SUBJECTIVE, OBJECTIVE, ASSESSMENT, AND PLAN - SEE ENCLOSED DOCUMENTATION INCLUDING MRI/IMAGING REPORTS, OFFICE VISIT/SOAP NOTES, ETC.

Peter J. Guzinski, DC

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
January 5, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980

Thursday November 12, 2015 Provider: Peter Guzinski DC EXAM

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: Date of Accident: October 31, 2015. Time of Accident: 4:55 PM.

Narrative Description of Accident: Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt; left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights, she is unable to read as much as she would like, she has headaches almost all the time, she cannot perform her usual work, her normal sleep has been mildly disturbed (1-2 hrs, sleepless) and she is only able to engage in a few of her usual recreational activities. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* getting worse since last week. *Pain:* achy, tingling; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has nausea and dizziness associated with the headaches. At times, light bothers her. *Cervical Disability Index:* 52%. *Recent medical treatment for this condition:* Immediate Care evaluation on November 1, 2015 with chest and neck x-rays. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient presented today with the chief complaint of middle back and left anterior chest

**Encounter dated 11/12/2015 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/05/2016**

pain. She states that the chest pain is exactly in the same direction of the seat belt from left shoulder across chest to right hip. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* getting worse, since last week. *Pain:* achy; level: 7/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* getting worse, since last week. *Pain:* achy; level: 7/10. *Pain is constant.* *Pain radicles to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Prior chiropractic treatment for this condition:* None.

Current medications: pantoprazole 40 MG Delayed Release Oral Delayed Release Oral Tablet; CLARITIN Disintegrating Oral Tablet. *Problem List:* neck pain; low back pain. *Allergies:* Keflex; codeine; biaxin; Clindamycin; ranidin; soma; penicillin; cipro. *Surgeries:* 1990 tonsillectomy & adenoidectomy; 06/2012 D & C. *Occupational history:* Caregiver. *Family history:* stroke, diabetes, high cholesterol (father); diabetes, asthma, allergies (mother). *Social history:* married, Never smoker. Alcohol: none. Caffeine: none. Exercise: never.

Activity of Daily Living Form Bathing/Showering: moderate impairment; Bending forward/backward: moderate impairment; Brushing teeth: mild impairment; Buttoning shirt: mild impairment; Driving: severe impairment; Drying Hair: severe impairment; Household chores: severe impairment; Laundry: severe impairment; Lifting less than 10 lbs: moderate impairment; Lifting more than 10 lbs: severe impairment; Kneeling: severe impairment; Making Meals: severe impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: moderate impairment; Putting shoes/socks on: severe impairment; Reaching above the shoulders: severe impairment; Restful night's sleep: severe impairment; Seated to standing position: moderate impairment; Sexual activity: severe impairment; Standing: moderate impairment; Squatting: severe impairment; Taking out the trash: severe impairment; Tying shoes: severe impairment; Using lavatory: severe impairment; Walking: moderate impairment.

Objective

Physical exam: Never smoker Temp: 97.6 BP (left): 170/80 Pulse (left/resting): 73. *Cervical:* Range of motion: flexion: 35/50 with pain neck and upper back; extension: 15/60 with pain neck and upper back; left rotation: 45/80 with pain neck and upper back; right rotation: 45/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 20/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe;

Encounter dated 11/12/2015 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/05/2016

Sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Reflexes:** bilateral upper extremity reflexes (C5, C6, C7) 2+. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive lower neck mostly to the left; right shoulder depression: Negative; neutral cervical compression: Positive lower neck mostly to the left; hyperextension cervical compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate to Severe. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 30/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 15/30 with pain lower back; right rotation: 30/30 with pain lower back; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain-lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Sensation:** left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Reflexes:** bilateral lower extremity reflexes (L4 and S1) 2+. **Orthopedic tests:** Patrick's/Fabre: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Ely's Heel to Buttock: Negative bilateral; Minor's sign: Negative; Nachlas : Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Hibbs test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015.

Diagnosis: S13.4XXA (Sprain of ligaments of cervical spine, initial encounter), S16.IXXA (Strain of muscle, fascia & tendon neck level, initial e), S33.5XXA (Sprain of ligaments of lumbar spine, initial encounter), S39.01ZA (Strain of muscle, fascia & tendon lower back, initial e), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M54.12 (Radiculopathy, cervical region), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic

Encounter dated 11/12/2015 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/05/2016

dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain). *Differential diagnosis:* Cervical disc herniation, Lumbar disc herniation, Thoracic disc herniation. *Prognosis:* Too early in care to determine. *Post-treatment analysis:* patient tolerated treatment without incident.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility; centralize pain; decrease muscular hypertonicity and tenderness. *Treatment schedule:* 3x/week for 2 weeks; 2x/week for 2 weeks; as needed for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily. *Home care:* ice; neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Informed consent:* Patient agreed to begin care, we discussed the possible side effects of treatment performed in this office, that post treatment soreness is to be expected, the importance of performing all prescribed home care, the possibility of their symptoms worsening before they improve, diagnosis was shared with patient and the patient verbalized an understanding. *Disability status:* Temporary partial starting on November 12 to December 12, 2015 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Peter J. Guzinski, D.C.

Abbreviations:
 ADL: activities of daily living
 MVA: motor vehicle accident
 ROM: range of motion
 WNL: within normal limits

• RX Date/Time

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P.001

01/05/2016 Tue 08:50

Buffalo MRI Reports 639-3338

ID: #582638 Page 1 of 2

3 Tesla MRI

1 Tesla Open MRI

PETER GUJINSKI, DC
345 DICK RD
DEPEW, NY 14203

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammography

Bone Density/DEXA

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 1/4/2016 1:16:16 PM, 1/4/2016
12:55:41 PM

1. CERVICAL MR
2. THORACIC MR

MRI CERVICAL SPINE W/O CONTRAST 30MIN,MRI THORACIC SPINE (DORSAL) W/O CONTRAST 30MIN

REASON FOR STUDY AND CLINICAL INFORMATION: MVA. Neck and back pain.

IMAGING SEQUENCES: Unenhanced multiplanar 3-T MR imaging of the cervical spine is performed.

FINDINGS: The cervical spine is imaged from the skull base to the T3 vertebral body level.

The height of the cervical vertebral bodies is well-maintained. The cervical cord is homogeneous in signal intensity. There is mild reversal of normal cervical lordosis. No cerebellar tonsillar herniation is seen. No prevertebral soft tissue edema is noted and no edema is seen within the cervical vertebral bodies.

At C2-3 and C3-4, the canal and neural foramina are patent.

At C4-5, there is disc space narrowing and there is a shallow central disc extrusion. The canal and neural foramina still maintain their caliber.

At C5-6, a shallow central disc extrusion is seen which barely flattens the thecal sac. The canal and neural foramina are patent. Mild uncovertebral spurring is noted.

At C6-7 and C7-T1, the canal and neural foramina are patent. No annular bulge is seen.

There is a gentle right sided curvature of the lower cervical spine is noted.

IMPRESSION:

1. SHALLOW DISC EXTRUSIONS ARE NOTED AT C4-5, C5-6. THE CANAL AND NEURAL FORAMINA ARE PATENT THROUGHOUT THE CERVICAL SPINE.
2. THERE IS MILD REVERSAL OF NORMAL CERVICAL LORDOSIS. GENTLE RIGHT SIDED CURVATURE OF THE LOWER CERVICAL SPINE IS PRESENT.
3. THE MRI FINDINGS ARE CONSISTENT WITH PHASE 2 PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEbral SUBLUXATION COMPLEX.



Buffalo Diagnostic
Imaging, PLLC

Snyder Place
4926 Main Street
Amherst, NY 14226

P: 716.639.3333
F: 716.639.3330
Toll-Free 888.MRI.3537

buffalomri.com

*Late J. Heyman, DC
1/4/2016*

01 28 16

01/05/2016 19:19 LANCASTER DEPEW CHIROPRACTIC

FAX:716.681.3037

P.008/008

RX Date/Time

01/05/2016 08:57 639-3338

P.002

01/05/2016 Tue 08:40

Buffalo MRI Reports 639-3338

ID: #58283B Page 2 of 2

3 Tesla MRI

1 Tesla Open MRI

PETER GUBINSKI, DC
345 DICK RD
DEPEW, NY 14203

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammography

Bone Density/DEXA

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 1/4/2016 1:16:16 PM, 1/4/2016

12:55:41 PM

MRI THORACIC SPINE (DORSAL) W/O CONTRAST 30MIN

REASON FOR STUDY AND CLINICAL INFORMATION: MVA. Neck and back pain.

IMAGING SEQUENCES: Unenhanced multiplanar 3-T MR Imaging of the thoracic spine is performed.

FINDINGS: The thoracic spine is imaged from T1-2 to the T12-L1 level.

The height of the thoracic vertebral bodies is well-maintained. No suspicious edema is seen within the thoracic vertebral bodies on the STIR images and no suspicious prevertebral soft tissue edema is seen. The height of the thoracic vertebral bodies is well-maintained and the thoracic cord is homogeneous in signal intensity.

From T1-2 to T9-10, the discs are well-hydrated. The canal and neural foramina are patent.

A hemangioma is seen within the T10 vertebral body.

At T10-11, mild facet arthropathy is seen. The canal and neural foramina are patent.

At T11-12 and T12-L1 the discs are well-hydrated. The canal and neural foramina are widely patent.

IMPRESSION:

1. THE CANAL AND NEURAL FORAMINA ARE PATENT THROUGHOUT THE THORACIC SPINE. THE HEIGHT OF THE THORACIC VERTEBRAL BODIES IS WELL-MAINTAINED. NO PREVERTEBRAL SOFT TISSUE EDEMA IS SEEN. A HEMANGIOMA IS NOTED WITHIN THE T10 VERTEBRAL BODY.
2. THE MRI FINDINGS ARE CONSISTENT WITH PHASE I PATHOPHYSIOLOGY OF THE CHIROPRACTIC CLINICAL DIAGNOSIS OF VERTEBRAL SUBLUXATION COMPLEX.

Thank you very much for referring this patient to us.

Sincerely,

Buffalo Diagnostic Imaging, PLLC

Snyder Place
4725 Main Street
Amherst, NY 14226

P:716.639.3333
F:716.639.3338
Toll-Free 888.MRI.3937

buffalomri.com

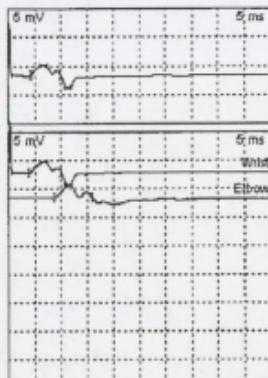
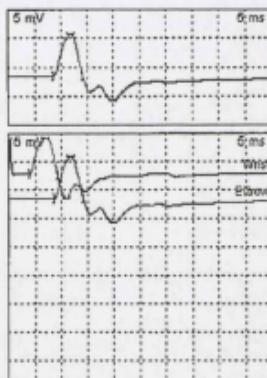
Signed by UZMA ALAM, MD at 1/5/2016 8:33:15 AM

KK 1/4/2016 2:20:45 PM

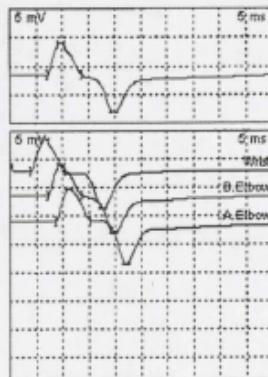
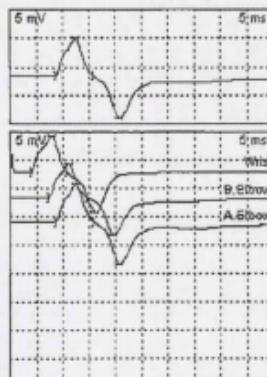
Uzma Alam, MD
01/05/2016

Patient: Harwell, Danielle UE

01/19/16

Motor Nerve Study**Median Nerve**

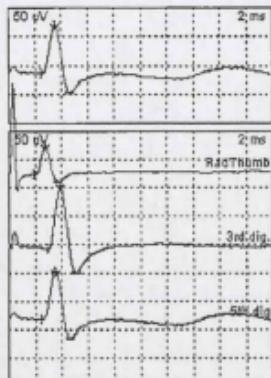
Rec Site: APB	Lat (ms)		Norm Lat.		Amp (mV)	Norm Amp		Dist (mm)	C.V. (m/s)		Norm C.V.
STIM SITE					L	R	L	R	L	R	
Wrist	4.1	4.2	4.2		10.3	4.0	5		80	80	
Elbow			8.7	8.9			11.3	3.2	280	290	61.1 61.1 60

**Ulnar Nerve**

Rec Site: ADM	Lat (ms)		Norm Lat		Amp (mV)	Norm Amp		Dist (mm)	C.V. (m/s)		Norm C.V.
STIM SITE					L	R	L	R	L	R	
Wrist	4.0	4.1	4.1		13.3	12.1	5		80	80	
B. Elbow	7.3	7.4			12.3	11.8			190	190	57.0 57.0 50
A. Elbow			8.8	9.0			13.6	13.0	100	100	66.7 63.2 50

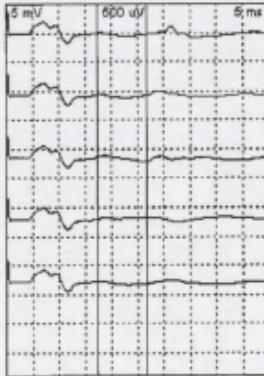
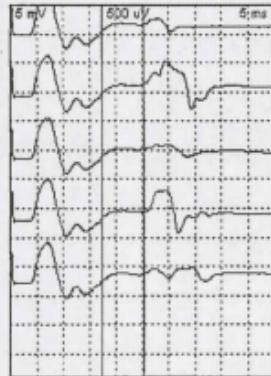
Patient: Harwell, Danielle UE

01/19/16

Sensory Nerve Study

Med/Uln/Rad Nerve

Stim Site: Wrist	Norm Lat		Pk Lat (ms)		Amp (uV)		Norm Amp		Dist (mm)	
	L	R	L	R	L	R	L	R	L	R
REC SITE										
RadThumb	3.0	2.8	2.9		80.8	19.6	5		100	100
3rd dig.	3.7		4.0	4.2	146.6	85.6	5		140	140
5th dig	3.7		3.6	3.7	117.5	18.6	5		140	140

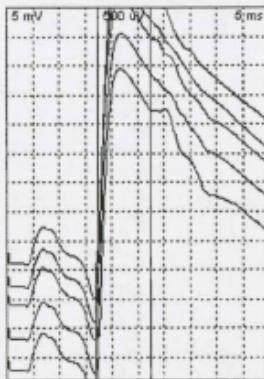
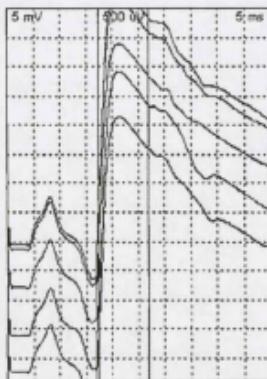
F-Wave Study

Median Nerve

Rec Site: APB	Latency		Normal	
Stim Site: Wrist	ms	ms	Latency	
	L	R		
M wave	4.06	4.58		
F wave	25.33	26.83	32 ms	

Patient: Harwell, Danielle UE

01/19/16

F-Wave Study

Ulnar Nerve

Rec Site: ADM	Latency	Normal
Stim Site: Wrist	ms	Latency
	L R	
M wave	4.25 4.25	
F wave	26.82 27.42	32 ms

H Reflex Study

Median Nerve

Rec Site: F Car. Rad	Latency	Normal
Stim Site: Elbow	ms	Latency
	L R	
M wave	4.00 3.92	
H wave	15.82 15.75	13-18

EMG Study

Name	Ins Act	Fib	PSW	Fascic	Polyph	MU Amp	MU Dur	Recruit
L. Deltoid	Normal							
L. Biceps	Normal							
L. Triceps	Normal							
L. Pectoralis	Normal							
L. APB	Normal							
L. ADM	Normal							
L. Cervical PS	Normal							

NEW YORK MOTOR VEHICLE NO-Fault INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment.)

GEICO NY PIP OFFICE
PO Box 9507
Fredericksburg VA 22403-9526

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
01/20/16	Danielle Harwell	0138739400101059	10/31/2015	0138739400101059

GDA CHIROPRACTIC PC dba/ General Diagnostic Associates
Gary Smith DC
5660 Clinton Street
Alma, NY 14009-9404

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

RENTAL INFORMATION ADDRESS
Penicille-Harmal 86 Barshayev Dr., Left Ambrose, NY 14228

2. DATE OF BIRTH 3. SEX 4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS
S13.4XXA Sprain of ligaments of cervical
S43.422A Sprain of left rotator cuff caps S16.1XXA Strain of muscle, fascia & tendon neck l
M79.609 Pain in unspecified limb

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 10/31/2015

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS
CONDITION? DATE: 01/18/2016

8 HAS PATIENT EVER HAD SAME OR SIMILAR CONDITIONS?

YES NO

8. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES NO

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES NO
IF "YES", describe:

NOT DETERMINABLE AT THIS TIME

xx

12. PATIENT WAS DISABLED (UNABLE TO WORK)
#12 AND #13 PLEASE CONSULT TREATING DOCTORS NOTES
FROM: THROUGH:

13. IF STILL DISABLED THE PATIENT SHOULD BE
ABLE TO RETURN TO WORK ON:

CONTINUE ON PAGE 2

Carrier Manifest

Geico

P O BOX 9507

Fredericksburg, VA 22403-9526

Attention Insurance Carriers: Any attached New York Workers' Compensation claims are already on file with the New York Workers' Compensation Board. DO NOT fax/mail these claims to the New York Workers' Compensation Board!

Total Claims: 121

Claims per Organization:

Brain and Spine Center : 2

BUFFALO NEUROSURGERY GROUP : 2

BUFFALO ORTHOPAEDIC GROUP, LLP : 1

Buffalo Spine and Sports Institute : 3

CLINICAL PRACTICE MANAGEMENT PLAN : 31

Comprehensive Orthopedic and Spine Care : 4

Empower Doctors llc : 27

Family Care Medical Group : 1

General Diagnostic Associates : 1

Hamilton Orthopaedics and Sports Medicine : 2

mount kisco medical group : 14

ORANGE RADIOLOGY AND MRI OF NEWBURGH : 4

ST. JOSEPH IMAGING ASSOCIATES : 2

Timothy D Groth MD PC : 8

University Orthopaedic Services, Inc. : 8

Vericle : 11

Organization Manifest

Timothy D Groth MD PC(8)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
02919278701010471 ✓		MORI, RONNIE	01/05/2016	01/05/2016
01352551701011643 ✓		ROSADO, ANNETH	01/05/2016	01/05/2016
05293727901010131 ✓		ALLEN, VICTORIA	01/05/2016	01/05/2016
03011808901011041 ✓		BAKER, DENISE	01/05/2016	01/05/2016
05253720601010101 ✓		BERTRAND, BERLINE	01/05/2016	01/05/2016
01592635501010523 ✓		MAVROVICH, LINDA	01/06/2016	01/06/2016
01214647701010891 ✓		SPERO, ROSEMARIE	01/06/2016	01/06/2016
01214647701010895 ✓		SPERO, ROSEMARIE	01/06/2016	01/06/2016

Organization Manifest

Empower Doctors llc(27)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
04025755501010131	✓	ORDONEZ, ANA	10/19/2015	10/19/2015
CL#0514340900101014	✓	VALOY, JUANA	12/07/2015	12/07/2015
CL#0514340900101014	✓	VALOY, JUANA	10/30/2015	10/30/2015
03153526601010441	✓	LOPEZ, ALBA	12/23/2015	12/23/2015
05000035601010151	✓	PARSONS, STONER	12/29/2015	12/29/2015
03791110101010442	✓	RODRIGUEZ, EDSON	11/18/2015	11/18/2015
05316408901010181	✓	PEREZ, MARIA	12/08/2015	12/08/2015
04214528901010521	✓	PAZ, CARLOS	12/28/2015	12/28/2015
03791110101010441	✓	PEREZ, MIGUEL	12/21/2015	12/21/2015
CL#0437400010101017	✓	VASQUEZ, MARIBEL	12/21/2015	12/21/2015
03994153201010161	✓	PAULINO, FELICIA	12/15/2015	12/15/2015
05458233101010161	✓	PORTILLO, CARLOS	12/23/2015	12/23/2015
02861036901010241	✓	SERRANO, LEIRA	12/21/2015	12/21/2015
04811256901010121	✓	OGUJE, AKEEM	12/29/2015	12/29/2015
03282433501011021	✓	SINGH, UMRAW	12/15/2015	12/15/2015
03791110101010444	✓	RODRIGUEZ, EDSON	01/11/2016	01/11/2016
04875118901010151	✓	BARSEGÓVA, GALINA	12/29/2015	12/29/2015
03791110101010441	✓	RODRIGUEZ, EDSON	12/12/2015	12/12/2015
04937688901010701	✓	PERSAUD, DOODNAUTH	12/15/2015	12/15/2015
010675101780101029	✓	SANTIAGO, LETICIA	12/08/2015	12/08/2015
04770184801010191	✓	LAPORTA, PAOLO	12/29/2015	12/29/2015
02861036901010241	✓	SERRANO, LEIRA	12/28/2015	12/28/2015
04157844501010901	✓	SOOKRAM, DHANWANTIE	12/14/2015	12/14/2015
05458233101010161	✓	RIVERA, MARIA	12/28/2015	12/28/2015
04025755501010131	✓	ORDONEZ, ANA	12/23/2015	12/23/2015
01067517801010291	✓	SANTIAGO, ANA	12/08/2015	12/08/2015
03888781401010241	✓	VILLATORO, VICTORIA	12/21/2015	12/21/2015

Organization Manifest

ST. JOSEPH IMAGING ASSOCIATES(2)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
04305760801010241	J	JIRIES, NADER	01/07/2016	01/07/2016
00119931601010391		BIAGIARELLI, JOANNA	01/08/2016	01/08/2016

Organization Manifest

ORANGE RADIOLOGY AND MRI OF NEWBURGH(4)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
05468580401010181	✓	ZAPATA GONZALEZ, CRISTIAN	01/14/2016	01/14/2016
05380785201010201	✓	COLON, SELENA	01/19/2016	01/19/2016
04308796501010301	✓	VERMILLING DUNN, LINDSAY	01/18/2016	01/18/2016
03055395901011591	✓	CALTENCO, SUSAN	01/18/2016	01/18/2016

Organization Manifest

Comprehensive Orthopedic and Spine Care(4)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03292946301010492	✓	ROSADO, JOSEPH	01/04/2016	01/04/2016
04582349701011865	✓	PAOLA, MARTINE	12/29/2015	12/29/2015
01179484301010307	✓	SERRANO, JENNIFER	12/09/2015	12/09/2015
01179484301010301	✓	SERRANO, JENNIFER	12/21/2015	12/21/2015

Organization Manifest

General Diagnostic Associates(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01387394001010595	✓	HARWELL, DANIELLE	01/19/2016	01/19/2016

Organization Manifest

BUFFALO ORTHOPAEDIC GROUP, LLP(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
054015051010101721		BROWN, DUSTIN	01/15/2016	01/15/2016

01 28 10

UNITED STATES POSTAL SERVICE®

PRIORITY MAIL
POSTAGE REQUIRED

FROM

UNITED STATES POSTAL SERVICE		Glick-N-Ship®
P		
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Commercial Mail Pricing 94050026 90300249 056302 9134051813220484		
PRIORITY MAIL 2-DAY™		
BOOK CODE	Estimated Delivery Date: 01/28/10	
118 S JEFFERSON RD STE 201 HARRISON MD 20738-1828	0004	
BOB6		
Customer is responsible for payment of postage.		
DENVER CO PO BOX 6000 FREDERICKSBURG VA 22403-9526		
USPS TRACKING #		
		
9405 0026 9030 0249 0563 82		
Electronic Rate Approved #038555749		

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ORDER FREE SUPPLIES ONLINE

WHEN USED INTERNATIONALLY,
APPLY CUSTOMS DECLARATION

P

★ MAIL ★

REGIONAL RATE BOX B
FOR DOMESTIC AND INTERNATIONAL USE

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES

NO

XX

IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED - ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
01/19/2016	see below*	Motor NCV w/ F-wave Global Billi	95903	349.84
01/19/2016	see below*	Sensory NCV Global Billing	95904	335.64
01/19/2016	see below*	H-REFLEX-OTHER THAN SOLVENT Global	95936	126.10
01/19/2016	see below*	Needle EMG 1 extremity w/ or w/o ** see attached **	95860	97.59
*5660 Clinton Street Elma, NY 14059-9494			TOTAL CHARGES TO DATES	951.22

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)
Smith Gary	D.C.	X007938	*****	** OWNER **	*****

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

GARY SMITH DC JEFFREY ROSS DC

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES

NO

XX

19. ESTIMATED DURATION OF FUTURE TREATMENT

N/A

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (Authorization to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of the form.

20. IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____
 PATIENT _____ PATIENT _____ DATE _____

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHOM I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME	<u>Danielle Harwell</u>	SIGNED		PATIENT	DATE
	PATIENT (Assignor)				

PRINT NAME	<u>Gary Smith DC</u>	SIGNED		PATIENT	DATE
	PATIENT (Assignee)				

***** SEE ATTACHED NF-AOB *****

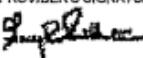
HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY
BEEN EXECUTED?

YES NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?

YES NO

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WC8 RATING CODE IF NONE, SPECIALTY
01/20/2016		22-3630040	D.C.

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-3 (Rev 1/2004)

Page 3 of 3

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN
Page 4: Attached Services

DATE	POLICYHOLDER	POLICY NO.	D.O.A.	FILE NO.
01/20/2016	Danielle Harwell	0138739400101059	10/31/2015	0138739400101059
Date	Place of Svc	Description of Treatment	Treatment Code	Fee
01/19/2016	see box 15	Comprehensive HX 30 min	99203	42.05

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, DANIELLE HARWELL, ("Assignor") hereby assign to General Diagnostic Associates Gary R. Smith, DC, ("Assignee")
 (Print patient's name) (Print hospital or health care provider name)
 all rights, privileges and remedies to payment for health care services provided by assignee to which I am
 entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
 shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
 due to the motor vehicle accident which occurred on 10-31-15, notwithstanding any other agreement
 (Print accident date)
 to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack
 of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON
 FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR
 PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE
 PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,
 IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,
 SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR
 CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR
 VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND
 SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF
 THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Danielle Harwell
 (Print name of Patient)

X Danielle Harwell
 (Signature of Patient)

56 Berg haven Drive, Loft
Anhensht NY 11228
 (Address of Patient)

1-19-16
 (Date of signature)

General Diagnostic Associates/ Gary R. Smith, DC
 (Print name of Provider)

Gary R. Smith DC
 (Signature of Provider)

3660 Clinton Street, Suite# 4
Elms, New York 14059-9494
 (Address of Provider)

1-19-16
 (Date of signature)



GARY R. SMITH, DC □ JEFFREY A. ROSS, DC □ J. DONALD DISHMAN, DC, MSc, DIBCN

PATIENT: HARWELL, Danielle
 Date of Study: 01/19/2016
 Type: Upper Extremity NCS/Needle EMG
 Date of Injury: 10/31/2015
 Referring: Dr. Peter Guzinski

ELECTRODIAGNOSTIC FINDINGS:

1. Normal distal motor latencies and amplitudes of the right and left Median and Ulnar nerves.
2. Normal F-responses of the right and left Median & Ulnar nerves.
3. Normal distal sensory latencies and amplitudes of the right and left Ulnar and Superficial Radial nerves.
4. Abnormal distal sensory peak latencies of the right and left Median nerves (Mild prolongation).
5. Normal right and left Median H-reflexes.
6. Normal monopolar needle EMG exam of the left upper extremity and cervical paraspinal muscles.

CONCLUSIONS: There are mild delays of the left and right median nerve distal sensory peak latencies with preservation of amplitudes. The remaining nerve conduction studies were unremarkable bilaterally. Late responses including F waves and median H reflexes were present and symmetrical bilaterally without prolongation.

The monopolar failed to yield any evidence of spontaneous potentials or chronic neuropathic motor units in any of the sampled left upper limb and cervical paraspinal muscles upon needle EMG thus, cervical radiculopathy could not be identified at this time. However, I cannot rule out cervical radiculopathy.

I recommend that Ms. Harwell continue to follow up with Dr. Guzinski for further conservative management and treatment recommendations. Ms. Harwell also has physical examination findings associated with left shoulder impingement. A left shoulder MRI and/or orthopedic shoulder evaluation are suggested for further evaluation if clinically indicated.

ELECTRODIAGNOSTIC IMPRESSION: These electrophysiological findings are consistent with:

1. Mild bilateral Carpal Tunnel Syndrome.
2. No electrophysiological evidence of a cervical radiculopathy, brachial plexopathy, peripheral polyneuropathy, or myopathy was observed.
3. Ms. Harwell also has some aspect of left shoulder dysfunction contributing to her left upper limb symptomatology. Left shoulder MRI and/or orthopedic evaluation are suggested for further evaluation if clinically indicated.

Gary R. Smith, D.C., D.I.B.E.

Diplomate, International Board of Electrodagnosis
 Board Certified in Electrodagnosis

Certified, Electrodagnosis
 National University of Health Sciences

Clinical Assistant Professor
 Department of Family Medicine
 SUNY Buffalo, School of Medicine & Biological Sciences

General Diagnostic Associates
5660 Clinton Street, Suite 4
Elma, NY 14069
(716) 686-0868 Phone (716) 686-0869 Fax

Patient:	Harwell, Danielle UE	Address:	56 Berchaven Dr., Left
Sex:	Female	City:	Amherst
Age:	35	State:	NY
Height:	63 inches	ZIP:	14228
Weight:	150 lbs	Phone:	716-536-0951
Ref. Dr.:	Dr. Peter Guzinski	Doctor:	Dr. Gary R. Smith
Insurance:	Geico Insurance	Test Date:	01/19/16

History & Physical Examination:

Dear Dr. Guzinski,

HISTORY: Thank you for asking me to see Ms. Danielle Harwell today to undergo further evaluation of injuries she sustained to her cervical spine that occurred as the result of a motor vehicle crash on October 31, 2015. As you know, she reports that she was the seatbelted driver of a Honda Odyssey that was rear-ended by another vehicle while stopped on Starin Avenue while waiting for the car in front of her to turn into a driveway. She reports that the car that struck her was rear-ended by another vehicle and that there were four vehicles involved in a collision. She reports that her vehicles airbags did not deploy. She denies any loss of consciousness or blood loss. She reports that she experienced immediate neck and lower back pain as well as pain in both arms. She did not seek any immediate medical attention however, the following day she presented to Immediate Care where she was examined, diagnostic imaging was performed and she was released. She followed up with her family physician, Dr. Panzarella, and was referred to your office for chiropractic therapy. Unfortunately, she continues to have persistent bilateral cervical spine pain with pain radiating to her left shoulder and proximal arm as well as diffuse paresthesias distally into the second through fifth digits of her left hand. She reports that her symptoms seem to be worse nocturnally. She denies any right upper limb symptomatology. She denies any bowel or bladder dysfunction. An upper extremity electrodiagnostic evaluation has been requested to aid in further delineating the etiology of these complaints.

PAST MEDICAL HISTORY: Past medical history was reviewed and it is noncontributory. She is currently taking loratadine, vitamin D 3 and pantoprazole. Surgical history includes prophylactically and D&C. She denies any history of diabetes and thyroid disease. She is allergic to codeine, clindamycin, renting again, Cipro, Keflex, Soma, penicillin and Biaxin.

PHYSICAL EXAMINATION: On physical examination, I have a pleasant 35-year-old female. Her cervical ROM is moderately diminished with localized muscular pain bilaterally. On palpation, there is moderate cervical paraspinal, left upper trapezius and left periscapular hypertonicity and moderate tenderness. Cervical compression tests produce localized cervical spine pain as well as pain reported to radiate to her left shoulder. Cervical distraction is negative. Upper extremity stretch reflexes were performed and graded as follows: Biceps 2+ bilaterally, Brachioradialis 2+ bilaterally and Triceps 2+ bilaterally. Upper limb sensory testing was performed and revealed reported paresthesias in the left C5-C7 dermatomes. Manual muscle testing of the upper limb musculature was performed and revealed weakness of the left deltoid, graded 4/5 with no focal motor deficits, graded, 5/5 bilaterally. Tinel's tap of the ulnar and median nerves at the wrists were provocative on the left and negative on the right. Tinel's tap of the ulnar nerves at the elbows were unremarkable bilaterally. Visual inspection of the upper limb musculature revealed no atrophy of the upper limb musculature including the thenar, hypothenar and periscapular musculature. Hawkins test is positive on the left. Supraspinatus press test is positive on the left.

Patient: Harwell, Danielle UE01/19/16

Cranial nerves are intact. Pupils are equal, reactive and accommodate. The tongue is midline and facial symmetry is normal. All extraocular movements are within normal limits without any noted nystagmus. Plantars are downgoing.

DIAGNOSTIC IMAGING: Advanced imaging (MRI) of her cervical spine was performed on January 4, 2016 at Buffalo MRI and the report indicates that there is C4-5 disc space narrowing with a shallow central disc extrusion. The canal and neural foramina still maintains her caliber. C5-6 has a shallow central disc extrusion, which barely flattens the thecal sac. The canal and neural foramina are patent. Mild uncovertebral spurring is noted. There is a gentle right-sided curvature of the lower cervical spine.

CLINICAL IMPRESSION:

1. Cervical sprain/strain S13.4XXA/S16.1XXA
2. Cervical disc herniation M50.21
3. Pain in the extremities M79.609 (undetermined etiology)
4. Disturbance of skin sensations R20.1 R20.2 (undetermined etiology)

DIFFERENTIAL DIAGNOSES:

1. Possible cervical radiculopathy M54.12
2. Rule out upper extremity peripheral neuropathy G56.90

CLINICAL DECISION MAKING: Based on Ms. Harwell's refractory cervical spine symptomatology coupled with her left upper extremity dysfunction noted above, further diagnostic evaluation is warranted in this patient. An upper extremity neurodiagnostic evaluation will be performed to isolate and delineate a suspected cervical radiculopathy as well as to rule out the likelihood of an upper extremity peripheral neuropathy in this individual with a history of cervical spine trauma with resultant upper extremity dysfunction.

Please see the attached EDX evaluation report and accompanying data tables that summarize the results of my evaluation.

Thank you again for allowing me the opportunity to participate in the care of Ms. Harwell.

Sincerely,

Gary R. Smith, DC, DIBE

CC: Geico Insurance



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA												PICA		
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPAIGN <input type="checkbox"/> GROUP <input type="checkbox"/> FEDERAL <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (DOD/DOD) (Member/Dep) (Plan) (Funding) (Other)													1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
													013873940-0101-059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/> 3. PATIENT'S BIRTH DATE <input type="checkbox"/> MM DD YY <input type="checkbox"/> SEX M <input type="checkbox"/> F <input type="checkbox"/> HARNELL, DANIELLE 8 29 1980 M													4. INSURED'S NAME (Last Name, First Name, Middle Initial) - on file -	
5. PATIENT'S ADDRESS (No., Street) <input type="checkbox"/> 6. PATIENT RELATIONSHIP TO INSURED 56 BIRCHRAVEN DR <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>													7. INSURED'S ADDRESS (No., Street)	
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE		CITY		STATE						
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE ()		TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME													10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>LINX</u> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FICA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME
													d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED <u>ON DATE</u> <u>01-06-2014</u>													SIGNED <u>ON DATE</u> <u>01-06-2014</u>	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY <u>QUAL</u>		15. OTHER DATE MM DD YY <u>QUAL</u>		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM <u>TO</u>										
17. NAME OF PREFERRED PROVIDER OR OTHER SOURCE <u>17a</u> <u>Gospalski, Peter, DC</u>		17b. <u>NP</u>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM <u>TO</u>										
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													20. OUTSIDE LABS <input type="checkbox"/> YES <input type="checkbox"/> NO <u>CHARGES</u>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind <input type="checkbox"/> A. <u>M50-22</u> B. <u>M51.21</u> C. <u>M99-03</u> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <u>M99-01</u> J. <u>M50.41</u> K. <u>S23-33XA</u> L. <input type="checkbox"/>													22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLAC OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) E. MODIFIER F. DIAGNOSIS POINTER G. DATES ON UNITS H. DRAFT PER UNIT I. ID J. RENDERING PROVIDER ID. # 1 6 16 1 6 16 11 97140 ABC-JS 55-00 3 NPI 3144462011 2 1 20 16 1 20 16 21 97140 ABC-JS 55-00 3 NPI 3144462011 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100													23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> 26. PATIENT'S ACCOUNT NO. <input type="checkbox"/> 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ <u>110.00</u> <input type="checkbox"/> 29. AMOUNT PAID \$ <u>0.00</u> <input type="checkbox"/> 30. RES for NUCC Use <u>110.00</u>													33. BILLING PROVIDER INFO & PH# <u>716</u> 725-0264	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <u>COLLEEN MARX, LMFT</u> <u>375 DICK RD</u> <u>DEPew, NY 14043</u> <u>SIGNED</u> <u>1.22.16</u> <u>1144462011</u>													32. SERVICE FACILITY LOCATION INFORMATION <u>COLLEEN MARX, LMFT</u> <u>375 DICK RD</u> <u>DEPew, NY 14043</u> <u>1144462011</u>	

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offence punishable under law and may be subject to civil penalties.

PAPERS TO GOVERNMENT PROGRAMS Q-E-Y

MEDICARE AND TRICARE PAYMENT: A provider's signature below indicates that payment be made and out-of-pocket expenses of any information necessary to process the claim and confirm health information provided in Blocks 1 through 12 is to be made available to Medicare or Medicaid and noninsured individuals and entities. In the case of a Medicare claim, this provider's signature authorizes any release to Medicare or Medicaid and noninsured information and services the person has employer upon health insurance, liability, no-fault, worker's compensation or other payments (such as in response to pay for services for which the Medicare claim is made. See 42 CFR 413.140(c). If there is a nonparticipating provider, the provider's signature authorizes release of the information to the health plan or non-participating plan. In Medicare assigned or TRICARE participation cases, if the physician agrees to accept the charge determination of the Medicare contractor, TRICARE local into-military or TRICARE full charge and the patient is responsible only for the deductible, copayments and non-covered services. Insurance and the deductible are based upon the charge during the initial visit of the Medicare or non-participating TRICARE local into-military or TRICARE full charge less the charges submitted by the physician. If the physician is not a Medicare insured, payment will be made by the physician for health services provided through certain affiliations with the United States Department of Defense or the patient's employer. It should be noted that TRICARE is not a third party insurer; payment will be made directly to the physician.

PLACE MINE AND FEGA CLAIMS

The provider agrees to accept the amounts paid by the Government as payment in full. See Block, Long and FECA instructions regarding record-keeping procedures and diagnosis coding systems.

EIGHTURE OF PHYSICAL OR SUPPLIER (MEDICARE, TRICARE, FICA AND BLACK LUMPS)

In submitting the claim for payment, I am stating, "here, I certify that, if the information on this form is true, accurate and complete, as I have furnished myself in all respects true, accurate, and payment, insurance, which are available from the Medicare contractor, by) I have provided or will provide sufficient information needed to allow the government to make an informed eligibility and payment decision; by the claim, whether submitted by me or on my behalf by my designated billing carrier, can be compared with all applicable Medicare rules, federal laws, regulations, and payment methods for payment including but not limited to the Federal Employees Health Benefits Plan and Physician Self-Referral law (commonly known as Stark law); 3) the services on this form were medically necessary and personally rendered by me or were rendered incident to my professional service (as commonly known as Stark law), except as otherwise expressly permitted by Medicare or TRICARE; 4) for each service rendered incident to my professional service, the identity (legible name and NPI number & SSN) of the primary individual rendering care, nor is it reported in the designated incident to services to be considered "incident to" a physician's professional services; 5) they must be rendered under the physician's direction, supervision or, as the case is of non-physicians, must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States' Government or a contract employee of the United States' Government, either civilian or military (refer to 6 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-rated disorder.

No Part B Medicare benefits may be paid unless this form is retained as required by contract law and regulations (42 CFR 424.321).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PICA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OASCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1632, 1672 and 1874 of the Social Security Act as amended, 42 CFR §11.81(a) and 424.5(p)(B), and 41 USC 3101.41 CFR 101 of seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 613, E.O. 8387

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carers, intermediaries, medical record boards, health plan, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties pay or to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

POR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37548, WED Sept. 12, 1990, or as updated from republished.

FOR OWCP CLIA 18: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

POLICY AND USERS: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, or to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recovery of claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a claim pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities and individual providers of care, on matters relating to enrollment, claims adjudication, fraud program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal law enforcement related to the operation of TRICARE.

DISCLOSURE: Voluntary, however, we provide information which result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failure to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 103-603, the "Computer Matching and Privacy Protection Act of 1996", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds. And that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office (716) 725-0834

Fax (716) 725-0855

Client Name: Danielle Howell Date: 11/6/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Cervical/V.A. 10-31-15 - ① Cervical/UE pain/contort reduces SNSDrop-off items by the end of the day. Lumber & shoulder in Cervical/UE 2nd EMG test yesterday. Adhesions seen into PLE's L & R. Client has numerous adhesions throughout C-T musculature. Tenderness noted SNS into PLE's L & R. Client has numerous adhesions throughout C-T musculature. Tenderness noted Action's Applied: (Check All that Apply) in all cervical musculature.

- Heat Packs Cold Packs Sombra/Biofreeze Light Pressure Massage Mod Pressure Massage Deep Tissue Massage Myofascial Release Friction Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist: Melissa

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office (716) 725-0834

Fax (716) 725-0855

Client Name: Danielle Howell Date: 11/20/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: 1st visit 1st appointment 1st Session. Pain reduced + shifted ↑ P

Action's Applied: (Check All that Apply) in Cervical/T.N.T.

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist: Melissa

01.29.16

01 29 16

"Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Dewey, NY 14043

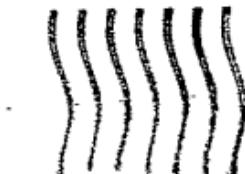
Attn: C. Marx

GEO - NY

PIP

P.O. Box 9507

22403526
JULY 19 1987
1987
02403 9521





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIGA										PICA
1 MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TICARE <input type="checkbox"/> (ADW/DCW)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (DOL)	FICA EXCLUDING <input type="checkbox"/> (DOL)	OTHER <input type="checkbox"/> (DOL)	1a INSURED'S ID NUMBER 013873940-0101-059	(For Program in Item 1)		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			3 PATIENT'S BIRTH DATE MM DD YY		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		4 INSURED'S NAME (Last Name, First Name, Middle Initial) - on file -			
5 PATIENT'S ADDRESS (No., Street) 56 HARRIBAVER DR			6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No., Street)					
CITY AMHERST	STATE NY	8 RESERVED FOR NUCC USE X		CITY		STATE				
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951			ZIP CODE	TELEPHONE (Include Area Code) ()					
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11 INSURED'S POLICY GROUP OR FICA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY					
			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>PLACE (State)</small> NY		b. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F					
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM										
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										
SIGNED <u>ON FILE</u> DATE 01-06-2016 SIGNED <u>ON FILE</u>										
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10-31-2015 CUAL	15. OTHER DATE QUAL	MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE GUZLINSKI, Peter, DC			17b. NPI		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										
20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A <u>L</u> B <u>I</u> C <u>L</u> D <u>I</u> E <u>L</u> F <u>I</u> G <u>L</u> H <u>I</u> I <u>L</u> J <u>I</u> K <u>L</u> L <u>I</u>										
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B PLACE OF SERVICE BMG	C	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E DIAGNOSIS CODING MODIFIER	F	G DAYS ON UNITS	H AMOUNT PER UNIT	I ID CANC.	J RENDERING PROVIDER ID #
1 1-25-16	1-25-16	1-25-16	11	93140			55	1.00	3	NPI 1144462043
2										NPI
3										NPI
4										NPI
5										NPI
6										NPI
25 FEDERAL TAX ID NUMBER 306513951	SSN EIN <input checked="" type="checkbox"/>	26 PATIENT'S ACCOUNT NO HARWELL, S		27 ACCEPT ASSIGNMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28 TOTAL CHARGE \$ 55 1.00	29 AMOUNT PAID \$ 0 00	30 Ref for NUCC USE 55 .00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMFT			32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD DEPew, NY 14043		33 BILLING PROVIDER INFO & PH# 716 725-0264					
SIGNED 1.25.16 DATE			a 1144462043 b 1144462043		GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD DEPew, NY 14043					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made upon the patient's release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and voucher to whom the patient has assigned his/her group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.2(b)(6). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assignment or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the final charge and the patient is responsible only for the deductible and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if it is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the dentist (legal name and NPI license #, if applicable) of the primary individual rendering each service is reported in the designation section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5333). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or omits essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and CWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is as follows: 209(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (8), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 801 et seq; 36 USC 613; E.O. 9387.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, centers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 08-70-0301, titled, "Common Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept 12, 1990, or as updated and republished.

FOR CWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, 800 ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determine that the services/supplies received are authorized by law.

PRINCIPLE USE(S): Information from claim and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation concerning their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with account recovery claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign governmental agencies, private bureaus, brokers, and individual providers of care, matters relating to entitlement, claims adjudication, trust, premium debts, utilization review, quality assurance, prior review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary, however, failure to provide information can result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under Title 38 programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged could prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 301-3012 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XXI plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

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 0938-1187. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-03, Baltimore, Maryland 21244-1950. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203
Office: (716) 725-0624 Fax: (716) 725-0665

Client Name: Danielle Harwell Date: 1/25/16

Client Status: (Check) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunctions: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliges ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client feeling better today. No △ in overall pain/pain in L (L.E. Client states she saw)

Chiro a day or 2 p.m.t. & made her worse & she

- Action's Applied: (Check All that Apply)
- Heat Packs Cold Packs Sombra/Biofreeze certain
 - Light Pressure Massage Mod Pressure Massage Client felt better
 - Deep Tissue Massage Myofascial Release Friction
 - Manual Traction Stretching Range-of-Motion M.T.
 - Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Danielle Harwell

01.29.16

01 29 16

"Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Dewey, NY 14043

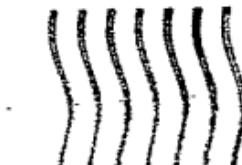
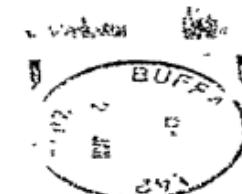
Attn: C. Marx

GEO - NY

PIP

P.O. Box 9507

22403526
JULY 19 1987
1987
02403 9521





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BUILDING OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member ID# <input type="checkbox"/> (DOD) <input type="checkbox"/> (DOD) <input type="checkbox"/> (DOD)										1a. INSURED'S ID NUMBER 013873940011059				(For Program in Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE					3. PATIENT'S BIRTH DATE MM DD YY 08291980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT					6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT									
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY										
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228				TELEPHONE (Include Area Code) (716) 536 0951				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980						
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NY					c. OTHER CLAIM ID (Designated by NUCC)						
					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10e. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																
SIGNED SIGNATURE ON FILE DATE SIGNED SIGNATURE ON FILE																
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 103115 QUAL 431					15. OTHER DATE MM DD YY QUAL 454 111215					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY					19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						
										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))					22. RESUBMISSION CODE 0					ORIGINAL REF. NO.						
A. M50.22		B. IM51.26		C. IM51.27		D. M54.12		23. PRIOR AUTHORIZATION NUMBER NPI								
E. I52.3 XXXA		F. IM99.01		G. IM99.03		H. IM99.02										
I. IM99.05		J. IM54.2		K. IM54.5		L. IM54.6										
24. A. DATES(S) OF SERVICE MM DD YY		B. C. PROCEDURES, SERVICES, OR SUPPLIES BM3 EXPLAIN UNUSUAL CIRCUMSTANCES		D. E. DIAGNOSIS CPT/HCPCS MODIFIER DIAGNOSIS POINTER		F. G. H. I. J. CHARGES MM DD YY ON UNITS ID CUAL RENDERING PROVIDER ID #										
01152016 01152016 11		99212 25		ABCD		20 29 1		NPI 1710014188								
01152016 01152016 11		98941		ABCD		32 28 1		NPI 1710014188								
01152016 01152016 11		97010		ABCD		10 53 1		NPI 1710014188								
01182016 01182016 11		98941		ABCD		32 28 1		NPI 1710014188								
01182016 01182016 11		97010		ABCD		10 53 1		NPI 1710014188								
25. FEDERAL TAX ID NUMBER 364500165		SSN SIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO 34382128		27. ACCEPT. ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 105.91		29. AMOUNT PAID \$		30. Rcv'd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this form are true and correct.) PETER GOULINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849						33. BILLING PROVIDER INFO & PH# (716) 681-3333								
SIGNED 01292016 DATE 1235256546								34. 1235256546								

02 01 16



Geico
P.O. Box 9507
Fredericksburg, VA 22403

345 Dick Rd.
Depew, NY 14043

INVESTIGATED
CITY OF BUFFALO

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
January 29, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday January 15, 2016 Provider: Peter Guzinski DC RE-EXAM

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights, she is unable to read as much as she would like, she has moderate headaches which come frequently, she cannot perform her usual work, her normal sleep has been moderately disturbed (2-3 hrs. sleepless) and she is able to engage in most, but not all of her usual recreational activities. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* getting worse. since last week. *Pain:* achy, dull, tingling, shooting, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has nausea and dizziness associated with the headaches. At times, light bothers her. *Cervical Disability Index:* 48%. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back and left anterior chest pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* getting worse. since last week. *Pain:* achy, dull, shooting; level: 7/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living.

Encounter dated 01/15/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

Alleviates symptoms: nothing. *Numbness:* none. *Weakness:* none. *Oswestry score:* 24%. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* getting worse. *since last week.* *Pain:* achy, dull, shooting, tingling, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 24%. *The Keele SStarT Back Screening Tool:* Medium risk. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Activity of Daily Living Form Bathing/Showering: mild impairment; Bending forward/backward: mild impairment; Driving: moderate impairment; Drying Hair: mild impairment; Household chores: moderate impairment; Laundry: severe impairment; Lifting less than 10 lbs: moderate impairment; Lifting more than 10 lbs: severe impairment; Kneeling: mild impairment; Making Meals: moderate impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: moderate impairment; Restful night's sleep: severe impairment; Seated to standing position: mild impairment; Sexual activity: severe impairment; Squatting: mild impairment; Tying shoes: mild impairment; Using lavatory: mild impairment; Walking: mild impairment.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Positive, lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck; right shoulder depression: Negative for right lower neck pain; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate to Severe. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Encounter dated 01/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

Lumbar/Sacral/Pelvis: Range of motion: flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. Heel to toe walking: WNL. Gait pattern: normal. Strength: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. Sensation: left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Reflexes:** bilateral lower extremity reflexes (L4 and S1) 2+. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Ely's Heel to Buttock: Negative bilateral; Minor's sign: Negative; Nachlas: Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Hibbs test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her initial visit on November 12, 2015 Mrs Harwell has made slow improvement with chiropractic treatment. Her active cervical flexion improved from 35 to 45 degrees, extension from 15 to 60 degrees, bilateral rotation from 45 to 60 degrees and right lateral flexion from 25 to 35 degrees. However her pain continues to remain unchanged. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL. Due to her left upper extremity pain, an EMG / NCV will be ordered to rule out radiculopathy. In addition, due to her continued headaches she will be referred to Dr. McVige at DENT, to rule out post concussion syndrome. **Diagnosis:** M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Lumbar assessment: Mrs. Harwell has made favorable improvement with chiropractic treatment since her initial evaluation on November 12, 2015. Her active lumbar flexion improved from 30 to 45 degrees and her left rotation improved from 15 to 35 degrees. In addition, she no longer has severe but now mild pain when squatting, tying her shoes, using the lavatory and while walking. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to sleep and lift with less pain. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left

Encounter dated 01/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

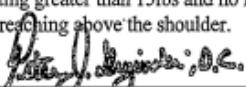
recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Smith for an UE EMG / NCV. Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain.

Disability status: Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Monday January 18, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain continues. Left arm continues to "hurt." Patient having the EMG tomorrow of the left UE. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change, since last week. **Pain:** achy, dull, tingling, shooting, numb; level: 7/10. **Pain is constant.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day.

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Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain continues with left chest pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has not been as intense. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise:

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Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Lumbar assessment: improving. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

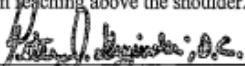
Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Smith for an UE EMG / NCV. Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the

Encounter dated 01/18/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain.

Disability status: Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Gajzinski, D.C.

Abbreviations:

ADL: activities of daily living

MVA: motor vehicle accident

ROM: range of motion

WNL: within normal limits



Item# 43568
Patent Pending





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

NUCC

<input type="checkbox"/> MEDICARE		<input type="checkbox"/> MEDICAID		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> GROUP HEALTH PLAN		<input type="checkbox"/> FECA EXCLUDING <input type="checkbox"/> (D&W)		<input type="checkbox"/> OTHER <input type="checkbox"/> (D&W)		1a. INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)	
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (TRICARE)		<input type="checkbox"/> (CHAMPVA)		<input type="checkbox"/> (Group Health Plan)		<input type="checkbox"/> (FECA Excluding D&W)		<input type="checkbox"/> (Other)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				SEX				4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARWELL DANIELLE				MM DD YY 08291980				M <input type="checkbox"/> F <input checked="" type="checkbox"/>				HARWELL DANIELLE					
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				Slt <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Chld <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street)					
56 BEREHAVEN DR LEFT												56 BEREHAVEN DR, LEFT					
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY		CITY AMHERST		STATE NY							
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH				SEX					
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				MM DD YY 08291980				M <input type="checkbox"/> F <input checked="" type="checkbox"/>					
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?				b. OTHER CLAIM ID (Designated by NUCC)									
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME									
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				GEICO									
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?									
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED SIGNATURE ON FILE				DATE				SIGNED SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115		15. OTHER DATE MM DD YY QUAL 454 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____				17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.	
a. M50.22 e. I22.3XXA i. M99.05		b. M51.26 f. M99.01 j. M54.2		c. M51.27 g. M99.03 k. M54.5		d. M54.12 h. M99.02 l. M54.6		22. PRIOR AUTHORIZATION NUMBER									
24. a. DATES OF SERVICE From MM DD YY To MM DD YY		b. PLACE OF SERVICE BMG		c. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS		d. MODIFIER		e. DIAGNOSIS POINTER		f. S CHARGES		g. PAYMENT OR UNITS		h. BILLING FIRM/PIN		i. ID QM#	
1 01052016 01052016 11 98941		ABCD		32 28		1		NPI		1710014188							
2 01052016 01052016 11 97010		ABCD		10 53		1		NPI		1710014188							
3 01082016 01082016 11 98941		ABCD		32 28		1		NPI		1710014188							
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5 01112016 01112016 11 98941		ABCD		32 28		1		NPI		1710014188							
6 01112016 01112016 11 97010		ABCD		10 53		1		NPI		1710014188							
25. FEDERAL TAX ID NUMBER SSN EIN 364500165		26. PATIENT'S ACCOUNT NO 34382127		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE 128.43		29. AMOUNT PAID 5		30. Revd for NUCC Use							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this form are true and correct to the best of my knowledge and belief.) PETER GOZINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849													
SIGNED 01292016 DATE 1235256546																	



Item# 43568
Patent Pending



02 01 16



INSTITUTE OF
TECHNOLOGY
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
January 29, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday January 5, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today with the chief complaint of continued neck pain. She states that her left arm and hand continues to feel weak. Patient stated that she had a neck MRI yesterday. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, tingling, shooting; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy; level: 6/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: Reviewed cervical MRI with the patient today. *Range of motion:* flexion: 35/50 with pain neck and upper back; extension: 15/60 with pain neck and upper back; left rotation: 45/80 with pain neck and upper back; right rotation: 45/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 20/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity &*

Encounter dated 01/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: Reviewed thoracic MRI with the patient today. **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate to Severe, **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: Reviewed lumbar MRI with the patient today. **Range of motion:** flexion: 30/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 15/30 with pain lower back; right rotation: 30/30 with pain lower back; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Sensation:** left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick.

Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Cervical assessment: Updated diagnosis based on recent MRI results. **Diagnosis:** M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged.

Prognosis: Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: Thoracic MRI was performed at Buffalo MRI on 01/04/2016 and revealed a T10 hemangioma in the vertebral body according to the radiologist. **Thoracic assessment:** unchanged. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: improving, VAS score improved from 5 to 4 out of 10. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with

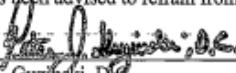
Encounter dated 01/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 (manual traction); C6 (manual traction); T2 right (diversified prone); T3 right (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 (manual traction); L5 (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left thromboid trigger point therapy. *Sent for tests:* electrodiagnostic testing of the left upper extremity due to left arm weakness and numbness. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec.

Home care: ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, DC.

Friday January 8, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today with the continued chief complaint of neck and left arm pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change since last visit. *Pain:* achy, tingling, shooting; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching;

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activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy; level: 6/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 35/50 with pain neck and upper back; extension: 15/60 with pain neck and upper back; left rotation: 45/80 with pain neck and upper back; right rotation: 45/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 20/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate to Severe. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: Reviewed lumbar MRI with the patient today. *Range of motion:* flexion: 30/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 15/30 with pain lower back; right rotation: 30/30 with pain lower back; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees

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for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s): L4, L5, Left SI.* *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: Thoracic MRI was performed at Buffalo MRI on 01/04/2016 and revealed a T10 hemangioma in the vertebral body according to the radiologist. *Thoracic assessment:* unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

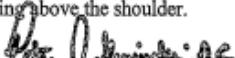
Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (supine mobilization); C6 left lateral flexion restriction (supine mobilization); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 (manual traction); L5 (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Sent for tests:* electrodiagnostic testing of the left upper extremity due to left arm weakness and numbness.

Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional Instructions:* Advised patient to monitor for any changes in

Encounter dated 01/08/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Monday January 11, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck "feels the same". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, tingling, shooting; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain has not been as intense. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy; level: 5/10. *Pain is constant.* *Pain radiates to:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has not been as bad. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 35/50 with pain neck and upper back; extension: 15/60 with pain neck and upper back; left rotation: 45/80 with pain neck and upper back; right rotation: 45/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 20/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left

Encounter dated 01/11/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Moderate to Severe. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: Reviewed lumbar MRI with the patient today. *Range of motion:* flexion: 30/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 15/30 with pain lower back; right rotation: 30/30 with pain lower back; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: Thoracic MRI was performed at Buffalo MRI on 01/04/2016 and revealed a T10 hemangioma in the vertebral body according to the radiologist. **Thoracic assessment:** improving, VAS score improved from a 6 to 5 out of 10. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: improving, VAS score improved from a 4 to 3 out of 10. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with

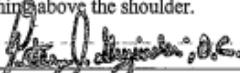
Encounter dated 01/11/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 01/29/2016

central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (supine mobilization); C6 left lateral flexion restriction (supine mobilization); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 (manual traction); L5 (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Sent for tests:* electrodiagnostic testing of the left upper extremity due to left arm weakness and numbness.

Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Gutzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/13

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER-

PICA										PICA																			
MEDICARE <input type="checkbox"/> (Medicare)		MEDICAID <input type="checkbox"/> (Medicaid)		TRICARE <input type="checkbox"/> (DoD/DoD)		CHAMPVA <input type="checkbox"/> (Master/DS)		GROUP HEALTH PLAN <input type="checkbox"/> (DHR)		FECA <input type="checkbox"/> (DOL)		OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER 013873940-0101-059		(For Program In Item 1)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM <input type="text"/> DD <input type="text"/> YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) - as file -															
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)																	
56 BEREHAVEN DR																													
CITY AMHERST					STATE NY					CITY																			
ZIP CODE 14228					TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE ()																			
8. RESERVED FOR NUCC USE X										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)																			
10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BIZ										12. INSURED'S DATE OF BIRTH MM <input type="text"/> DD <input type="text"/> YY M <input type="checkbox"/> F <input type="checkbox"/>																			
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										13. OTHER CLAIM ID (Designated by NUCC)																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										e. INSURANCE PLAN NAME OR PROGRAM NAME																			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM <input type="text"/> DD <input type="text"/> YY 10 31 2015 QUA										15. OTHER DATE QUAL <input type="text"/> NM <input type="text"/> DD <input type="text"/> YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM <input type="text"/> DD <input type="text"/> YY TO MM <input type="text"/> DD <input type="text"/> YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Guzinski, Peter, DC										17a. <input type="text"/> 17b. <input type="text"/> NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM <input type="text"/> DD <input type="text"/> YY TO MM <input type="text"/> DD <input type="text"/> YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LABS <input type="checkbox"/> YES <input type="checkbox"/> NO										\$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))										ICD Ind		22. RESUBMISSION CODE <input type="checkbox"/> YES <input type="checkbox"/> NO										ORIGINAL REF. NO.							
A <input type="text"/>	B <input type="text"/>	C <input type="text"/>	D <input type="text"/>	E <input type="text"/>	F <input type="text"/>	G <input type="text"/>	H <input type="text"/>	I <input type="text"/>	J <input type="text"/>	K <input type="text"/>	L <input type="text"/>	23. PRIOR AUTHORIZATION NUMBER																	
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. RACE OF SERVICE EMR		C. GENDER OPT/HCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. DIAGNOSIS POINTERS		G. DATES OR UNITS		H. AMOUNT Per Visit Per Day Per Family Per Visit		I. L. QUL		J. REFERRING PROVIDER ID #											
02 03 16 02 03 16 31																													
02	03	16	02	03	16	31	97340											NPI	144462011										
3																		NPI											
4																		NPI											
5																		NPI											
6																		NPI											
25. FEDERAL TAX I.D. NUMBER	SSN <input type="text"/> EIN <input type="text"/>	26. PATIENT'S ACCOUNT NO HARVELL, S		27. ACCEPT ASSIGNMENT (For post claim, see box)		28. TOTAL CHARGE \$ 55.00		29. AMOUNT PAID \$ 0.00		30. Paid for NUCC Use 55.00																			
099606323				<input type="checkbox"/> YES <input type="checkbox"/> NO																									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof)										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD DEPew, NY 14043																			
										33. BILLING PROVIDER INFO & PH# 716 725-0264																			
COLLEEN MARX, LMT 02.08.16 RECD BY: <input type="text"/> DATE: <input type="text"/>																													

NIJCC Instruction Manual available at: www.niijcc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.
NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to penalties.

REFERS TO GOVERNMENT PROGRAM ONLY

MEDICARE AND TRICARE PAYMENTS A patient's signature is required. Real payment will be made and a written release of any information necessary to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release in Medicare medical and nonmedical information and/or whether the person has employer group health insurance, liability, no-fault, 3rd-party compensation or other insurance which is responsible to pay for the services for which this Medicare claim is made. See 42 CFR 111.2(a)(3). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE preferred network cases. The physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE itself (or beneficiary if it is less than the charge submitted). TRICARE is not a health insurance program but makes payment for health services provided through civilian facilities with less Unfinished Services. When there is a conflict between the patient's signature and the information provided in these items, the information in "Item 9" is given priority.

BY XIAOJUN HE AND RICHARD CLARKSON

The provider agrees to accept the amounts paid by the Government as payment in full. See BIA, Lemo and FECA instructions regarding required procedure and claimants cannot assert rights under other laws.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, PDS, AID BLENCH, LIMO)

In certifying this claim for payment from Federal funds I certify that: 1) The information on this form is true, accurate, and complete; 2) I am a licensed physician or all applicable laws, regulations, and program instructions; 3) I have used the NPI number assigned to me by the National Plan and Review; 4) I have provided to the provider sufficient information required to make an informed eligibility and payment determination; 5) I am a citizen, alien, or national admitted to or on my behalf by my designated billing company, complete with all applicable documents, and/or medical laws, regulations, and procedures used for treatment including but not limited to the Federal Office of Health Care and Physician Self-Referral laws (commonly known as Stark law); 6) All services on this form were rendered by myself and personally furnished by me to one or more patients assigned to my professional service by my employer, or my direct supervisor, except as otherwise expressly permitted by law (also see TRICARE); 7) For each service furnished outside my professional service, the identity (legal name and NPI, license #, or SBN) of the primary individual rendering the service is indicated in a separate column. Services to be considered "incident to" a physician's professional services, such as may be rendered under the physician's direct supervision or by his/her associates, may be integral, although incidental, part of a covered physician service; 8) They must be of levels commonly furnished in physician's office; and 9) The services of nonphysician, cannot be included on the physician's bills.

For TRICARE claim: I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (year 3 of USC 3398). For Black Lung claim: I further certify that the services performed were for a Black Lung-related disease.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 421.320).

NO FEE: Any non-profit organization or individual organization that receives payment from Federal funds requested by this firm may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PEGA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and CMC to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(i), 180, 187, and 187A of the Social Security Act as amended, 42 CFR 411.24(a) and 426(b)(6), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1085, 5 USC 8101 et seq, and 30 USC 901 et seq, 28 USC 613, E.O. 1387

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to issue final payment if necessary.

The information may also be given to other providers of services, clinics, intermediaries, medical injury boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs. It will require other third parties to apply only to Federal program, and as often as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Administrative disclosures are made through routine records of information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Change Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37548, Wed. Sept. 12, 1990, or as updated and republished.

FOR O/WCP CLAIMS: Deposition of Luent, Privacy Act of 1974, 'Republication or Notice of Systems of Records.' Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-3, ESA-6, ESA-12, ESA-13, ESA-30, or 7-10 replaced and republished.

FOR TRICARE CLIA/F: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services received are authorized by law.

ROUTINE USE (RUR): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of its litigants in civil cases, to the Investment Recovery Service, prior to collection agencies, and consumer reporting agencies in connection with repayment claims, and to Congressional Offices in response to inquiries made at the request of a person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, tribal, foreign government agencies, private business entities, and individual providers of care, on a needs related basis, in claims adjudication, program abuse utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and oral and criminal litigation related to the conduct of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. While the one exception discussed below, there are no penalties under this policy for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FBCA could be deemed an admission.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-508, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost sharing charge.

STATEMENT OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or representations, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0334

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 2/3/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client feels tension + restriction today.
 in DUE neck. ↑ Adhesions of trPs today
 esp on D/S Ile. Chiro shifting @/knee

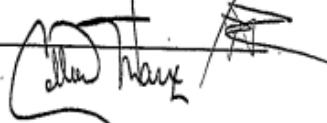
Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

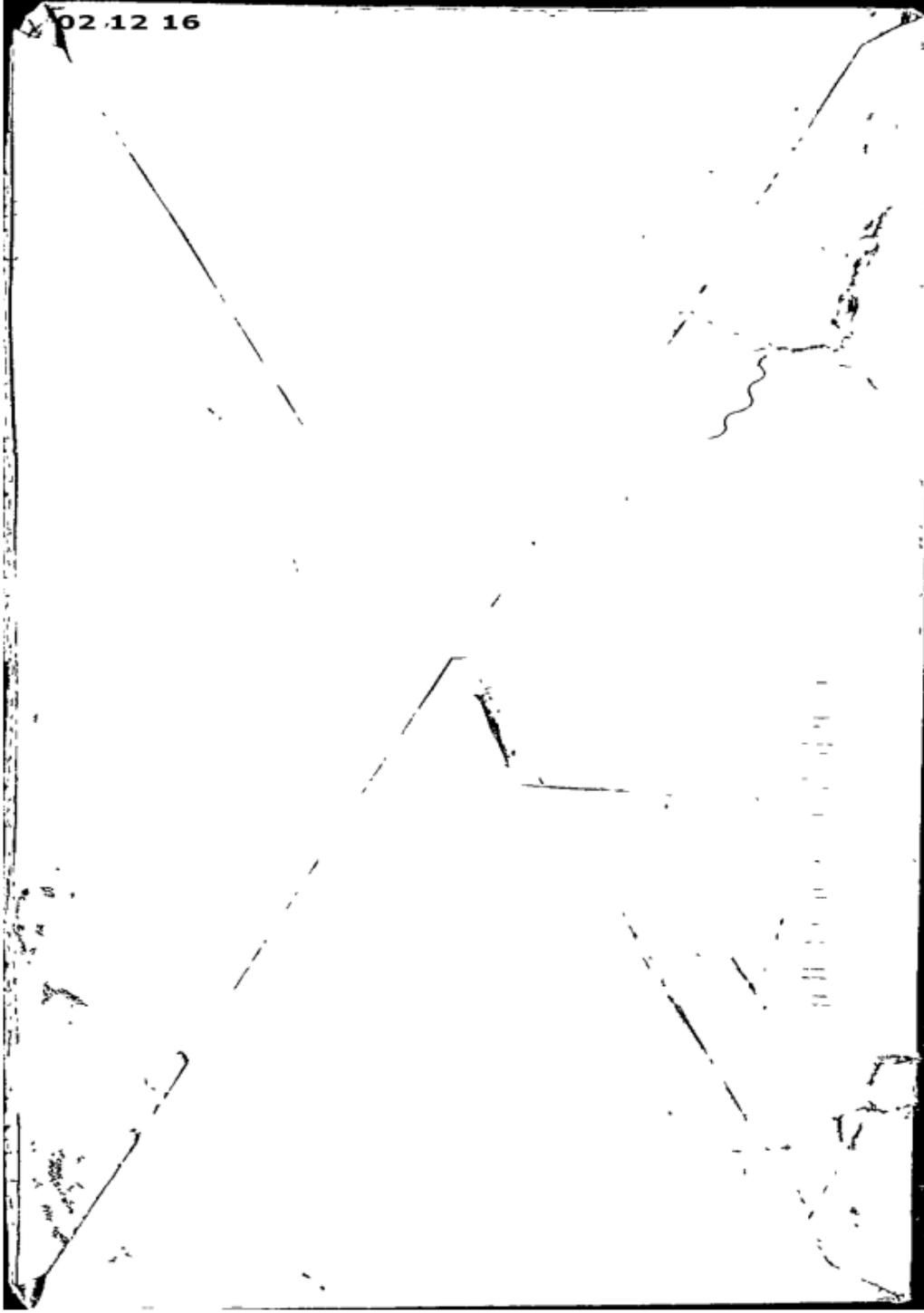
Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Cont' Meds Ice / Heat

Therapist:



02.12.16

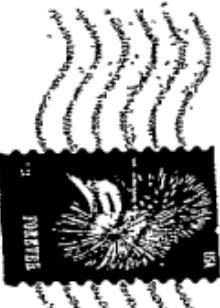


02 12 16

Great Lakes Therapeutic Massage

Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14243

18 FEB 2016 PM 11
447740 NY 142



GULCO-NY
P.O. Box 9507
Fredericksburg, VA
22403

22403952607



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403
RESUBMISSION

* * * * * REGISTRATION * * * * *

CARRIER -

FICA													
1. MEDICARE <input type="checkbox"/> Medicare	2. MEDICARE <input type="checkbox"/> Medicare	3. TRICARE <input type="checkbox"/> Tricare (Medicare) <input type="checkbox"/> (Medicare) <input type="checkbox"/> (DoD/MCRA)	4. CHAMPVA <input type="checkbox"/> Champva (Member ID) <input type="checkbox"/> (DoD/MCRA)	5. GROUP HEALTH PLAN <input type="checkbox"/> (DoD) <input type="checkbox"/> (DoD)	6. FECA BOOKLING <input type="checkbox"/> (DoD)	7. OTHER <input type="checkbox"/>	8. INSURED'S ID NUMBER 038873940-0101-059	(For Program Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
HARWELL, DANIELLE					M F <input type="checkbox"/>		-						
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)						
56 BEREHAVEN DR					8. RESERVED FOR NUCC USE X		CITY STATE ZIP CODE TELEPHONE (Include Area Code)						
AMHERST NY 14228 (716) 536-0951							CITY STATE ZIP CODE TELEPHONE (Include Area Code)						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER						
					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>NY</u>		a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
b. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE							c. INSURANCE PLAN NAME OR PROGRAM NAME						
d. INSURANCE PLAN NAME OR PROGRAM NAME					10. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNED <u>ON</u> <u>PTLR</u> <u>DATE</u> <u>01-06-2016</u>					SIGNED <u>ON</u> <u>PTLR</u> <u>DATE</u>								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 2015 QUA					15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Guzinski, Peter, DC					17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-J to services line below (24E) ICD 10:													
A. <u>M00.72</u>		B. <u>MS1.16</u>		C. <u>MS1.77</u>		D. <u>MS1.17</u>		E. <u>MS1.12</u>		F. <u>S23.3KVA</u>			
22. RESUBMISSION CODE ORIGINAL REF NO													
23. PRIOR AUTHORIZATION NUMBER													
24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMR C. D. PROCEDURES, SERVICES, OR SUPPLIES (List in usual circumstances) CPT/HCPCS I. MODIFIER E. DIAGNOSIS CODES (ICD-10) F. G. H. I. J. \$ CHARGES DAYS OR UNITS ID # RENDERS PROVIDER ID #													
1. 125 16 1 25 16 31 97140 ABC176 55 00 3 NPI 1144662032													
2. NPI													
3. NPI													
4. NPI													
5. NPI													
6. NPI													
25. FEDERAL TAX ID NUMBER SSN BIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (For group claims, see back) YES <input type="checkbox"/> NO										28. TOTAL CHARGE	29. AMOUNT PAID	30. Reserved for NUCC Use	
099606323										\$ 55.00	\$ 0.00	\$ 55.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH #
COLLEEN MARX, LM2 1.25.16 SIGNED DATE										GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD DEPew, NY 14043			716 725-0264
										GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD DEPew, NY 14043			
										1444620111 b			

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement, or claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal and punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient or beneficiary requests that payment be made and authorizes release of any information necessary to process the claim and evidence that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE+ interpretation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the bill charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's spouse, should be provided in those items captioned "Instead", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable laws, regulations, and program instructions for payment including but not limited to the Federal and/or State statute and Physician Self-Referral (commonly known as Star), Item 8) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional services by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for services rendered incident to my professional services, the identity (legal name and NPI), license #, or NRC# or the attorney individual rendering such service is listed in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be of kinds commonly rendered in physician's offices, and 2) the services of non-physician must be indicated in the physician's office; 2) they may be in an event (injury) incident plan of a covered physician even so, 3) they must be of kinds commonly rendered in physician's offices, and 4) the services of non-physician must be indicated in the physician's office.

For TRICARE claims, I further certify that I (or my employee) who furnish and services am not a career duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government either civilian or military (refer to 5 USC 9308). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless the form is received as required by existing law and regulations (42 CFR 414.22).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PAYMENT AGENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CWA, TRICARE and CWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1082, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(p)(6), and 44 USC 3.01-1 CFR 101 et seq. and 10 USC 1078 and 1086; 5 USC 8101 et seq., and 30 USC 901 et seq., 38 USC 818, E.C. 10, 9307.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other individuals paying to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine tests for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 06-70-0601, titled, Center Medicare Claims Record, published in the Federal Register, Vol. 66 No. 177, page 87549, Wed. Sept. 12, 1990, as updated and republished.

FOR CWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28 1990, See ESA-5, ESA-6, ESA-12, ESA-13, FSA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

BOUTIQUE LIST(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities and to TRICARE/CHAMPVA, and to the Dept. of Justice, for representation of the Secretary of Defense in and related to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate end-users may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care on matters relating to entitlements, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties and/or fines for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1138B of the Social Security Act and 51 USC 3801-0812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAO PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amounts paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were actually furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and adjudication of this claim will be from Federal and State funds, and that any false claim, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1187. The time required to complete the information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-96-05, Baltimore, Maryland 21244-1850. The address is for comments and/or suggestions, not to mail COMPLETED CLAIM FORMS TO THIS ADDRESS.

Px 12 16



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

NF GEICO
PO BOX 9507

FREDERICKSBURG VA 22403

CARRIER

PICA															
1 MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TRICARE <input type="checkbox"/> (DOD/DoD)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (GHP)	FECA EXCLUDING <input type="checkbox"/> (DVA)	OTHER <input checked="" type="checkbox"/> (DVA)	1a. INSURED'S ID NUMBER 0138739400101059 (For Program in Box 1)								
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980 <input checked="" type="checkbox"/> F <input type="checkbox"/> M								
4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							5 PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DRIVE								
6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							7 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DRIVE								
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY									
ZIP CODE 14228		TELEPHONE (Include Area Code) (716)-536-0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716)-536-0951									
8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
b RESERVED FOR NUCC USE DBD16761000							b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)								
c RESERVED FOR NUCC USE							c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
d INSURANCE PLAN NAME OR PROGRAM NAME							10d CLAIM CODES (Designated by NUCC)								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															
SIGNATURE ON FILE 02 11 2016 SIGNED _____ DATE _____															
13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.															
SIGNATURE ON FILE SIGNED _____															
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) 10/31/2015 QUA 431							15 OTHER DATE QUA MM DD YY								
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN JAMES PANZARELLA DO							16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)							22 SUBMISSION CODE ORIGINAL REF NO								
A MS42	B R51	C M5116	D M5020												
E L	F L	G L	H L												
I L	J L	K L	L L												
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY							B. PLACE OF SERVICE BNG	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	D. MODIFIER	E. DIAGNOSIS CODE POINTERS	F. CHARGES	G. DAYS ON UTI	H. PAYOR ID NPI	I. ID CLM	J. RENDERING PROVIDER ID #
1 02 08 16		11	99204		ABCD	119.61	1			G2					
2										NPI					
3										NPI					
4										NPI					
5	<i>*Please see attached Notes</i>														
6										NPI					
25 FEDERAL TAX ID NUMBER 030445678	SSN EIN <input checked="" type="checkbox"/>	26 PATIENT'S ACCOUNT NO 102251	27 ACCEPT ASSIGNMENT FOR MEDICAL BENEFITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28 TOTAL CHARGE 119.61	29 AMOUNT PAID \$ 0.00	30 Reserved for NUCC Use *									
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof.) POLLINA, JOHN, MD							32 SERVICE FACILITY LOCATION INFORMATION UNIVERSITY AT BUFFALO NEU 3980A SHERIDAN DRIVE AMHERST NY 14226-1727					33 BILLING PROVIDER INFO & PH # (716) -218-1030 UB NEUROSURGERY, INC PO BOX 8000 DEPT 883 BUFFALO NY 14267-0002			
SIGNED 02 11 16 DATE 1306896220							* 1740266048 G2								

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary for the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. **Coinsurance** and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-fraud/abuse statute and Physician Self-Referral law (commonly known as Stark Law); 5) the services on this form were medically necessary and personally furnished to me by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI), license #, or SSN of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinda commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5338). For Black-Lung claims, I further certify that the services performed were for a Black-Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2056(a), 1982, 1972 and 1974 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (8), and 44 USC 9101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 813; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0001, titled, "Carmer Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 87349, Wed. Sept. 12, 1980, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb. 28, 1980. See ESA-6, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/claims received are authorized by law.

EQUITY/INFLUENCE: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made of the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1120B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-03, Baltimore, Maryland 21244-1650. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

February 8, 2016

Peter Guzinski DC
345 Dick Road
Depew, NY 14043

Patient Name:	Danielle Harwell
Date of Birth:	08/29/1980
No-Fault Carrier:	NF Geico
CL#:	0138739400101059
Date of Injury:	10/31/15
Date of Exam:	02/08/16

Dear Dr. Guzinski:

I had the pleasure of seeing Danielle Harwell in the office today.

History: Danielle Harwell was seen in neurosurgical initial consultation on 02/08/2016 with complaints of neck pain, mid back pain, low back pain, left leg pain, left shoulder and arm pain as well as headache. She states she was a belted driver involved in a rear-ended motor vehicle accident on 10/31/2015. She developed progressive symptomatology as listed above and the next day sought care and evaluation from Western New York Immediate Care. She then was referred to her primary care physician, Dr. Panzarella, who referred her to Dr. Guzinski for chiropractic care and massage. She is getting some slight improvement with this treatment modality. She is here today for neurosurgical spine consultation. She states her pain is 5-7/10 on the Visual Analog Pain Scale.

Allergies: Keflex, Codeine, Clindamycin, Biaxin, Soma Penicillin, Cipro, Ranidin

Physical Examination: Examination of the lumbar spine fails to reveal deformity. There is no midline point tenderness or paraspinal spasm. There is intact power in the legs in all muscle groups. There is no dermatomal sensory loss noted. Symmetrical reflexes at the knees and ankles. Toes are downgoing. There is normal gait and station. There is no pain with passive range of motion of the hips. No straight leg raising pain. Feet are warm with no edema, there is no atrophy or deformity noted in the lower extremities.

Constitutional: The patient is well developed, well nourished, appears appropriate for age and is in no distress.

Cognition: The patient is alert and oriented, with recent and remote memory and language function appearing intact.

Cranial Nerves: The patient has symmetrical smile and frown. Tongue protrudes in midline without fasciculations or atrophy. Shoulder shrug is symmetrical.

Head: Normocephalic.

Neck: Supple, with no point tenderness or paraspinal spasm. No masses are palpable. Full range of motion is noted. No Lhermitte's.

Power: The patient has intact power in the deltoids, biceps, triceps, brachioradialis, wrist flexors and extensors, grips and first dorsal interossei. Normal power in the legs.

Sensation: There is intact pin sensation with no dermatomal sensory loss in the arms. Graphesthesia is intact. Joint position sense in the legs is intact.

Reflexes: Symmetrical reflexes at the biceps, triceps, knees and ankles. Toes are downgoing.

Cerebellar: There is no dysmetria noted on finger-to-nose testing.

Gait: The patient has normal gait and station. She can tandem walk without difficulty.

Extremities: Warm with no deformities. No edema. Normal muscle bulk and tone. There is no pain on passive range of motion of the shoulders or hips. Tinel's sign is negative bilaterally.

Review of Imaging: MRI of the lumbar spine done on 01/04/2016 does show a disk herniation on the left at L5-S1. There is a central disk herniation at L4-L5, both are acute in nature.

MRI of the thoracic spine done on 01/04/2016 is normal.

MRI of the cervical spine done on 01/04/2016 shows disk herniations both at C4-C5 and C5-C6.

Medical Decision Making: Danielle has cervicalgia, low back pain and cervical and lumbar radiculopathy in addition to headaches all related to injuries sustained to her cervical and lumbar spine as the result of a motor vehicle accident on 10/31/2015. I discussed with her the natural history of myofascial injury and disk herniations. I would like her to continue with chiropractic treatment and massage therapy. I would hold off on any surgical intervention to date because this will likely heal with ongoing chiropractic treatment. We will continue to follow her. If she has regression or persistent symptoms, we may change her treatment modality to a surgical approach, but again, this is early in the treatment paradigm for this.

Thank you very much for allowing me to participate in the ongoing care of this patient.

Diagnosis: Cervicalgia, Headache, Intervertebral disc disorders with radiculopathy, lumbar region, Other cervical disc displacement, unspecified cervical region, Low back pain

Sincerely,

Electronically signed by John Pollina, MD

John Pollina, Jr., M.D.

Clinical Vice Chairman

Director of Spine Surgery

Assistant Professor of Neurosurgery

WC#: CNS/201503

JP/dlp

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**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

XXPIKA

NUCC 2012

CARRIER											
PATIENT AND INSURED INFORMATION											
PHYSICIAN OR SUPPLIER INFORMATION											
1. MEDICARE <input type="checkbox"/> NHICARD <input type="checkbox"/> TRICARD <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> PSCA EXCLUDING <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (N/A) <input type="checkbox"/> (JUN)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE						3. PATIENT'S BIRTH DATE MM DD 29 1980 <input type="checkbox"/> M <input checked="" type="checkbox"/> F					
4. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR.						5. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR.					
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY					
ZIP CODE 14228		TELEPHONE (Include Area Code) ()		ZIP CODE 14228		TELEPHONE (Include Area Code) ()					
6. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE											
7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR.											
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 											
9. OTHER INSURED'S POLICY OR GROUP NUMBER 											
10. IS PATIENT'S CONDITION RELATED TO: <ul style="list-style-type: none"> a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 											
11. INSURED'S POLICY GROUP OR FICA NUMBER DOI 10/31/15											
12. INSURED'S DATE OF BIRTH MM DD 08 29 1980 <input type="checkbox"/> M <input checked="" type="checkbox"/> F											
13. OTHER CLAIM ID (Assigned by NUCC) 											
14. INSURANCE PLAN NAME OR PROGRAM NAME 											
15. CLAIM CODES (Designated by NUCC) 											
16. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT OR AUTHORIZED PERSON'S SIGNATURE I acknowledge the inclusion of any medical or other information necessary to process the claim. I also acknowledge payment of government benefits either to myself or to the party who accepted assignment below. PETER J GUCINSKI											
17. NAME OF REFERRING PROVIDER OR DENTAL SOURCE DIN PETER J GUCINSKI											
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 											
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (A-E)) ICD-9-CM 0 A. M791 B. L C. L D. I E. L F. L G. I H. L I. L J. L K. I L. I											
20. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PAYOR C. CPT/HCPCS D. PROCEDURE, SERVICE, OR SUPPLIES E. DIAGNOSIS 02 11 16 02 11 16 11 20553 A F. B. DATE OF USES G. ICD-9-CM H. PAYOR I. ID. # J. RENDERING PROVIDER ID # 161582336 EI 161582336 NPI 1710978598											
21. B. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY G. CHARGES H. PAYOR I. ID. # J. RENDERING PROVIDER ID # 1710014108 0 YES EI 161582336 NPI 1710978598											
22. OUTPATIENT CHARGES H. PAYOR I. ID. # J. RENDERING PROVIDER ID # 0 YES EI 161582336 NPI 1710978598											
23. PHARM AUTHORIZATION NUMBER 											
24. B. FEDERAL TAX ID NUMBER SSN/HIN C. PATIENT'S ACCOUNT NO. D. ADJUSTMENT ASSESSMENT 161582336 X 1311693 X E. DATE F. AMOUNT CHARGED G. AMOUNT PAID H. REWORK NUCC USE 02 16 16 5 95 74 1 0 00											
25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DELEGATES OR CREDITHOLDERS I certify that the treatments on the reverse apply to this bill and are made a part hereof. Dentist McHugh MD											
26. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 3RD FLR 3980 SHERIDAN DRIVE, 3RD FLOOR AMHERST NY 14226-1727											
27. BILLING PROVIDER INFO & PAY # 716 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002											



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HEADACHE & NEURO-ONCOLOGY CENTER

Lagido Mchitter, MD, Director

Jennifer W. McVay, MD
Nicholas Sakali, MD

Kathy A. Benarachi, RNP-C
Robessa Brumfield, PA-C
Sydney B. Grabau, PA
Lorraine Jendrovec, RPA-C
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Kathryn L. Murphy, FNP
Maria Sizzi, RPA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Garsenda, FNP-C
Christopher Zelenicki, FNP-C

Sydney B Grabau, PA

Procedure Note Date: 02/11/2016

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 35 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion

History of Present Illness

General:

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

This is Danielle's first round of trigger point injections. She has tried chiropractic and massage therapy with minimal relief. She is concerned about sensitivity to several medications and prefers to do the injections today without Steroid.

Current Medications

- Taking Vitamin D 50,000 int'l units capsule 1 cap(s) 2 times a week
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking Rizatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

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Batavia Office | 33 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Debra George, Clinic Manager
Antonia Mazzafra
Tilene Stew
Alice Trzaski

INFUSION CENTERS
Barbara Makrigiorgi, RN, Manager

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a non-smoker.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 122/68, HR 76, RR 16, Ht 63, Wt 150, BMI 26.57, BSA 1.74.

ExaminationNEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

ProceduresInjections:

(716) 250-2000
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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0713
Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Stawn Fazio, Clinic Manager
 Amanda McMyrdle
 Elton Stasi
 Alisa Trzeciak

INFUSION CENTERS

Roberta Mollerig, RN, Manager

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 7 cc was injected with a 25-gauge needle without complication into 7 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Follow Up

4 Weeks

*spns for PA-C
J*

Electronically signed by Sydney Grabau , PA on 02/11/2016 at 05:50 PM EST

Sign off status: Completed

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ADMINISTRATIVE SUPPORT
Shawn Fenger, Clinic Manager
Amanda Molyday
Eileen Szare
Alicia Trzasko
INFUSION CENTERS
Barbara Mullerig, RN, Manager

Receive Date: 2/19/2016 Front End

Region 2: NY PIP MAIL

Indexing Category:

Sorted by U62. _____

Tip Date: _____

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Order Form for

Dent Tower 3rd Flr

3980 Sheridan Drive, 3rd Floor,
Amherst, NY, 142261727
Tel: 716-250-2000 Fax: 716-250-2045

Jennifer McVige, MD (NPI:1649596495)

Provider Code:

State License No: 257529

Neurology

Patient: Harwell, Danielle

DOB: 08/29/1980 **Sex:** Female **Phone:** 716-536-0951

Address: 56 Berehaven Dr., Amherst, NY 14228

Order Date: 02/09/2016 01:30 PM

Today: 02/09/2016 02:35 PM

Primary Insurance Name:

Insurance Address:

Subscriber Number:

Insured Name: Address:

DIAGNOSTIC IMAGING:

Code	Diagnostic Name	Assessment(s)	Notes	Instructions
	MASSAGE Therapy	G44.309, Post-traumatic headache		

Electronically Signed By: Jennifer McVige, MD

Signature of Patient/Guardian

Patient: Harwell, Danielle DOB: 08/29/1980

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0264

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 2/11/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Hypertonic cervical region
more than (R), deep muscle stripping
applied, Adhesions present upper poster

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

Danielle Harrell

M

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist: _____

92.19 16

02 19 16

Great Lakes Therapeutic Massage

Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043



GEICO INS CO of NY
P.O.BOX 9507
FREDRICKSBURG, VA 22403

224039526 EOCES

[REDACTED]

02 19 16



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403
** RESUBMISSION **

CARRIER

PIRA

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FEDERAL BUILDING <input type="checkbox"/> OTHER (Medicare) (Medicaid) (TRICARE) (Champva) (Group Health Plan) (FEDERAL BUILDING) (Other)										1a. INSURED'S ID NUMBER (For Programs in Item 1) 013873940-0101-055																							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARMILL, DANIELLE										3. PATIENT'S BIRTH DATE MM DD YY 08 29 1986										4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARMILL, DANIELLE													
5. PATIENT'S ADDRESS (No., Street) 56 BERKLAVER DR										6. PATIENT RELATIONSHIP TO INSURED Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) ()													
CITY AMHERST					STATE NY					8. RESERVED FOR NUCC USE X					CITY ()					STATE ()													
ZIP CODE 14228					TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE ()					TELEPHONE (Include Area Code) ()																		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR PICA NUMBER													
a. OTHER INSURED'S POLICY OR GROUP NUMBER ()										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										b. OTHER CLAIM ID (Designated by NUCC) ()													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME ()													
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED ON DATE 01-05-2016										SIGNED ON DATE 01-05-2016													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 01 05 2016										15. OTHER DATE MM DD YY QUAL					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO																		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. J. H. HARMILL, DC										17a. 17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO																		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										19a. 19b. NPI					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/>					5. CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24c)) A M50.22 B M51.26 C M54.52 D E H L G H L K M54.2 L										ICD IND.					22. RESUBMISSION CODE ORIGINAL REF. NO.																		
24. a. DATES OF SERVICE From MM DD YY To MM DD YY Place of Service EMR										b. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					e. DIAGNOSIS POINTER					f. S CHARGES G DATES ON UNITS H INDEX PER REF. I ID QM					j. RENDERING PROVIDER ID #								
1	01	06	16	01	06	16	11	97310		ABC1JK	55.00	3																NPI	2144462011				
2	01	20	16	01	20	16	31	97340		ABC1JK	55.00	3																		NPI	2144462011		
3	01	25	16	01	25	16	21	97240		ABC1JK	55.00	3																			NPI	2144462011	
4	02	09	16	02	03	16	31	97340		ABC1JK	55.00	3																			NPI	2144462011	
5																																NPI	
6																																NPI	
25	FEDERAL TAX ID NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO. HARMILL, D					27. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					28. TOTAL CHARGE \$ 220.00					29. AMOUNT PAID \$ 0.00					30. Reason for NUCC Use 220.00							
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, TMS SIGNED 02.11.2016										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043										33. BILLING PROVIDER INFO & PH # GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043 716 725-0264												

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, inaccurate or misleading information may be guilty of a criminal offense punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

HEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature certifies any duty to release to Medicare medical and non-medical information and whether the person has employer group health insurance, liability, auto, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency known in Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if that is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in short names captioned in "Insurer" i.e. Items 4, 6, 7, 9 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government in payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-fraud statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering such service is reported in line designated Section For Services to be conducted "incident to" a physician's professional services; 7) they must be rendered under the physician's direct supervision by "other" employees; 2) they must be on the grid, although incidental part of a covered physician service; 3) they must be of little common furnished in physician's office; and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I nor any employee(s) who furnished services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 3 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 203(c), 1982, 1972 and 1974 of the Social Security Act as amended, 42 CFR 411.2(a) and 404.5(a) (b), and 41 USC 3161; 11 CFR 101 et seq and 10 USC 1079 and 1089; 3 USC 8101 et seq, and 30 USC 801 et seq, 38 USC 813, E.O. 13937.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to assure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties paying to pay premium to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-70-0301, titled, "Comer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Repopulation of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, SSA-12, SSA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility or medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

DISCLOSURE (IF ANY): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services under the Dept. of Transportation contract with their statutory administrator, two congressional under TRICARE/CHAMPVA, the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign governmental agencies, private businesses entities, and individual providers of care or services related to admissions, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, anti-drip and denial litigation related to the operation of HICRME.

DISCLOSURES: Voluntarily however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us, if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by use of computer matches.

FEDICO PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment, or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1650. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRICO Ins Co NF
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIKA

<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BUKUNG (X)	OTHER	1a. INSURED'S ID NUMBER 013873940-0101-059	(For Program in Item 1)	
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (DIN)	<input type="checkbox"/>	<input type="checkbox"/>			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARWELL, DANIELLE			MM <input type="text"/> DD <input type="text"/> YY	M <input type="checkbox"/> F <input checked="" type="checkbox"/>	- SAMS -				
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)				
56 BREEZHAVEN DR			Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>			
CITY AMHERST	STATE NY	8. RESERVED FOR NUCC USE		CITY		STATE			
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951	X		ZIP CODE	TELEPHONE (Include Area Code)		()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO,			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. EMPLOYMENT (Current or Previous)			a. INSURED'S DATE OF BIRTH			
			<input type="checkbox"/> YES <input type="checkbox"/> NO	MM <input type="text"/> DD <input type="text"/> YY			SEX	M <input type="checkbox"/> F <input type="checkbox"/>	
b. RESERVED FOR NUCC USE			c. AUTO ACCIDENT?	PLACE (SHM)			b. OTHER CLAIM ID (Designated by NUCC)		
			<input type="checkbox"/> YES <input type="checkbox"/> NO	LNX-L					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODE# (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
						<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, complete items 9, 9a, and 9d		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ON 01-06-2016DATE 01-06-2016SIGNED ON 01-06-2016

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (I.M.P.) MM <input type="text"/> DD <input type="text"/> YY 1-0-31-2015	15. OTHER DATE QUAL QUAL	MM <input type="text"/> DD <input type="text"/> YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM <input type="text"/> DD <input type="text"/> YY TO MM <input type="text"/> DD <input type="text"/> YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE McVIE, JENNIFER, M.D.	17a <input type="checkbox"/> NPI	17b <input type="checkbox"/> NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM <input type="text"/> DD <input type="text"/> YY TO MM <input type="text"/> DD <input type="text"/> YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (24e)) A. <u>LGA4-309</u> B. <u> </u> C. <u> </u> D. <u> </u>	ICD Ind <input type="checkbox"/>	22. RESUBMISSION CODE NPI	ORIGINAL REF. NO
E. <u> </u> F. <u> </u> G. <u> </u> H. <u> </u>	K. <u> </u> L. <u> </u>	23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM <input type="text"/> DD <input type="text"/> YY To MM <input type="text"/> DD <input type="text"/> YY	B. PLACE OF SERVICE ENG. <input type="checkbox"/>	C. PROCEDURES, SERVICES, OR SUPPLIES (English Unless Otherwise Specified) CPT/HCPCS <input type="checkbox"/>	D. MODIFIER <input type="checkbox"/>	E. DIAGNOSIS pointer <input type="checkbox"/>	F. \$ CHARGES <input type="checkbox"/> \$ DAYS ON <input type="checkbox"/> H PAYMENT PER <input type="checkbox"/> I. ID QMUL. <input type="checkbox"/> \$ CHARGES	J. RENDERING PROVIDER ID #
1 02 11 16 02 11 16 31					55 00 0	NPI 1144462011
2						NPI
3						NPI
4						NPI
5						NPI
6						NPI

25. FEDERAL TAX ID NUMBER 099606323	SSN BIN v	26. PATIENT'S ACCOUNT NO. HARWELL, D	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 55 00	29. AMOUNT PAID \$ 0 00	30. Rev'd for NUCC Use 55 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMH			32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			33. BILLING PROVIDER INFO & PH # 716 725-0264
SIGNED <u> </u> DATE <u>02.11.2016</u>			<u>a. 1144462011</u>			<u>b. 1144462011</u>

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE participation cases. The physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are set by the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's spouse should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-fraud statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE, 6a) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is repeated in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government, either civilian or military (refer to 5 USC 5338). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 404.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(b), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.24(a) and 424.5(a) (b), and 44 USC 3101,41 CFR 101 et seq and 10 USC 1078 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 6103, E.O. 13387.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, cancer intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Appropriate disclosures are made through means necessary for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-00-0001, MBR - Cancer Medicaid Claims Record," published in the Federal Register, Vol. 53 No. 177, page 37199, Wed. Sept. 12, 1990, as an update and re-published.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40 VR d Frth Jil 1970, 5r - ESR-6, DSA u. ESR-12, ESR-13, ESR-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PAYOR(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are sufficient by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, privacy collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individuals providers of care, on matters relating to enrollment, adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DIRECTIONS: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding my payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for these claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: It is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: GMB, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21264-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

02 19 16



Patient Name: Danielle Harwell

DOB: 08/29/80

Massage Therapy frequency of treatment: 1x per week for 8 weeks

- No Fault
 Workers' Compensation

Current Diagnosis:

M50.22, M51.2k, M51.27, M54.12, S23.3xxA,
M99.01, M99.03, M99.02, M99.05, M54.2, M54.5, M54.6

If you have any questions, please don't hesitate to contact our office at (716) 681-3333.
Thank you for your time.

Sincerely,

Date: 01/06/16

- Jason D. Cichocki, DC
 Peter J. Guzinski, DC
 Lisa A. DeMarco, DC

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(For accidents occurring on or after 03/01/02)**

I, Danielle Harwell, ("Assignor"/Patient's name - print), hereby assign to Colleen Marx, L.M.T. ("Assignee"/Print hospital or health care provider's name) all rights, privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51, (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on 10/31/15 (print date), not withstanding any other agreement to the contrary.

This agreement may be revoked by the Assignee when benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLES OR STATED CLAIM FOR EACH VIOLATION.

Patient/Client Information:

Danielle Harwell
(Print Name of Patient)

Danielle Harwell
(Signature of Patient)

Sue Berghaven Dr.

11/10/16

(Date of Signature)

Amherst, NY 14228
(Full Address of Patient/Client on the 2 Lines Above)

Provider Information:

Colleen Marx, L.M.T.

Colleen Marx
Great Lakes Therapeutic Massage
& Bodywork Practitioners
375 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Marx

Colleen Marx
11/10/16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0234

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0234

Fax: (716) 725-0235

Client Name: Danielle Hanwell Date: 1/10/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific (Treatment MVA 10-31-15 - ① Cervical/UE pain content) *subdues S&S*Dropping items by the end of the day. Lumber Lumbosacral Cervical L1-E10 yesterday. AdhesionsSos into LE's R. Chest has numerous adhesions Continue in C-T musculature. Tenderness noted Action's Applied: (Check All that Apply) Cervical

- Heat Packs Cold Packs Sombra/Biofreeze Hypertonic therapy
 Light Pressure Massage Mod Pressure Massage Soft scarpa
 Deep Tissue Massage Myofascial Release Friction *soft tissue*.
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage *cleaned*

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

DR. MAY

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0234

Fax: (716) 725-0235

Client Name: Danielle Hanwell Date: 1/20/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific (Chart left at 1st session. Pain returns + stated ↑ P)

Action's Applied: (Check All that Apply) Cervical M.T.

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

DR. MAY

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0364

Fax: (716) 725-0365

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0364

Fax: (716) 725-0365

Client Name: Danielle Harwell Date: 1/25/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client feeling better today. No ↑ in overall numbness/pain in LUE. Client states she saw Chiro a day or 2 p.m. t. & made her worse & she

Action's Applied: (Check All that Apply) *felt "poked up" in upper back*
 Heat Packs Cold Packs Sombra/Biofreeze certain tx.
 Light Pressure Massage Mod Pressure Massage *Client felt better*
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion *p.m.t.*
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Cool Meds Ice / Heat

Therapist:*Danielle Harwell*Client Name: Danielle Harwell Date: 2/3/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client feels ↑ tension & restriction today.
in LUE/reck. ↑ Adhesions & fibs today
esp on R side. Client still having pain at site.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massages
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Cool Meds Ice / Heat

Therapist:*Danielle Harwell*



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

NUCC

PICA

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> OTHER <input checked="" type="checkbox"/>												1a INSURED'S ID NUMBER (For Program in Item 1) 0138739400101059							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							
5 PATIENT'S ADDRESS (No., Street) 56 BERESHAVEN DR.												7. INSURED'S ADDRESS (No., Street) 56 BERESHAVEN DR.							
CITY AMHERST		STATE NY		8 RESERVED FOR NUCC USE		CITY AMHERST		STATE NY											
ZIP CODE 14228		TELEPHONE (Include Area Code) ()				ZIP CODE 14228		TELEPHONE (Include Area Code) ()											
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO:							
a OTHER INSURED'S POLICY OR GROUP NUMBER												a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
b RESERVED FOR NUCC USE												b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO c RESERVED FOR NUCC USE							
d INSURANCE PLAN NAME OR PROGRAM NAME												c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE												11 INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15							
SIGNED _____ DATE 02 09 16												b INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>							
13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE												c OTHER CLAIM ID (Designated by NUCC) d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items b, b-a, and b-d							
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL <input type="checkbox"/>												15 OTHER DATE MM DD YY QUAL 439 10 35 15				16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI												17a IG U62607				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19a OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22 RESUBMISSION CODE ORIGINAL REF NO							
A M791 B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/>												23 PRIOR AUTHORIZATION NUMBER							
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE C D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E CPT/HCPCS F MODIFIER G DIAGNOSIS H POINTERS I ID J RENDERING PROVIDER ID #												F. \$ CHARGES G. DAYS OF UNITS H. CREDIT PER UNIT I. ID QUAL J. RENDERING PROVIDER ID #							
1	02	11	16	02	11	16	11	20553		A	95	74	1	EI	161582336				
2														NPI					
3														NPI					
4														NPI					
5														NPI					
6														NPI					
25 FEDERAL TAX ID NUMBER	SSN	BN	26 PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT?	28 TOTAL CHARGE	29 AMOUNT PAID	30 Reserved for NUCC Use												
161582336			1311893	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	\$ 95	74	\$ 0 00												
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements to the reverse apply to this bill and are made a part thereof.)</small> <i>Dr Jennifer McHugh MD</i>												32 SERVICE FACILITY LOCATION INFORMATION DENT TOWER 3RD FLR 3980 SHERIDAN DRIVE, 3RD FLOOR AMHERST NY 14226-1727							
SIGNED DATE 02 16 16												33 BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002							
a. 1497850911												b. EI161582336							

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1957-58 - 1958-59 - 1959-60

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Table 1. The effect of different concentrations of *S. enteritidis* on the growth of *C. annuum* L.

It is the author's opinion that the best way to approach the problem of the relationship between the two types of data is to first determine the relationship between the two types of data at the level of the individual subject. This can be done by examining the correlation coefficient between the two types of data for each individual subject.

Scattered small-scale clusters of galaxies are also found in the field, and some of them are associated with the filamentary structures.

On the other hand, the results of the present study indicate that the use of a single dose of *Leishmania* antigen in the ELISA test is not sufficient to detect all the infected individuals.

For more information about the study, contact Dr. Michael J. Klag at (301) 435-2080 or via e-mail at mklag@jhu.edu.

For example, the following code creates a `Table` object with three columns:

For the first time, we have been able to measure the effect of the magnetic field on the rate of the reaction.

$\mu_1^{\text{opt}} = \frac{1}{2} \ln \left(\frac{1 + \sqrt{1 + 4\alpha^2}}{2} \right)$, $\mu_2^{\text{opt}} = -\frac{1}{2} \ln \left(\frac{1 + \sqrt{1 + 4\alpha^2}}{2} \right)$, $\mu_3^{\text{opt}} = \frac{1}{2} \ln \left(\frac{1 - \sqrt{1 + 4\alpha^2}}{2} \right)$, $\mu_4^{\text{opt}} = -\frac{1}{2} \ln \left(\frac{1 - \sqrt{1 + 4\alpha^2}}{2} \right)$.

For the first two terms in (2.1), we have the following lemma.

PM2.5 (Fig. 1) was 197.70 $\mu\text{g m}^{-3}$ (range = 146.50–240.00 $\mu\text{g m}^{-3}$) and PM10 (Fig. 2) was 320.00 $\mu\text{g m}^{-3}$ (range = 220.00–420.00 $\mu\text{g m}^{-3}$).

¹² See also the discussion of the relationship between the two in the section on "Theoretical Implications."

Figure 1. The effect of the addition of 10% of the following materials on the mechanical properties of polypropylene.

Figure 10 shows the results of the simulation of the effect of the variation of the number of nodes in the network on the performance of the proposed scheme.

¹ See also, Borchert (1998) for a discussion of the relationship between the two concepts.

For more information about the U.S. Census Bureau's 2010 Census, visit www.census.gov.

Figure 1. The relationship between the number of species and the area of forest cover in each state.

Other studies have shown that the use of a single dose of dexamethasone can reduce the incidence of postoperative nausea and vomiting.

¹ See also the discussion of the relationship between the two in the section on "Theoretical Implications" below.

For more information about the National Institute of Child Health and Human Development, please call the NICHD Information Resource Center at 301-435-2936 or visit the NICHD Web site at www.nichd.nih.gov.



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

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Marie Rizzo, RPA-C
Elizabeth D. Smith, CNP, ANP
Andrea Gassalit, FNP-C
Christopher Zdziarski, FNP-C

Sydney B Grabau, PA

Procedure Note

Date: 02/11/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion

History of Present Illness

General.

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

This is Danielle's first round of trigger point injections. She has tried chiropractic and massage therapy with minimal relief. She is concerned about sensitivity to several medications and prefers to do the injections today without Steroid.

Current Medications

- Taking Vitamin D 50,000 intl units capsule 1 cap(s) 2 times a week
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) pm headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

(716) 250-2000
www.dentinstitute.com

Amherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Steven Ferger, Clinic Manager
Amanda McFayden
Eileen Scott
Alice Trzcienski

INFUSION CENTERS

Barbara Meldberg, RN, Manager

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History**Tobacco Use:**

Smoking Patient is a non smoker.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 122/68, HR 76, RR 16, Ht 63, Wt 150, BMI 26.57, BSA 1.74.

Examination**NEUROLOGICAL:**

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures**Injections:**

(716) 250-2000
www.dentinstitute.com

ADMINISTRATIVE SUPPORT

Shawn Fager, Clinic Manager
 Amanda McPhees
 Eileen Stute
 Alice Trzcielski

INFUSION CENTERS

Barbara Mulderig, RN, Manager

Amherst Offices | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14227 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 7 cc was injected with a 25-gauge needle without complication into 7 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Follow Up

4 Weeks

from dr for pac
J

Electronically signed by Sydney Grabau , PA on 02/11/2016 at 05:50 PM EST

Sign off status: Completed

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Orchard Park Office | Sterling Medical Park • 209 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-6015
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Sharon Fugitt, Clinic Manager
Amanda McFayden
Eileen Stasi
Alice Trzaski

INFUSION CENTERS
Barbara Mulderrig, RN, Manager

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO.	3204
DESTINATION ADDRESS	18562945154
SUBADDRESS	
DESTINATION ID	Geico PIP Claims
ST. TIME	02/16 09:46
TX/RX TIME	00' 59
PGS.	4
RESULTS	OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL INSTITUTE OF AMERICAN EDUCATION

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100, 100

1. INSURANCE	NAME/NAME (Middle)	INSURANCE (Middle)	TRICARE (DOD/DoD)	CHAMPVA (Member/103)	GROUP (NIN)	DISABILITY PLAN (DPA)	DISABILITY LEVEL (DML)	OTHER (DOD)	10. INSURANCE ID. NUMBER 0138739400101059 (For Persons In State)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARRELL, DANIELLE	3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M F							4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARRELL, DANIELLE				
5. PATIENT'S ADDRESS (No., Room) 56 BERERHAVEN DR.	6. PATIENT'S RELATIONSHIP TO INSURED SPOUSE							7. INSURED'S ADDRESS (No., Room) 56 BERERHAVEN DR.				
CITY AMHERST	STATE NY	8. RESERVED FOR MUCC USE							CITY AMHERST	STATE NY		
ZIP CODE 14228	TELEPHONE (Include Area Code) ()								ZIP CODE 14228	TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											10. IS PATIENT'S CONDITION RELATED TO: DOT 10/31/15	
a. OTHER INSURED'S POLICY OR GROUP NUMBER											b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR MUCC USE											c. AUTO ACCIDENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. HOME/WORK/HOBBY/INTEREST											e. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
f. INSURANCE PLAN NAME OR PROGRAM NAME											11. INSURED'S POLICY GROUP OR FEDA NUMBER MM DD YY 08 29 1980 M F	
g. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											12. OTHER CLAIM ID (Designated by MUCC) MM DD YY 08 29 1980 M F	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Print) (Indicates the release of any kinds of or other information necessary to process this claim. I also expect payment of government benefits either to myself or to the party who accepts assignment below.)											13. OTHER CLAIM ID (Designated by MUCC) MM DD YY 08 29 1980 M F	
SIGNATURE ON FILE											14. IF TRUE AND YOUR HEALTH INSURANCER PAY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If true, complete lines 8, 9c, and 9d.	
DATE: 02 09 16											15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Indicates payment of medical benefits to the unauthorized physician or supplier for services rendered below.)	
16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) GUNL 08 29 15											SIGNATURE ON FILE	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DR. PEYER, J. GULZINSKI											17. DATE OF REFERRAL MM DD YY 16 062607	
18. OTHER DATE MM DD YY 10 09 15											18. OTHER DATE RELATED TO CURRENT ILLNESS MM DD YY 10 09 15	
19. ADDITIONAL CLAIM INFORMATION (Designated by MUCC)											19. DATE OF REFERRAL MM DD YY 1710014108	
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate A-I to satisfy line below [NPI]) A. M791 B. L C. L D. L E. L F. L G. L H. L I. L J. L											20. ICD-9 CODE NPI 0	
21. A. DATE(S) OF SERVICE MM DD YY 02 11 16 To B. D. PROCEDURE, SERVICE, OR SUPPLY CODE NPI/CPT/HCPCS C. E. (Specify Underline Circumstances) NDC/MHEN											21. UNIFORM FORMAT 01040500 F DAYS ON BED NPI 95 74 1	22. RENDERING PROVIDER NAME NPI BT 161562335 NPI 1710976598
22. UNIFORM FORMAT 01040500 F DAYS ON BED NPI												
23. prior Authorization Number												



DENT

NEUROLOGIC INSTITUTE

Vernice Bates, MD	François M. Gengen, PhD	Bennett Myers, MD
Bela Ajzen, MD	Sanjay Gupta, MD	Maha Fatai, MD
Alfred Rojas III, MD	Tomas Halász, MD	Mohamed M. Qasimov, MD
Horacio Capote, MD	J. Maurice Houser, MD	Michelle M. Kueka, PhD
Deena M. Czernecik, PhD	Xish Li, MD	Luisa Reyes, MD
Steve Doflat, MD	Laeticia Medeiros, MD	Nicolas Salikali, MD
J. Anthony Despoin, PhD	Jessie W. McVige, MD	Lixia Zhang, MD, PhD
Marc S. Frost, MD	Karenna R. Murray, MD	Joseph V. Pritz, PhD, PAD

February 16, 2016

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

DIAGNOSTICS & SERVICES	
<i>MRI/CT</i>	<i>Neuropsychology</i>
<i>Arthrography</i>	<i>Posturography</i>
<i>Breath</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>ImPACT</i>	<i>VNG</i>
<i>Infrared</i>	

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Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2945

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FIRST CLASS MAIL



02 19 16
DENT NEUROLOGIC INSTITUTE
BILLING OFFICE
3980 SHERIDAN DRIVE SUITE 501
BUFFALO, NY 14226



FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE MEXICAO TRICARE CHAMPVA GROUP HEALTH PLAN FECA EXCLUDED OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> IDA/DoD <input type="checkbox"/> Member/ID <input type="checkbox"/> (NDA) <input type="checkbox"/> (DDR) <input type="checkbox"/> (NM)												1a. INSURED'S ID NUMBER 013873940011059			(For Programs in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3. PATIENT'S BIRTH DATE SEX 08291980 M F			4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE					
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT					
CITY AMHERST		STATE NY		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951		CITY AMHERST		STATE NY		ZIP CODE 14228		TELEPHONE (Include Area Code) (716 536 0951						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980					
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NY			c. OTHER CLAIM ID (Designated by NUCC)					
												d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			e. INSURANCE PLAN NAME OR PROGRAM NAME GEICO					
d. INSURANCE PLAN NAME OR PROGRAM NAME												104. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED SIGNATURE ON FILE												DATE			SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115												15. OTHER DATE MM DD YY 111215			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))												22. RESUBMISSION CODE ORIGINAL REF. NO.								
A M50.22	B M51.26	C M51.27	D M54.12																	
E I823.3XXA	F IM99.01	G M99.03	H M99.02																	
I IM99.05	J IM54.2	K M54.5	L IM54.6																	
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY												25. FEDERAL TAX ID NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? FOR GOV. COMP. AND MED. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rcv'd for NUCC Use		
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Encounter dated 02/09/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016



Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living

MVA: motor vehicle accident

ROM: range of motion

WNL: within normal limits

VAS: Visual Analog Scale

02 25 16



02 25 16

\$3.62⁰⁰

U.S. POSTAGE
FIRST CLASS
0005000714045



0005000714045
0005000714045

~~345 Dick Rd.~~
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
February 18, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday February 1, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain continues with radiation into her upper back. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain continues. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* worse. *since last visit.* *Pain:* achy, dull, shooting; level: 7/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain continues with radiation down her left posterior thigh. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 6/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck

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and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius.

Orthopedic tests: left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Moderate to Severe; Thoraco-Lumbar Muscle Group Right Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: worse. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

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mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 (cervical decompression); C6 (cervical decompression) supine for 10 minutes at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday February 4, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been slightly better but still sore. Patient also has been experiencing a lot of left shoulder pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 6/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent*

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infection or fever: No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. Today about a "4". *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain continues. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* worse. *since last visit.* *Pain:* achy, dull, shooting; level: 7/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. Left posterior thigh pain has not been as intense. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 6/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Left Moderate to Severe; Thoraco-Lumbar Muscle Group Right Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleton's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all

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other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical-disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving. VAS score improved from a 7 to 6 out of 10. However her left shoulder pain continues and she will be referred to an ortho for an evaluation. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: improving, less posterior left thigh pain. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient will be referred to Dr. Ostempowski due to continued left shoulder pain. *Patient treated to:* relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks.

Subluxations found on assessment and adjusted: C5 (cervical decompression); C6 (cervical decompression) supine at 10 degrees for 10 minutes at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left thromboid trigger point therapy. *Patient referred to:* Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult. *Patient given:* home exercise program:

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advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Peter J. Guzinski, D.C.

Tuesday February 9, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been better. Patient saw Dr. Pollina who recommended continued chiropractic care. Patient seeing Dr. McVige later today. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. Today about a "4". *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been slightly better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent*

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Infection or fever: No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 70/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar

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region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, VAS score improved from a 6 to 5 out of 10. *Prognosis:* Guarded.

Post-treatment analysis: patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: improving, VAS score improved from a 7 to 5 out of 10. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: improving, VAS score improved from a 6 to 5 out of 10. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient will be referred to Dr. Ostempowski due to continued left shoulder pain. *Patient treated to:* relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks.

Subluxations found on assessment and adjusted: C5 (cervical decompression); C6 (cervical decompression) supine at 10 degrees for 10 minutes at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Ostempowski for and orthopedic consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec.

Home care: ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA										PICA							
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN (AM)	FICA SPLITTING (AM)	OTHER (ND)	1a INSURED'S ID NUMBER 013873940011059			(For Program in Item 1)							
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP HEALTH PLAN (AM)	<input type="checkbox"/> FICA SPLITTING (AM)	<input type="checkbox"/> OTHER (ND)	1a INSURED'S ID NUMBER 013873940011059			(For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE										
HARWELL DANIELLE			08291980				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT										
6. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			8. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				8. RESERVED FOR NUCC USE										
CITY AMHERST	STATE NY	ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951					CITY AMHERST	STATE NY	ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FICA NUMBER											
			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NY			b. INSURED'S DATE OF BIRTH MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F								
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. OTHER CLAIM ID (Designated by NUCC)											
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																	
SIGNED SIGNATURE ON FILE						DATE											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115						15. OTHER DATE QUAL. 431		MM DD YY 454		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 111215 TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to A-L to service line below (24E) ICD IND A M50.22 B M51.26 C M51.27 D M54.12 E I22.3 XXXA F I99.01 G M99.03 H M99.02 I I99.05 J I54.2 K I54.5 L I54.6						ICD IND I		22. RESUBMISSION CODE		ORIGINAL REF. NO							
24. A. DATES OF SERVICE From MM DD YY To MM DD YY 01212016 01212016						B. PLACE OF SERVICE EMR 11		C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) OPTRHCPCS 98941		D. MODIFIER ABCD		E. DIAGNOSIS POINTER 32 28 1	F. CHARGES 32 28 1	G. DAYS ON WEEK END TUE 1	H. EXPDT FROM TUE 1	I. ID GUID NPI	J. RENDERING PROVIDER ID # 1710014188
1 01212016 01212016 11 98941 ABCD 32 28 1 NPI 1710014188																	
2 01212016 01212016 11 97010 ABCD 10 53 1 NPI 1710014188																	
3 01262016 01262016 11 98941 ABCD 32 28 1 NPI 1710014188																	
4 01292016 01292016 11 98940 ABCD 20 29 1 NPI 1710014188																	
5 01292016 01292016 11 97124 59 ABCD 11 63 1 NPI 1710014188																	
6 01292016 01292016 11 97010 ABCD 10 53 1 NPI 1710014188																	
25. FEDERAL TAX ID NUMBER SSN ENR 26. PATIENT'S ACCOUNT NO 364500165 <input type="checkbox"/> <input checked="" type="checkbox"/> 34382129						27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>For govt. claims see back</small>		28. TOTAL CHARGE \$ 117.54		29. AMOUNT PAID \$ 117.54		30. Rvd for NUCC Use 0					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>I certify that the statements on the reverse apply to this bill and am responsible for payment.</small> PETER GOZINSKI DC																	
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849								33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849									
SIGNED 02182016 DATE 1235256546								34. 1235256546									

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US POSTAGE
FIRST-CLASS

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345 Dick Rd.
Depew, NY 14043

Geico
P.D. BOX 9507
Fredericksburg, VA 22403

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
February 18, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday January 21, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain remains the same. EMG was performed on Tuesday. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last week.* *Pain:* achy, dull, tingling, shooting, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain continues with left chest pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck

**Encounter dated 01/21/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016**

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius.

Orthopedic tests: left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Shepplemans: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Sensation:** left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive-right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild

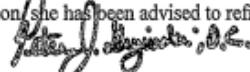
Encounter dated 01/21/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016

bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 (cervical decompression); C6 (cervical decompression) supine at a max pull of 18 lbs for 15 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult.

Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Tuesday January 26, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been worse since last visit. She stated that the decompression therapy really aggravated her neck and middle back. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* slightly worse, since last week. *Pain:* achy, dull, tingling, shooting, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:*

Encounter dated 01/26/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016

Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain feels worse. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* getting worse. *since last visit.* *Pain:* achy, dull, shooting; level: 6/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been more intense since last visit. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* getting worse. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on*

Encounter dated 01/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016

palpation: left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: slightly worse. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Lumbar assessment: worse. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 (cervical decompression); C6 (cervical decompression) supine at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical cold therapy (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain;

Encounter dated 01/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016

improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Friday January 29, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been worse since has last visit. She stated that the decompression therapy really aggravated her neck and middle back. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain feels the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 6/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain

Encounter dated 01/29/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016

neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Sensation:** left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** better since last visit, VAS score improved from a 7 to 5 out of 10. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

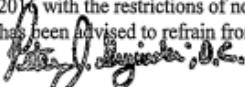
Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to

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DOB:08/29/1980 Last 4 digits SS#: Today's date: 02/18/2016

moderate left recess and neural foraminal narrowing and mild right neural foraminal recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 (cervical decompression); C6 (cervical decompression) supine for 10 minutes at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Pollina (neurosurgeon) for consult, Dr. McVige for neurological consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending-or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

- ADL: activities of daily living
- MVA: motor vehicle accident
- ROM: range of motion
- WNL: within normal limits
- VAS: Visual Analog Scale



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FBOA	OTHER	1a. INSURED'S ID. NUMBER	(For Program in Item 1)
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (SIN#)	<input type="checkbox"/> (SSN#)	<input type="checkbox"/>	033873940-0101-059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		3. INSURED'S NAME (Last Name, First Name, Middle Initial)	
EARWELL, DANIELLE			MM	DD	YY		Same	
4. PATIENT'S ADDRESS (No., Street)			5. PATIENT RELATIONSHIP TO INSURED				6. INSURED'S ADDRESS (No., Street)	
56 BEREHAVEN DR			Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>		
CITY AMHERST	STATE NY	8. RESERVED FOR NUCC USE		CITY		STATE		
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951	X		ZIP CODE		TELEPHONE (Include Area Code)	()	

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FICA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	b. INSURED'S DATE OF BIRTH	
<input type="checkbox"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM DD YY	SEX
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (SWIM)	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	<input type="checkbox"/> M <input type="checkbox"/> F
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	d. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
<input type="checkbox"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, complete items 9, 9a, and 9d	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED <u>ON FILE</u>	DATE 01-06-2016		SIGNED <u>ON FILE</u>
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)	15. OTHER DATE	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY	MM DD YY	MM DD YY	FROM MM DD YY TO MM DD YY
1-10-15	QUAL		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. <input type="checkbox"/> NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
McGIVIGE, JENNIFER, M.D.	17b. <input type="checkbox"/> NPI	FROM MM DD YY	TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? \$ CHARGES		
A <u>L44-309</u>	B <u> </u>	C <u> </u>	D <u> </u>
E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>
I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e)	ICD IND	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A <u>L44-309</u>	<input type="checkbox"/>		
B <u> </u>	<input type="checkbox"/>	23. PRIOR AUTHORIZATION NUMBER	
C <u> </u>	<input type="checkbox"/>		
D <u> </u>	<input type="checkbox"/>		

1	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMG	C. CPT/HCPCS CODE	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS CODER/ICD-9-CM CODE/ICD-10-CM CODE	F. \$ CHARGES	G. DAYS OR UNITS	H. PAYOR PER UNIT RATE	I. ID QUAL	J. RENDERING PROVIDER ID #
1	02-17-16 - 02-17-16 - 31			97140		55.00	0	NPI	1144462001	
2	02-19-16 - 02-19-16 - 31			97140		55.00	0	NPI	1144462011	
3								NPI		
4								NPI		
5								NPI		
6								NPI		

25. FEDERAL TAX ID NUMBER	SSN/BIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Reserved for NUCC Use
099606323	<input type="checkbox"/>	HARWELL, D		\$ 110.00	\$ 0.00	110.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#			
COLLEEN MARK, LMT	GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEEPM, NY 14043		(716) 725-0264			
SIGNED DATE 02-20-2016	4. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		5. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.124(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency whom Medicare assigned or TRICARE participation cases. If the physician agrees to accept the charge, certification of the Medicare carrier or TRICARE local intermediary as the full source and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain extensions with the Uniformed Services. Information on the patient's sponsor should be provided in those items as indicated in "Initiated", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedures and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided to you sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished to me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license # or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered professional service, 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 8538). For Black Lung claims I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or furnishes false or misleading information to secure payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1882, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.26(a) and 424.5(b) (8), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 8101 et seq and 30 USC 901 et seq; 30 USC 813; E.O. 13087.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties pay to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Center Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37519, Wed Sept 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, Sec ESA-6, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services furnished are authorized by law.

DISCLOSURE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a report pertains. Appropriate disclosures may be made in other federal, state, local, foreign governmental agencies, private business entities, and individual providers of care, on matters relating to enrollment, fraud, program abuse, utilization review, quality assurance, prior review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under this program for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matching.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XXX plan and to furnish information regarding any payment claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were genuinely furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the burden of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0834

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0834

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 2/19/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client reports about HA to chiropractor yesterday.
had severe HA all day & continues into today @ less

interval. Altercations noted in subcervical region.

- Action's Applied: (Check All that Apply)
- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage Friction
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Danielle Harwell

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0264

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 2/11/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Hypertonic cervical region, more than 6, deep muscle stripping applied, Adhesions present upper posterior thoracic region

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze region
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

ellen maeClient Name: Danielle Howell Date: 2/17/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has cervical stiffness esp. driving. She has difficulty turning her head 2^o due to restriction.Large fibrotic knot in trapezius. Client felt

Action/Applied: (Check All that Apply)

- better ↓ DENT ↑ tx to
 Heat Packs Cold Packs Sombra/Biofreeze 2x/wk.
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

ellen mae

02 25 16

02 25 16

Great Lakes Therapeutic Massage

Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043

BUFFALO NY 142

2014 SEP 28 PM 11:11



GEICO INS CO of NY
P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403552507



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/97

NUCC FORM

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

1. MEDICARE MEDICARE TRICARE CHAMPVA GROUP HEALTH PLAN HSA SAVING OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> Champva <input type="checkbox"/> Group Health Plan <input type="checkbox"/> HSA Saving <input checked="" type="checkbox"/> Other												14. INSURED'S ID. NUMBER (For Program in Item 1) 0138739400101059		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												15. PATIENT'S BIRTH DATE (MM DD YY) 08 29 1980 M <input checked="" type="checkbox"/>		
3. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR.												16. INSURED'S POLICY GROUP OR NUCC NUMBER DOI 10/31/15		
4. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR.												17. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR.		
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY		CITY AMHERST			STATE NY			
ZIP CODE 14228		TELEPHONE (Include Area Code) ()		ZIP CODE 14228		TELEPHONE (Include Area Code) ()		ZIP CODE 14228			TELEPHONE (Include Area Code) ()			
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												18. INSURED'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
6. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? (Place: (State)) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
7. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? (Place: (State)) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
8. INSURED'S OR AUTHORIZED PERSON'S NAME AND ADDRESS SIGNED SIGNATURE ON FILE DATE 02 09 16												19. CLAIM CODES (Designated by NUCC) READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I, the undersigned, declare that I am the holder of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
												20. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complications 9, 9a, and 9b.		
												21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I, the undersigned physician or supplier for services described below.		
												22. SIGNATURE ON FILE		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL 439												15. OTHER DATE MM DD YY QUAL 10 31 15		
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 10 062607												17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 17 170014188		
18. OUTSIDE LABS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		
20. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service 02 09 16 02 09 16 11 99244												21. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) CPT/HCPCS Modifier G44309		
22. PHYSICIAN'S ID. NUMBER 161582336												23. HOSPITAL ID. # 161582336		
24. PATIENT'S ACCOUNT NO. 1310216												25. ADJUSTMENT AMOUNT \$ 0.00		
26. TOTAL CHARGE \$ 190.59												27. AMOUNT PAID \$ 0.00		
28. HUMLA TAX ID NUMBER 161582336												29. HOW INV NUCC USE NPI		
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING FIGURES OR CREDENTIALS (Usually list the statements on the reverse side to this box and can make a just check.) JENNIFER W MCVIGE, MD 02 12 16 RINNED												31. SERVICE LOCATION INFORMATION DENT TOWER 3RD FLR 3980 SHERIDAN DRIVE, 3RD FLOOR AMHERST NY 14226-1727 DATE 1497850911		
												32. BILLING PROVIDER INFO & PTF 716 2502010		
												33. BILLING PROVIDER INFO & PTF DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002		



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Luisito Mechler, MD, Director

Jennifer W. McVige, ND
Nicole Salkoff, MDKerly A. Bernasoli, PA-C
Rebecca Battaglia, PA-C
Sydney B. Gruber, PA
Laurie Jendrzejewski, PA-C
Megan Kuczkla, PA-C
Cathleen T. Moloney, PA-CKatelyn L. Murphy, FNP
Maria Blum, PA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Gentile, FNP-C
Christopher Zukowski, FNP-C

Jennifer McVige, MD

Consultation

Date: 02/09/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Neck/back pain

History of Present Illness

General:

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic consultation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York. The following is a summary of my assessment and recommendations.

Danielle is a wonderful 35-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. Patient was the seat-belted driver. She stopped, waiting for a truck and was rear-ended. This caused chain reaction where multiple cars hit each other. She had her children and her husband in the car. Patient hit her head against the headrest and then was jolted forward. She was seen at the urgent care the next day. Initially she had pain but was unaware of how serious it would become. She complained of dizziness, difficulty with attention and concentration, headaches, poor sleep, but denies any mood changes. She had significant amount of pain in the left upper extremity and shoulder. She felt this was from the seatbelt pulling.

In regard to the headaches, they occur in the bifrontal area and the neck, 3 to 7 out of 10 on the pain scale, described as pressing. They are happening about 4 times a week. They do interfere with her ability to function and concentrate. She has not had any family history of migraines, but she herself has had past history of very infrequent migrainous headaches and was followed here at DENT previously. Since the accident, though, she feels that these symptoms have been exacerbated. She does not have a history of previous head injury.

On reviewing headache triggers, she does not exercise regularly, does not skip meals. She does have sleeping issues and the headaches do wake her from sleep. There is no depression or anxiety. Associated headache symptoms include sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face. Things that can exacerbate the headache are sleep irregularity, stress, physical activity, missing a meal, seasonal changes, processed meats and certain medications. To treat the headaches she has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and recently has seen Dr. Pollina, a neurosurgeon, on 02/08/2016. Dr. Pollina has recommended physical therapy and then followup afterwards. Patient did have an MRI of her brain in the past, 06/12/2015, that did show no abnormalities. This was done for her history of migraines. She recently had an MRI of the CT and L spine on 01/05/2016 that showed mild multilevel degenerative changes, but

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Shawn Fager, Clinic Manager
Arianna McPhee
Eileen Stute
Alice Trzebinski

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INFUSION CENTERS
Kathy Melding, RN, Manager

there are disk extrusions seen at C4-C5 and C5-C6.

She did have an EMG 01/19/2016, but I do not have these results.

Patient has been getting regular chiropractic treatment 2 times a week and does feel this has been helpful. She follows with Dr. Guzinski.

Current Medications

- Taking Vitamin D 50,000 inti units capsule 1 cap(s) 2 times a week
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Discontinued Wellbutrin XL 150 mg/24 hours tablet, extended release 1 tab(s) every 24 hours
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking: Patient is a non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse. Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro

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Shawn Fugate, Office Manager
Anastasi McFayden
Elaine Stahl
Alice Truelove

INJECTION CENTERS
Barbara Maderig, RN, Manager

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- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headaches, weakness, tremors, numbness, confusion, sleep problems, weight gain, blurry vision, ringing in the ears, earache, palpitations, heartburn, abdominal pain, sexual dysfunction, joint pain, neck stiffness, thyroid problems, anemia. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 112/76, HR 72, RR 16, Ht 63, Wt 150, BMI 26.67, BSA 1.74.

Examination

NEUROLOGICAL:

Mental Status: Orientation to person, place, and time was normal. Recent and remote memory was intact. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Language for naming objects, repetition and spontaneous speech was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Plantar responses were downgoing bilaterally. Coordination: Test of coordination, finger-nose-finger, fine motor and pronator drift were all within normal limits. Gait and Station: Within normal limits. Tandem walk, standing on 1 foot bilaterally, and Romberg were all within normal limits. Sensory: Sensation is normal x4 extremities, aside from the left upper extremity, from the elbow to the fingers there is perceived numbness and tingling. Strength is 5/5 globally aside from the left upper extremity 4+/5.

GENERAL EXAMINATION:

General Appearance: Patient well nourished, well developed, in moderate distress. Neck: Firm trigger points to palpating the trapezius bilaterally. Decreased range of motion of the neck. She has pain with palpation of the upper shoulder. Cardiovascular: S1, S2, no murmurs, regular rate. Normal peripheral pulses. Extremities: Full range of motion of extremities x4. No edema. Skin: No rashes or lesions obvious on exam.

CRANIAL NERVES:

Cranial Nerve II: Visual fields full. Disc margins clear bilaterally. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

- Cervical radiculopathy - M54.12 (Primary)
- Concussion, without loss of consciousness, initial encounter - S06.0X0A
- Post-traumatic headache - G44.309

Danielle is a wonderful 35-year-old young woman who was involved in a motor vehicle accident 10/31/2015. There was no loss of consciousness, but she has struggled with postconcussive symptoms including headache, dizziness, attention and concentration issues. As well, she has significant myofascial spasm in the upper cervical region. Pain with palpation of the shoulder. Numbness and tingling as well as weakness in the left upper extremity. These symptoms are consistent with a radiculopathy. She is following with Dr. Pollina in Neurosurgery in addition to the chiropractic therapy she has been doing, which has been

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Annette McFayden
Elaine Stolt
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INFUSION CENTERS

Barbara Mullerig, RN, Manager

very helpful. Patient is now starting into physical therapy for myofascial spasms.

TREATMENT:

1. I am recommending trigger point injections to loosen up the upper cervical paraspinous spasm.
 2. Physical therapy for vestibular symptoms. Patient was very dizzy on examination.
 3. Magnesium oxide to decrease headaches.
 4. Naprosyn for the lesser headaches and neck pain.
 5. Rizatriptan for severe debilitating migraines.
 6. Laboratory studies to rule out metabolic or vitamin deficiency causes for patient's symptoms.
 7. Massage therapy is also recommended if patient so chooses.
 8. Her biggest complaint is that she cannot sleep because of the pain. I have recommended melatonin.
- Thank you for allowing me to care for the patient. If there are any questions or concerns, feel free to contact me at any point in time.
 cc: Peter Guzinski]

Treatment

1. Cervical radiculopathy

PHYSICAL THERAPY Vestibular nos1027093

Notes: trigger injections.

2. Post-traumatic headache

Start magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day, 30 days, 60, Refills 5

Start Naprosyn tablet, 500 mg, 1 tab(s), orally, prn headache, up to BID, 30 day(s), 30, Refills 5

Start rizatriptan tablet, 10 mg, 1 tab(s), orally, prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3, 30 days, 12, Refills 5

LAB: COMP METABOLIC PANEL W/EGFR

LAB: VITAMIN D25-OH LCMSMS

LAB: VITAMIN B12 SERUM

LAB: CBC W/DIFF & PLT

LAB: TSH WITH REFLEX TO FREE T4

PHYSICAL THERAPY Cervical Myofascial Spasm1027087

MASSAGE Therapy1027088

3. Others

Start Melatonin tablet, 3 mg, 1 tab(s), orally, once (at bedtime), 30 days, 30, Refills 5

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 02/09/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 02/09/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 02/09/2016.

Follow Up

3 Weeks

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 Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Shawn Fugate, Clinic Manager
 Amanda McFayden
 Eileen Stutz
 Alice Tuszinski

INFUSION CENTERS

Barbara Molinsky, RN, Manager

Patient: Harwell, Danielle | DOB: 08/29/1980 | Consultation

Page 5 of 5

Electronically signed by Jennifer McVige , MD on 02/26/2016 at 02:10 PM EST**Sign off status: Completed**

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ADMINISTRATIVE SUPPORT

Shawn Fenger, Clinic Manager
Amanda McFayden
Bilene Rose
Alice Tricinelli

INFUSION CENTERS

Sorbecke Maderig, RN, Manager

DENT NEUROLOGIC INSTITUTE**NO-FAULT**

SUPPLEMENTAL INFORMATION FORM

Patient Name: Danielle Harwell

Social Security No: 055-76-3355

Date of Accident:

10/31/15

Are You Currently Out of Work as a Result of this
Accident: Yes No

Injury Sustained: Whiplash, herniated disks in my neck & back.

INSURANCE CARRIER INFORMATION

Insurance Carrier Name:

 Geico

Name of Adjuster:

Laura Weidner
Phone: (518) 714-7147

Insurance Carrier Address:

P.O. Box 9501
Fredericksburg, VA 22405

Claim Number:

0138739400101059
Fax: (855) 244-5154**ACCIDENT DETAILS**

Location of Accident: Starin Dr.

Briefly Describe how the Accident Occurred: I was stopped behind a truck that was turning left into his driveway and was rear-ended by 3 cars.

Were you a: Driver Passenger PedestrianIf Driver or Passenger, were you: Belted Not-BeltedHave you Filed a Claim with your Carrier: Yes NoHave you Completed and Returned your No-Fault Application: Yes No**ATTORNEY INFORMATION**

Attorney Name: Cheryl Reed

Attorney Address:

Phone: (716) 444-4444 Fax: (716) 444-4444

6720 Main St. #100
Williamsville, NY 14221**AUTHORIZATION TO PAY BENEFITS**

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

Any person knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, aids, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

Signature:

Danielle Harwell

Date:

10/31/15

FOR OFFICE USE ONLY

PROVIDER:DENT NEUROLOGIC GROUP
PO Box 8000 Dept 057
Buffalo, NY 14267

CLAIM# 0138739400101059

DATE OF LOSS: 10/31/15

CARRIER: Geico

Signature:

J



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARHORN

1. MEDICARE [Medicare] <input type="checkbox"/> [Medicaid] <input type="checkbox"/> TRICARE [TRICARE] <input type="checkbox"/> CHAMPVA [Champva] <input type="checkbox"/> GROUP HEALTH PLAN [Group Health Plan] <input type="checkbox"/> FECA WORKERS COMP. [FECA Workers Comp] <input type="checkbox"/> OTHER [Other] <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) - 033873940-0101-059							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE										4. INSURED'S NAME (Last Name, First Name, Middle Initial) _____							
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR										7. INSURED'S ADDRESS (No., Street) _____							
CITY AMERIST					STATE NY		CITY					STATE					
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951			ZIP CODE		TELEPHONE (Include Area Code) ()										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) _____										10. IS PATIENT'S CONDITION RELATED TO _____							
a. OTHER INSURED'S POLICY OR GROUP NUMBER _____										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
b. RESERVED FOR NUCC USE _____										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO <u>NY</u>							
c. RESERVED FOR NUCC USE _____										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME _____										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 8, 9e, and 9f.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										SIGNED <u>ON FILE</u> DATE <u>01-06-2016</u>							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim, I also request payment of government benefits either to myself or to the party who accepts assignment below										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below							
SIGNED <u>ON FILE</u>										SIGNED <u>ON FILE</u>							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY <u>10 31 2015</u> QM/L <u>QUAL</u>					15. OTHER DATE MM DD YY <u>17b</u> NM <u>NPI</u>					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY _____							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE McVIGIL, JENNIFER, M.D.										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY _____							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) _____										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <u>G44.309</u> B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE ORIGINAL REF ID NO _____							
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service BMG CPT/HCPCS E MODIFIER _____										23. PRIOR AUTHORIZATION NUMBER F. G. H. I. J. \$ CHARGES DAYS OF HRS PER DAY L ID QM RENDERING PROVIDER ID # _____							
02 23 16 02 23 16 11 97140 h 55 00 3 NPI 1144462031																	
02 26 16 02 26 16 11 97140 h 55 00 3 NPI 1144462011																	
5										NPI							
6										NPI							
7										NPI							
8										NPI							
9										NPI							
10										NPI							
25. FEDERAL TAX I.D. NUMBER 099606323					SSN/IN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO HARWELL, D		27. ACCIDENT ASSESSMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 110 00		29. AMOUNT PAID \$ 0 00		30. Rcv'd for NUCC Use 110 00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (Do not let the signatures on the reverse apply to this bill and are made a part thereof)										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2				33. BILLING PROVIDER INFO & PH # (716) 725-0264			
										GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2							

All ICC installations must be conducted at www.psu.com

BY EASE PRINT OR TYPE

APPROVED: OMB-0938-1192 FORM 1500 (03-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal contemptable offence and may be subject to civil penalties.

בנוסף לוגו גוונטן וווג-וואטס צייר

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the patient has employer group health insurance, liability, nobility, or other insurance which is managed, or pay for the services for which this Medicare claim is made. See 42 CFR 437.14(b). If this box is checked, we, the patient's signature authorizes release of your information to the health plan or other agency that manages Medicare payments to the physician. If this box is checked, we, the patient's signature authorizes release of your information to the health plan or other agency that manages TRICARE payments to the physician. In Medicare, if the physician agrees to accept assignment, the deductible and the copayments are based upon the charge determined by the physician, or cancer or TRICARE local beneficiary rates. In Medicare, the charges submitted to TRICARE and a health insurance "program" that makes payment for health care services provided through facilities and/or the Uniform Services Information System, etc., its spouse should be provided in the same manner as in Block 12, items 14, 15, 16, 17, and 18.

BLACK HAWK CITY NEWS CLASS

This provider agrees to accept the amount, paid by the Government as payment in full. See Block 13a and ECA instructions regarding required procedure and disbursements.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FICA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, when submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare laws, regulations, and program instructions for payments, including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were authorized in writing to my professional service by my employer and/or my direct supervisor; 6) receipts, otherwise expressly permitted by Medicare or TRICARE; 7) for each service rendered in my professional capacity, the relevant CPT, HCPCS, or BSKU or the entity identifier, claim sets or as reported in the decategorialized record; 8) services to be considered "incident to" a physician's physical service(s); 1) they must be paid-and-received under the physician's direct supervision by his/her employee; 2) they must be an integral, although incidental part of a covered physician service; 3) they must be of kinds commonly furnished as physician's office, and 4) the services of non-physician must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government, either civilian or military (refer to 5 USC 5338). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations [42 CFR 424.321].

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and CWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1767 of the Social Security Act as amended, 42 CFR 411.21(a) and 424.5(a) (6), and 44 USC 3101; 1 CFR 101 et seq and 10 USC 1079 and 1088, 5 USC 8101 et seq and 30 USC 901 et seq, 38 USC 6103; E.C. 5057.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Cancer Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FDICWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

POLICY/LIABILITY: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumers regarding accounts with occupant, claimants, and to Congressional Offices in response to inquiries made at the request of the person to whom it record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntarily; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, could delay payment of the claim. Failure to provide medical information such as ICD-9-CM codes could also delay payment.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1120B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 10-503, the Computer Matching and Privacy Protection Act of 1998, grants the power to verify information on behalf of consumer credit reporting agencies.

Персонал відповідь передається системою

I hereby agree to keep such records as are necessary to disclose fully the information provided to individuals under the State's Title XIX plan and to furnish information concerning any payments I made for providing such services as the State agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full the amount paid by the Medicaid program for the charges rendered for payment under this program, with the exception of enhanced deductible, insurance co-payment or similar cost sharing charge.

DEFINITION OF PHYSICIAN (OR SELF-EMPLOYEE): I clearly limit the services I render to those who medically need me and care for the health of the patient and who personally furnish my services under my personal direction.⁵

any false claims, statements, or documents, or otherwise commit a misdemeanor, may be prosecuted under applicable Federal or State laws.

Information for this form is contained in the following sections of the Information Collection Request:

- 1. **Section I: General Information** - This section contains information about the purpose of the collection, the types of information collected, how it will be used, and your rights regarding the information.
- 2. **Section II: Data Elements** - This section lists the specific items of information being collected, such as name, address, and telephone number.
- 3. **Section III: Privacy Act Statement** - This section provides information about how your information will be protected under the Privacy Act of 1974.
- 4. **Section IV: Response Options** - This section provides instructions on how to respond to the survey or collection request.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0824

Fax: (716) 725-0365

Client Name: Danielle Harwell Date: 2/19/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Chest/pain/slight HA is dir to yesterday.
Had severe HA all day & continues into today w/less
intensity. Alterations noted in suboccipital regionAction's Applied: (Check All that Apply) Heat Cold Sombra/Biofreeze
 Heat Packs Cold Packs Sombra/Biofreeze region
 Light Pressure Massage Mod Pressure Massage HA was better
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

John Wayne

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0824

Fax: (716) 725-0365

Client Name: Danielle Harwell Date: 2/23/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Next stoke feeling better, noticing certain
motion/active yesterday. Pain not as severe today.

Severe headache remains in cervical musculature

Action's Applied: (Check All that Apply) A, Adhesions noted in
 Heat Packs Cold Packs Sombra/Biofreeze Shoulders,
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

John Wayne

03 01 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
 315 Dick Rd Dewey, NY 14043
 Office: (716) 725-0264 Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners
 315 Dick Rd Dewey, NY 14043
 Office: (716) 725-0264 Fax: (716) 725-0265

Client Name: Danielle Harvey Date: 2/24/16

Spicy

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy
- Anxiety
- Burning
- Depressed
- Fatigued
- Low Energy
- Pain
- Restlessness
- Restricted
- Sore
- Numbness
- Tingling
- ↓ Strength
- Inability to Sleep
- Headaches/Migraines
- Spasms
- Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head
- Jaw
- Sinus/Eye Pressure
- Cervical (Posterior)
- Cervical (Anterior)
- Upper Thoracic (Anterior)
- Upper Thoracic (Posterior)
- Mid/Thoracic
- Ribs
- Scapula (R)
- Scapula (L)
- Abdomen/Obliges
- ASIS
- PSIS
- Lumbar
- Sacrum
- Coccyx
- Hips
- Glutes (R?) (L?)
- IT Band
- Quads
- Hamstrings
- Knee (R)
- Knee (L)
- Calf Muscles (R)
- Calf Muscles (L)
- Ankle (R)
- Ankle (L)
- Foot (R)
- Foot (L)
- Shoulder (R)
- Shoulder (L)
- Upper Arm (R)
- Upper Arm (L)
- Forearm (R)
- Forearm (L)
- Hand (R)
- Hand (L)

Specific: Client reports 1/5 vs relief from M.T. before

Symptoms: Pain returns. Feeling better today. Client continues

to have multiple aches/tension thru C-T spine + musculature.

Actions Applied: (Check All that Apply) Client presenting deep

- Heat Packs
- Cold Packs
- Sombra/Biofreeze
- Pressure as
- Light Pressure Massage
- Mod Pressure Massage
- Well. Felt better.
- Deep Tissue Massage
- Myofascial Release
- Friction
- Manual Traction
- Stretching
- Range-of-Motion
- Compression
- Lymph Drainage
- Stripping
- Compression
- Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O
- Follow-Up w/ Chiro
- Follow-up w/ M.D.
- Follow-up w/ PT
- Stretches
- Can't Meds
- Ice / Heat

Therapist:

Danielle Harvey

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy
- Anxiety
- Burning
- Depressed
- Fatigued
- Low Energy
- Pain
- Restlessness
- Restricted
- Sore
- Numbness
- Tingling
- ↓ Strength
- Inability to Sleep
- Headaches/Migraines
- Spasms
- Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head
- Jaw
- Sinus/Eye Pressure
- Cervical (Posterior)
- Cervical (Anterior)
- Upper Thoracic (Anterior)
- Upper Thoracic (Posterior)
- Mid/Thoracic
- Ribs
- Scapula (R)
- Scapula (L)
- Abdomen/Obliges
- ASIS
- PSIS
- Lumbar
- Sacrum
- Coccyx
- Hips
- Glutes (R?) (L?)
- IT Band
- Quads
- Hamstrings
- Knee (R)
- Knee (L)
- Calf Muscles (R)
- Calf Muscles (L)
- Ankle (R)
- Ankle (L)
- Foot (R)
- Foot (L)
- Shoulder (R)
- Shoulder (L)
- Upper Arm (R)
- Upper Arm (L)
- Forearm (R)
- Forearm (L)
- Hand (R)
- Hand (L)

Specific: _____

Actions Applied: (Check All that Apply)

- Heat Packs
- Cold Packs
- Sombra/Biofreeze
- Light Pressure Massage
- Moderate Pressure Message
- Deep Tissue Massage
- Myofascial Release
- Friction
- Manual Traction
- Stretching
- Range-of-Motion
- Stripping
- Compression
- Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O
- Follow-Up w/ Chiro
- Follow-up w/ M.D.
- Follow-up w/ PT
- Stretches
- Can't Meds
- Ice / Heat

Therapist: _____

03 01 16

03 01 16

Great Lakes Therapeutic Massage

Colleen Marx, LMT

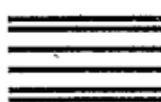
375 Dick Road, Suite #2

Buffalo, NY 14043

EUPTAUS

NY 142

25 APR '96



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IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 1010 WASHINGTON DC

POSTAGE WILL BE PAID BY ADDRESSEE

GEICO[®]

NY PIP

PO BOX 9507

FREDERICKSBURG VA 22403-9527



Receive Date: 3/3/2016 Front End**Region 2: NY PIP MAIL****Indexing Category:**

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|--|--|
| <input checked="" type="checkbox"/> NY FPM Bills | <input type="checkbox"/> Unreadable Original |
| <input type="checkbox"/> PIP SHQ | <input type="checkbox"/> Notary Seal |
| <input type="checkbox"/> NY FPM PSR Provider Letters | <input type="checkbox"/> Box Work |
| <input type="checkbox"/> NY FPM PL Peer Response | <input type="checkbox"/> No Date Sheet
Needed |

Sorted by U62: GHSTip Date: 3-4

#21 Pink

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 3599
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 02/26 14:35
 TX/RX TIME 01' 35
 PGS. 7
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE (NUCC) 6-19

2010-10A

FICA (2010)

1. MEDICARE	AMERICAN	TRICARE	DIWAPVA	GROUP	HMO	OTHER	16. INSURED'S ID. NUMBER	(For Programs Item 16)
<input type="checkbox"/> Medicare	<input type="checkbox"/> American	<input type="checkbox"/> TRICARE	<input type="checkbox"/> DIWAPVA	<input type="checkbox"/> GROUP	<input type="checkbox"/> HMO	<input checked="" type="checkbox"/> OTHER	0138739400101059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				
HARWELL, DANIELLE				MM	DD	YY	MM	
5. PATIENT'S ADDRESS (No., Street)				08	29	1980	<input checked="" type="checkbox"/>	
56 BEREHAVEN DR.				<input checked="" type="checkbox"/> Return	<input type="checkbox"/> CRM	<input type="checkbox"/> CRM		
6. CITY	STATE	6. RESERVED FOR NUCC USE						
AMHERST	NY							
ZIP CODE	TELEPHONE (Include Area Code)							
14228	()							
7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				
HARWELL, DANIELLE				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
8. OTHER INSURED'S POLICY OR GROUP NUMBER				11. EMPLOYMENT (Current or Previous)				
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
9. REFERRAL FOR NUCC USE				12. AUTO ACCIDENT?				
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	PLATE (BRN)		
13. RESERVED FOR NUCC USE				14. OTHER ACCIDENT?				
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
15. INSURANCE PLAN NAME OR PROGRAM NAME				16. CLAIM CODE# (Designated by NUCC)				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I acknowledge the release of any medical or other information necessary to process this claim. I also request payment of guaranteed benefits either to myself or to the party who accepts assignment below.								
13. SIGNATURE ON FILE				DATE 02 09 16				
14. DATE OF CURRENT ILLNESS, INJURY, OR MEDICAL EMERGENCY (MM DD YY)				16. OTHER DATE		MM	DD	YY
				GUE		08	31	15
17. NAME OF REFERRING PHYSICIAN OR OTHER PROVIDER				18. I.D.		19. DENTAL PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		
DR. PETER J GUZINSKI				U62607		MM	DD	YY
17. I.D. #				1710014188		PHON	TO	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
				MM	DD	MM	DD	
21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY (Indicate One Below) ICD-10				21. OUTSIDE LAB TEST/HOME				
A. M5412				22. REFERRAL				
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February 26, 2016

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

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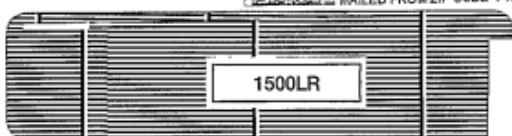
DIAGNOSTICS & SERVICES	
<i>MRI/CT</i>	<i>Neuropsychology</i>
<i>Angiograms</i>	<i>Ptoseurography</i>
<i>Bates</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>ImPACT</i>	<i>VNG</i>
<i>Injection</i>	

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**INSURANCE CLAIM
FORMS ENCLOSED**

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

X-10912A

RICA X-10912

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FEDERAL BUILDING <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (DVA) <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (DVA/DOD) <input type="checkbox"/> (Member/DI) <input type="checkbox"/> (DVA)												1a INSURED'S ID NUMBER (For Program in Item 1) 0138739400101059							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3 PATIENT'S BIRTH DATE (MM DD YY) 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			
5 PATIENT'S ADDRESS (No, Street) 56 BEREHAVEN DR.												6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7 INSURED'S ADDRESS (No, Street) 56 BEREHAVEN DR.			
CITY AMHERST			STATE NY			CITY AMHERST			STATE NY										
ZIP CODE 14228		TELEPHONE (Include Area Code) ()				ZIP CODE 14228		TELEPHONE (Include Area Code) ()											
8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO...							
a OTHER INSURED'S POLICY OR GROUP NUMBER												a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
b RESERVED FOR NUCC USE												b AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____							
c RESERVED FOR NUCC USE												c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d INSURANCE PLAN NAME OR PROGRAM NAME												104 CLAIM CODES (Designated by NUCC)							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below							
SIGNATURE ON FILE												SIGNATURE ON FILE							
SIGNED _____				DATE 02 09 16				SIGNED _____											
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QMNL				15 OTHER DATE MM DD YY QMNL 439 10 31 15				16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN: PETER J GUZINSKI				17a 1G U62607				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
17b NPI: 1710014188																			
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 8 CHARGES							
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-E to service line below (24E) ICD IND O												22 RESUBMISSION CODE ORIGINAL REF. NO							
A M5412	B S060X0A	C G44309	D L	E L	F L	G L	H L	I L	J L	K L	L L								
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY				B PLACE OF SERVICE C EMB				D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MCDFMR				E DIAGNOSIS CODE	F G DAYS OF STAY H I ID RENDERING PROVIDER ID #						
1 02 09 16	02 09 16	11						ABC	190 59 1	NPI		161582336							
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3										NPI									
4										NPI									
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25 FEDERAL TAX ID NUMBER 161582336				SSN BN <input checked="" type="checkbox"/>				26 PATIENT'S ACCOUNT NO 1310216				27 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28 TOTAL CHARGE 6 190 59 s	29 AMOUNT PAID 0 00	30 Rev'd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to the bill and are made a part thereof) JENNIFER W MCVIGE, MD												32 SERVICE FACILITY LOCATION INFORMATION DENT TOWER 3RD FLR 3980 SHERIDAN DRIVE, 3RD FLOOR AMHERST NY 14226-1727				33 BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002			
SIGNED DATE 02 12 16												*1497850911				* 1497850911			

在《中華人民共和國憲法》第56條規定：「中華人民共和國公民有維護國家統一和民族團結的義務。」

Figure 1. The effect of the number of nodes on the performance of the proposed algorithm.

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¹ See also the discussion of the relationship between the two concepts in the section on "The concept of 'cultural capital'".

For more information about the National Institute of Child Health and Human Development, please call the NICHD Information Resource Center at 301-435-2936 or visit the NICHD Web site at www.nichd.nih.gov.

在這段時間內，我們已經開始研究如何將這些知識應用於實際問題上。我們希望能夠通過這種方法來解決一些具體的社會問題。

$$m_1 = \frac{1}{2} \left(\frac{1}{2} + \frac{1}{2} \right) = \frac{1}{2}, \quad m_2 = \frac{1}{2} \left(\frac{1}{2} - \frac{1}{2} \right) = 0, \quad m_3 = \frac{1}{2} \left(\frac{1}{2} + \frac{1}{2} \right) = \frac{1}{2},$$

The present study suggests that the relationship between the two variables is not as simple as it appears at first sight. The results indicate that the relationship between the two variables is not as simple as it appears at first sight.

¹ The term "soft power" was coined by Joseph Nye, Jr., in his book *The Paradox of Power: Why Soft Power Is the New Politics* (New York: Oxford University Press, 2000).

For the first time, we have shown that the *in vitro* growth of *Candida albicans* biofilms can be inhibited by the addition of a low concentration of the antifungal agent amphotericin B.

1960-1961: The first year of the new program was a success. The new curriculum was well received by students and faculty alike. The new facilities were utilized effectively, and the new teaching methods proved to be successful.

¹ See, e.g., *U.S. v. Babbitt*, 100 F.3d 1250, 1254 (10th Cir. 1996) (“[T]he [Bald Eagle] Act does not prohibit the killing of bald eagles; it prohibits the ‘take’ of bald eagles.”).

For $\mu = 0$, the solution is given by (2.1)–(2.3). For $\mu > 0$, we have $\lambda_1 < \lambda_2 < \lambda_3$. The solution is given by (2.1)–(2.3) with $\lambda_1, \lambda_2, \lambda_3$ replaced by $\lambda_1 + \mu, \lambda_2 + \mu, \lambda_3 + \mu$.

For the first time, we have shown that the $\text{P}(\text{H}_2\text{O})$ dependence of the $\text{P}(\text{H}_2)$ production rate is linear over a wide range of pressures.

W. H. Guggenheim, "The Economics of the Oil Industry," *Review of Economics and Statistics*, Vol. 32, No. 1, February 1950.

Systematic analysis of the data from the present study revealed that the mean total daily energy intake was significantly higher than the recommended intake for all age groups.

10. The following table shows the number of hours worked by each employee in a company.



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HEADACHE & NEURO-ONCOLOGY CENTER

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Jennifer W. McVige, MD
Nicole Saikali, MD

Karly A. Bezzant, RPA-C
Rebecca Battacca, PA-C
Sydney B. Gruber, PA
Lauren Jendronicki, RPA-C
Megan Kuehne, PA-C
Colin T. Meloney, PA-C

Kathryn L. Murphy, FNP
Maria Nixon, RPA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Gunnells, FNP-C
Christopher Zielinski, FNP-C

Jennifer McVige, MD

Consultation
Date: 02/09/2016

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 35 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- Neck/back pain

History of Present Illness

General:

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic consultation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York. The following is a summary of my assessment and recommendations.

Danielle is a wonderful 35-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. Patient was the seat-belted driver. She stopped, waiting for a truck and was rear-ended. This caused a chain reaction where multiple cars hit each other. She had her children and her husband in the car. Patient hit her head against the headrest and then was jolted forward. She was seen at the urgent care the next day. Initially she had pain but was unaware of how serious it would become. She complained of dizziness, difficulty with attention and concentration, headaches, poor sleep, but denies any mood changes. She had significant amount of pain in the left upper extremity and shoulder. She felt this was from the seatbelt pulling.

In regard to the headaches, they occur in the bifrontal area and the neck, 3 to 7 out of 10 on the pain scale, described as pressing. They are happening about 4 times a week. They do interfere with her ability to function and concentrate. She has not had any family history of migraines, but she herself has had past history of very infrequent migraineous headaches and was followed here at DENT previously. Since the accident, though, she feels that these symptoms have been exacerbated. She does not have a history of previous head injury.

On reviewing headache triggers, she does not exercise regularly, does not skip meals. She does have sleeping issues and the headaches do wake her from sleep. There is no depression or anxiety. Associated headache symptoms include sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face. Things that can exacerbate the headache are sleep irregularity, stress, physical activity, missing a meal, seasonal changes, processed meats and certain medications. To treat the headaches she has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and recently has seen Dr. Pollina, a neurosurgeon, on 02/08/2016. Dr. Pollina has recommended physical therapy and then followup afterwards. Patient did have an MRI of her brain in the past, 05/12/2015, that did show no abnormalities. This was done for her history of migraines. She recently had an MRI of the CT and L spine on 01/05/2016 that showed mild multilevel degenerative changes, but

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Barbara Muldrig, RN, Manager

there are disk extrusions seen at C4-C5 and C5-C6

She did have an EMG 01/19/2016, but I do not have these results.

Patient has been getting regular chiropractic treatment 2 times a week and does feel this has been helpful. She follows with Dr. Guzinski.

Current Medications

- Taking Vitamin D 50,000 int'l units capsule 1 cap(s) 2 times a week
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Discontinued Wellbutrin XL 150 mg/24 hours tablet, extended release 1 tab(s) every 24 hours
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A

- D&C

- Endoscopy

- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy

Social History

Tobacco Use:

Smoking Patient is a non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive. Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro

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- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headaches, weakness, tremors, numbness, confusion, sleep problems, weight gain, blurry vision, ringing in the ears, earache, palpitations, heartburn, abdominal pain, sexual dysfunction, joint pain, neck stiffness, thyroid problems, anemia. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 112/76, HR 72, RR 16, Ht 63, Wt 150, BMI 26.57, BSA 1.74.

Examination

NEUROLOGICAL:

Mental Status: Orientation to person, place, and time was normal. Recent and remote memory was intact. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Language for naming objects, repetition and spontaneous speech was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Plantar responses were downgoing bilaterally. Coordination Test of coordination, finger-nose-finger, fine motor and pronator drift were all within normal limits. Gait and Station: Within normal limits. Tandem walk, standing on 1 foot bilaterally, and Romberg were all within normal limits. Sensory: Sensation is normal x4 extremities, aside from the left upper extremity, from the elbow to the fingers there is perceived numbness and tingling. Strength is 5/5 globally aside from the left upper extremity 4+/5.

GENERAL EXAMINATION:

General Appearance: Patient well nourished, well developed, in moderate distress. Neck: Firm trigger points to palpating the trapezius bilaterally. Decreased range of motion of the neck. She has pain with palpation of the upper shoulder. Cardiovascular: S1, S2, no murmurs, regular rate. Normal peripheral pulses. Extremities: Full range of motion of extremities x4. No edema. Skin: No rashes or lesions obvious on exam

CRANIAL NERVES:

Cranial Nerve II: Visual fields full. Disc margins clear bilaterally. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

- Cervical radiculopathy - M54.12 (Primary)
- Concussion, without loss of consciousness, initial encounter - S06.0X0A
- Post-traumatic headache - G44.309

Danielle is a wonderful 35-year-old young woman who was involved in a motor vehicle accident 10/31/2015. There was no loss of consciousness, but she has struggled with postconcussive symptoms including headache, dizziness, attention and concentration issues. As well, she has significant myofascial spasm in the upper cervical region. Pain with palpation of the shoulder. Numbness and tingling as well as weakness in the left upper extremity. These symptoms are consistent with a radiculopathy. She is following with Dr. Pollina in Neurosurgery in addition to the chiropractic therapy she has been doing, which has been

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very helpful. Patient is now starting into physical therapy for myofascial spasm.

TREATMENT:

1. I am recommending trigger point injections to loosen up the upper cervical paraspinous spasm.
 2. Physical therapy for vestibular symptoms Patient was very dizzy on examination
 3. Magnesium oxide to decrease headaches
 4. Naprosyn for the lesser headaches and neck pain.
 5. RizatRIPTAN for severe debilitating migraines
 6. Laboratory studies to rule out metabolic or vitamin deficiency causes for patient's symptoms.
 7. Massage therapy is also recommended if patient so chooses
 8. Her biggest complaint is that she cannot sleep because of the pain. I have recommended melatonin.
- Thank you for allowing me to care for the patient. If there are any questions or concerns, feel free to contact me at any point in time.
cc: Peter Guzinski).

Treatment

1. Cervical radiculopathy

PHYSICAL THERAPY Vestibular nos1027093

Notes: trigger injections.

2. Post-traumatic headache

Start magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day, 30 days, 60, Refills 5

Start Naprosyn tablet, 500 mg, 1 tab(s), orally, pm headache, up to BID, 30 day(s), 30, Refills 5

Start rizatRIPTAN tablet, 10 mg, 1 tab(s), orally, pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3, 30 days, 12, Refills 5

LAB: COMP METABOLIC PANEL WEGFR

LAB: VITAMIN D,25-OH,LCMSMS

LAB: VITAMIN B12,SERUM

LAB: CBC WDIF& PLT

LAB: TSH WITH REFLEX TO FREE T4

PHYSICAL THERAPY Cervical Myofascial Spasm1027087

MASSAGE Therapy1027086

3. Others

Start Melatonin tablet, 3 mg, 1 tab(s), orally, once (at bedtime), 30 days, 30, Refills 5

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 02/09/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 02/09/2016.

Exercise. Patient counseled on importance of moderate physical activity daily 02/09/2016.

Follow Up

3 Weeks

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 Barbara Maledrig, RN, Manager

Electronically signed by Jennifer McVige , MD on 02/26/2016 at 02:10 PM EST

Sign off status: Completed

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NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name: Danielle Harwell

Social Security No: 055-70-3355

Date of Accident:

10/31/15

Are You Currently Out of Work as a Result of this
Accident: Yes No

Injury Sustained: Whiplash; herniated disks in my neck & back.

INSURANCE CARRIER INFORMATION

Insurance Carrier Name:

 Geico

Insurance Carrier Address:

P.O. Box 9507
Fredericksburg, VA 22403

Claim Number:

0138739400101059
Fax: (BSW) 294-5134

ACCIDENT DETAILS

Location of Accident: Starin Dr.

Briefly Describe how the Accident Occurred: I was stopped behind a truck
that was turning left into his driveway and was
rear ended by 2 cars.Were you a: Driver Passenger PedestrianIf Driver or Passenger, were you: Belted Not-Belted

Have you Filed a Claim with your Carrier: Have you Completed and Returned your No-Fault

 Yes No Application: Yes No

ATTORNEY INFORMATION

Attorney Name: Cheryl Reed

Attorney Address:

Phone: (716) Fax: (716)
444-44446720 Main St. #100
Williamsville, NY 14221

AUTHORIZATION TO PAY BENEFITS

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR
SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO
WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

Any person knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claims for each violation.

Signature:


FOR OFFICE USE ONLY

Date:

10/19/16

PROVIDER:

DENT NEUROLOGIC GROUP
PO Box 8000 Dept 057
Buffalo, NY 14267CLAIM# 0138739400101059
DATE OF LOSS: 10/31/15
CARRIER: Geico

Signature:





GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

RICA

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BUILDING		OTHER		1a. INSURED'S ID NUMBER		(For Program in Item 1)			
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> Group Health Plan		<input type="checkbox"/> FECA Building		<input type="checkbox"/> Other		013873940011059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				SEX				4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
HARWELL DANIELLE				MM DD YY				M <input checked="" type="checkbox"/> F <input type="checkbox"/>				HARWELL DANIELLE							
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)											
56 BEREHAVEN DR LEFT				Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				56 BEREHAVEN DR, LEFT											
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE				CITY AMHERST		STATE NY									
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH		SEX									
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				MM DD YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?		PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)											
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<u>NY</u>													
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME											
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				GEICO											
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, complete items 8, 9a, and 9d									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE																			
MM DD YY		MM DD YY		MM DD YY		MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
103115		0411431		1111215				MM DD YY		MM DD YY									
FROM		TO		FROM		TO		FROM		TO									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		17b. NPI		17c. NPI		17d. NPI		17e. NPI		17f. NPI		17g. NPI		17h. NPI			
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																			
20. OUTSIDE LAB?																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (NL))																			
ICD-10-CM																			
A M50.22		B M51.26		C M51.27		D M54.12		E M54.5		F M54.6		G M54.6		H M54.6		I M54.6		J M54.6	
E IS23.3XXA		F M99.01		G M99.03		H M99.02		I M99.05		J M54.2		K M54.5		L M54.6		M M54.6		N M54.6	
24. A. DATES OF SERVICE		B. PLACE OF SERVICE		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances)		D. MODIFIER		E. DIAGNOSIS		F. CHARGES		G. DAYS OR UNITS		H. GRANT FEE PAY		I. ID		J. RENDERING PROVIDER ID #	
From MM DD YY		To MM DD YY		BENF		CPT/HCPCS		MODIFIER		ABCD		32 28		1		NPI		1710014188	
1 02152016		02152016		11		98941				ABCD		10 53		1		NPI		1710014188	
2 02152016		02152016		11		97010				ABCD		32 28		1		NPI		1710014188	
3 02182016		02182016		11		98941				ABCD		10 53		1		NPI		1710014188	
4 02182016		02182016		11		97010				ABCD		32 28		1		NPI		1710014188	
5																			
6																			
25. FEDERAL TAX ID. NUMBER		SSN EN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? DENTAL/DEPT/GEN. MED/PHARM		28. TOTAL CHARGE		29. AMOUNT PAID		30. Reserved for NUCC Use							
364500165		<input type="checkbox"/> <input checked="" type="checkbox"/>		3438Z1211		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 85.62		\$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DISCLOSURE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and no more than one statement is present on each page.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH#		(716) 681-3333									
PETER GOZINSKI DC				CICHOCKI & CICHOCKI LLP				CICHOCKI & CICHOCKI LLP		345 DICK ROAD									
				345 DICK ROAD				345 DICK ROAD		DEPEW NY 140431849									
SIGNED 03012016		DATE		1235256546 ^b				1235256546 ^b											

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
March 1, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday February 15, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been better. Patient saw Dr. McVige who performed trigger point injections on her neck. Patient seeing Dr. Ostempowski next week. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit:* *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are no longer daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also has dizziness associated with the headaches but she denies any nausea. Today about a "4". *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit:* *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain

Encounter dated 02/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/01/2016

neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 70/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Sensation:** left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc

Encounter dated 02/15/2016 for Danielle Harwell #3438
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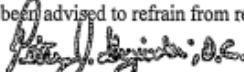
extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 (cervical decompression); C6 (cervical decompression) supine at 10 degrees for 13 minutes at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Ostempowski for and orthopedic consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday February 18, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31,

Encounter dated 02/18/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/01/2016

2015.

Subjective

Cervical: Patient stated that her neck pain has been slightly better. "I think the trigger point injections kind of helped." Patient seeing Dr. Ostempowski next week. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches are no longer daily but every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient has not experienced as much dizziness with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting; level: 3/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been slightly better. Left foot numbness continues to come and go. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left/lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 80/180 pain left shoulder; internal rotation: WNL

**Encounter dated 02/18/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/01/2016**

80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

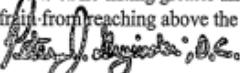
Thoracic assessment: improving, VAS score improved from a 5 to 3 out of 10. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: improving, VAS score improved from a 5 to 3 out of 10. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Encounter dated 02/18/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/01/2016

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 (cervical decompression); C6 (cervical decompression) supine at 10 degrees for 13 minutes at a max pull of 15 lbs for 10 sec with a min pull of 10 lbs for 15 sec; T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Ostempowski for and orthopedic consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform broom stick elevations 2 sets of 10 daily. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

ADL activities of daily living
MVA motor vehicle accident
ROM range of motion
WNL within normal limits
VAS Visual Analog Scale

03 07 16

03.07.16

\$6.45⁰⁰
US POSTAGE
FIRST CLASS
082000718033


Geico
P.O. Box 9507
Fredericksburg, VA 22403

~~MAILING LIST~~
CHITWOOD
345 Dick Rd.
Depew, NY 14043



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

PIC										PICA		
<input type="checkbox"/> MEDICARE		<input type="checkbox"/> MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN (ID#)	FEDA SCHOOLING (ID#)	OTHER (ID#)	1a INSURED'S I.D. NUMBER 0138739400101059	(For Program in Item 1)
<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (DAD/DOD)		<input type="checkbox"/> (Member ID#)							1b INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANTELLIE	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980		
4. INSURED'S ADDRESS (No., Street) 56 BEREHAVENDR										5. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		
CITY AMHERST					STATE NY					6. PATIENT'S ADDRESS (No., Street) 56 BEREHAVENDR		
ZIP CODE 14228		TELEPHONE (Include Area Code) ()										
7. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) JANICE H. HARWELL										8. RESERVED FOR NUCC USE		
9. OTHER INSURED'S POLICY OR GROUP NUMBER PROJECT 61000										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
d. RESERVED FOR NUCC USE										11. INSURED'S POLICY GROUP OR FICA NUMBER GEICO		
e. INSURANCE PLAN NAME OR PROGRAM NAME INDEPENDENT HEALTH										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items B, C, and D		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below										14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 03 02 16										15. OTHER DATE MM DD YY 03 02 16		
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. MICHAEL J OSTEMPONSKI MD										17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 1447262209		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind D										22. RESUBMISSION CODE ORIGINAL REF ID		
A. M25512	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 02 16										B. PLACE OF SERVICE EMG CPT/HCPCS 97001		
C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 97110										D. DIAGNOSIS MODIFIER A		
E. DIAGNOSIS MODIFIER 58.71										F. B. CHARGES G. B. CHARGES H. B. CHARGES I. B. CHARGES J. RENDRING PROVIDER ID # NPI 1922108281		
K. B. CHARGES L. B. CHARGES M. B. CHARGES N. B. CHARGES O. B. CHARGES P. B. CHARGES Q. B. CHARGES R. B. CHARGES S. B. CHARGES T. B. CHARGES U. B. CHARGES V. B. CHARGES W. B. CHARGES X. B. CHARGES Y. B. CHARGES Z. B. CHARGES												
25. FEDERAL TAX I.D. NUMBER SSN SIN 201325251										26. PATIENT'S ACCOUNT NO HARDAB001		
27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										28. TOTAL CHARGE \$ 832.32		
29. AMOUNT PAID \$ 0										30. REAS FOR NUCC USE 6329200		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)										32. SERVICE FACILITY LOCATION INFORMATION BUFFALO PT SPORTS REHAB PC 192 PARK CLUB LANE SUITE 110 WILLIAMSVILLE NY 14221-5242		
33. BILLING PROVIDER INFO & PH# THOMAS F ZDROJEWSKI PT 192 PARK CLUB LANE SUITE 110 WILLIAMSVILLE NY 14221-5242										34. SIGNATURE ON FILE 1922108281		
35. SIGNATURE ON FILE SIGNED 03/04/16 DATE										36. DASHBOOK CPD SUBSIDIED INFORMATION		

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

NMEDICARE AND TRICARE PAYMENTS: A patient's signature requires that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.2(a)(g). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provision through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items explained in "Invoicing". Ls., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Block Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (NMEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment, including but not limited to the Federal anti-kidnapping statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SRRN) of the primary individual rendering each service is reported in the designated section for services to be considered "incident to" a physician's professional services; 7) they must be rendered under the physician's direct supervision by his/her employee; 2) they must be an integral, although incidental part of a covered physician's service; 8) they must be of funds kindly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5338). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 427.32).

NOTICE: Any one who manufactures or leases essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(d), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.2(h) and 424.3(g) (b), and 44 USC 3101; 1 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 8101 et seq. and 30 USC 801 et seq.; 38 USC 612; E.O. 13379.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties payers to pay primary to Federal programs and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice mailing system No. 09-70-0591 titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

BOUTLINES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with repayment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under Beta programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or class number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HHS, Ctrs. 7500 Security Boulevard, Attn: PRA Response Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21244-1860. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

03 08 16

02/24/16

BUFFALO ORTHOPAEDIC GROUP LLP
Patient Therapy Order Requisition

Page 1

Harwell, Danielle
56 Berehaven Drive
Amherst, NY 14226

H-Phone: (716) -536-0951 DOB :08/29/1981
W-Phone: (716) - -
C-Phone: (716) - - Sex :F
Race :Unknown Chart:
Residence: 1408

Co#: 28 Policy#: 0138739400101055
Geico
PO Box 9507
Fredericksburg, Va 22403

PRIMARY INSURANCE

Enclosed Name: Danielle Maxwell

Group Number:

Plan Name: _____

Expired Date: 00/00/00

Co#: 19 Policy#: DBD16761Q00
Iha
511 Farber Lakes Drive
Buffalo, NY 14221

SECONDARY INSURANCE

Insured Name: Danielle Marwell

Group Number: 600005

Plan Name : _____

Expired Date: 00/00/00

Status : Open
Doctor : Erin Leone, RPA-C NPI : 1811909518
Address : 192 PARK CLUB LANE, SUITE 10 LIC : 009109
Address2 : WILLIAMSVILLE, NY 14221-5383
Address3 :
Phone : (716)-204-1101 Fax: (716)-204-0914
Therapist:
Address1 :
Address2 :
Phone : Fax:

— THERAPY ORDER —

Ordered Date: 03/24/20

start date : 00/00/00

End Date : 30/09/00

Duration : 6 Weeks

Therapy PHYSICAL THERAPY Frequency 2x week

Diagnosis: M25.512 Pain in left shoulder

INSTRUCTIONS

Evaluate and treat. Left shoulder impingement/Cervicalgia

Referring Physician's Signature:



Electronically signed by Brian Leeson, RPA-C on 02/24/16 at 11:09 am

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Danielle Harwell ("Assignor") hereby assign to Buffalo PT, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on 10/31/15, notwithstanding any other agreement (Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTORS VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Danielle Harwell
(Print name of Patient)

T. Danielle Harwell
(Signature of Patient)

546 Berehaven Dr.

3/2/16

(Date of signature)

Amherst, NY 14228
(Address of Patient)

Thomas F. Zdrojewski msar
(Print name of Provider)

Thomas F. Zdrojewski
(Signature of Provider)

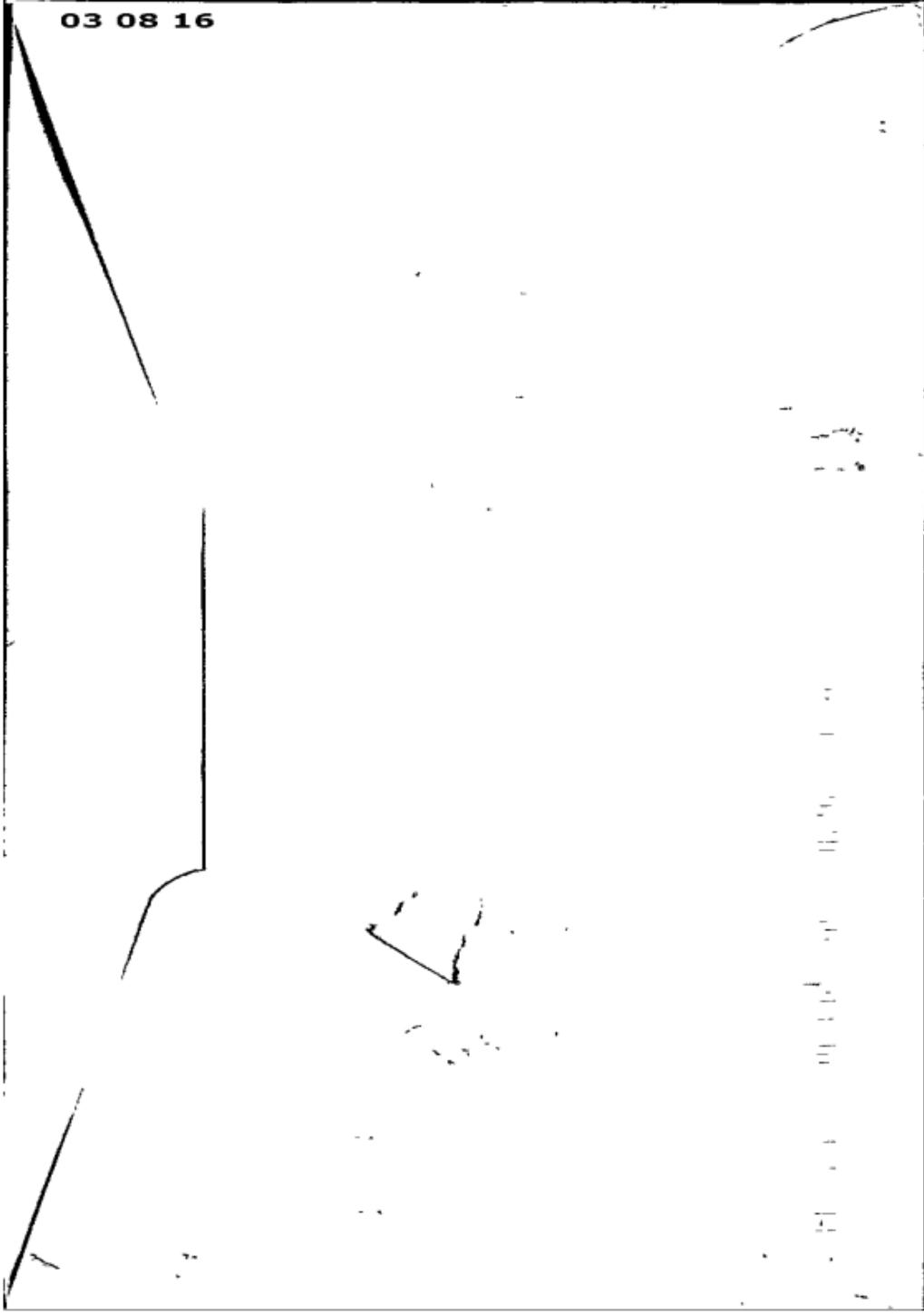
Buffalo PT
192 Park Clrck Lane

3/2/16

(Date of signature)

Williamsville, NY 14221
(Address of Provider)

03 08 16



03 08 16



**BUFFALO PHYSICAL THERAPY
& SPORTS REHABILITATION, P.C.**

192 Park Club Lane Suite 110
Williamsville, NY 14221

04 MAR 2016 PM 51 :

BUFFALO NY 142



22403552607



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22603

CARRIER

PIKA

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> ERGLUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (ERGLUNG) <input type="checkbox"/> (Other)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 013873940-000-0059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE										3. PATIENT'S BIRTH DATE MM DD YY SEX F			
5. PATIENT'S ADDRESS (No. Street) 56 BRASSAVIEN DR										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X		CITY .		STATE .		2b. ZIP CODE () TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) .										10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO LNY c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
b. OTHER INSURED'S POLICY OR GROUP NUMBER .										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE .										c. INSURANCE PLAN NAME OR PROGRAM NAME .			
d. INSURANCE PLAN NAME OR PROGRAM NAME .										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of payment of benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED ON <u>01-06-2016</u> DATE <u>01-06-2016</u>										SIGNED ON <u>01-06-2016</u>			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) MM DD YY QUAL.										15. OTHER DATE MM DD YY MM DD YY QUAL.			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE MCYCLE, JENNIFER, M.D.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) .										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24e) ICD IND <input type="checkbox"/> A. <u>L64.309</u> B. <u></u> C. <u></u> D. <u></u> E. <u></u> F. <u></u> G. <u></u> H. <u></u> I. <u></u> J. <u></u> K. <u></u> L. <u></u>										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. CHARGES .			
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE BMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. DIAGNOSIS (Specify Pointer) MODIFIER										22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER .			
1. <u>03-01-16</u> <u>03-01-16</u> <u>A</u> <u>97140</u> <u>A</u> <u>55.00</u> <u>3</u> 2. <u>03-04-16</u> <u>03-04-16</u> <u>A</u> <u>97140</u> <u>A</u> <u>55.00</u> <u>3</u> 3. <u></u> <u></u> <u></u> <u></u> <u></u> <u></u> 4. <u></u> <u></u> <u></u> <u></u> <u></u> <u></u> 5. <u></u> <u></u> <u></u> <u></u> <u></u> <u></u> 6. <u></u> <u></u> <u></u> <u></u> <u></u> <u></u>										F G. CHARGES H. DAYS OR UNITS I. J. RENDERING PROVIDER ID. # I.D. QMRL NPI <u>12344462011</u> I.D. QMRL NPI <u>12344462011</u> I.D. QMRL NPI I.D. QMRL NPI I.D. QMRL NPI I.D. QMRL NPI			
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. HARWELL, D										27. ACCEPT ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ <u>110.00</u> 29. AMOUNT PAID \$ <u>0.00</u> 30. Reward for NUCC Use \$ <u>110.00</u>			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARX, LMT										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043			
33. BILLING PROVIDER INFO & PH # <u>716</u> <u>725-0264</u> SIGNED <u>03-04-2016</u> <u>1144462011</u> a. (NPI) <u>1144462011</u> b.										GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043			

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature on this form will be made and will attest to the fact that all information necessary to process this claim are contained in the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any study or review to determine if Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, health-risk worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR § 411.94(a). If claim is appealed, the patient's signature authorizes release of the information to the health plan or agency that is responsible to pay for the services. In Wisconsin, assigned or TRICARE prepayment cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE Final determination as the full charge and the patient is responsible only for the deductible contribution and any copay required. Overpayments and line item debits are based upon the charge determination in the Medicare carrier or TRICARE final determination and are to be returned in the correct amount. TRICARE is not a health insurance program but makes payment for health benefits provided through certain providers with the Uniformed Services. Information on one's sponsor should be provided in three items captioned in "Assigned," i.e., items 4, 8, 7, 9, and 11.

BLOCK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required providers and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: (1) all information on this form is true, accurate and complete; (2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare carrier; (3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; (4) the claim, whether submitted by me or on my behalf by an attorney or by my physician or by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal and State/territory status and Physician Self-Referral law (commonly known as Stark Law); (5) the services on this form were medically necessary and reasonably furnished by me or were furnished incident to my professional services by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; (6) for each service rendered incident to my professional services, the identity (legal name and NPI license, if any, or SBN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services: (1) they must be rendered under the physician's direct supervision by his/her employee; (2) there must be an integral, although incidental part of a covered physician service; (3) they must be of lands commonly furnished in physician's offices, and (4) the services of non-physicians must be included on the physician's bill;

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 36 USC 5338). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or omits essential information to receive payment from Federal funds required by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWC to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2051(a), 1022, 1072 and 1074 of the Social Security Act as amended. (42 CFR 411.34(a) and 434.5(a)) (B), and 44 USC 3101-41 CFR 101 of et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq; 38 USC 119; E.O. 13397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies for the effective administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosure is made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-5501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 63 No. 177, page 37549, Wed Sept. 12, 1990, as updated and republished.

FOR OWC CLAIMS: Department of Labor, Privacy Act of 1974, Republification of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-93 or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies rendered are authorized by law.

FOR DOD USES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory authority and responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumers reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care on matters relating to entitlement, claims adjudication, fraud, program abuses, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE/LFR: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged could prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XXI plan and to furnish information regarding any payments claimed for providing such services to the State Agency or Dept. of Health and Human Services as may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary in the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and not any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1187. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improving the form, please write to: OMB, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-36 05, Baltimore, Maryland 21244-1850. The address is for comments - not for suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14203
Office: (716) 725-0334 Fax: (716) 725-0355

CMW

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14203
Office: (716) 725-0334 Fax: (716) 725-0355

Client Name: Danielle Howell Date: 3/4/16

Client Status: (Check) Better Progressing Worse (Same) No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports frequent severe HT's and in a lot of stress lately neck remains the same

Static PT & Shoulder Activities prevent

Action/s Applied: (Check All that Apply) Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage region 10/
 Deep Tissue Massage Myofascial Release Friction W/T,
 Manual Traction Stretching Range-of-Motion Well
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretchss Con't Meds Ice / Heat

Therapist: Deb Hayek

Client Name: _____ Date: _____

Client Status: (Check) Better Progressing Worse (Same) No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action/s Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretchss Con't Meds Ice / Heat

Therapist: _____

03 10 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

315 Dick Rd Depew, NY 14203

Office: (716) 725-0284

Fax: (716) 725-0285

CMV

Client Name: Dawn M. Haney Date: 2/20/16

Slowly

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 **6** 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports 145 lbs relief from M.T. before

Subject: Client returns. Feeling better today. Client continues Client tx. Client continues to have multiple adhesions

to have multiple adhesions thru C-T spine + musculature in R shoulder region R > L @ supraspinatus/lat

Actions Applied: (Check All that Apply) Client feeling better

- Heat Packs Cold Packs Sombra/Biofreeze Pressure as
 Light Pressure Massage Mod Pressure Massage w/J.I. Felt better.
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Dawn M. Haney

Great Lakes Therapeutic Massage & Bodywork Practitioners

315 Dick Rd Depew, NY 14203

Office: (716) 725-0284

Fax: (716) 725-0285

Client Name: Dawn M. Haney Date: 3/11/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 **7** 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Best of thoracic P today that radiates into LUE p

Actions Applied: (Check All that Apply) Client felt better R > L

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Dawn M. Haney

03 10 16- .

THE BIBLICAL THEOLOGY OF JESUS CHRIST

03 10 16

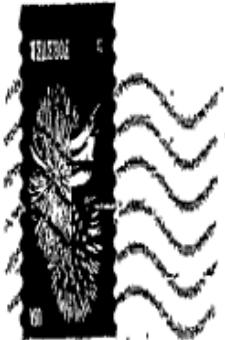
22408952607

FREDRICKSBURG, VA 22403

P.O. BOX 9507

GEICO INS CO of NY

Great Lakes Therapeutic Massage
Colleen Hart, LMT
375 Dick Road, Suite #2
Buffalo, NY 14203
07 MAR 2016 PM 9:19





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
NY PIP
P O BOX 9507
FREDERICKSBURG VA 22403

CARRIER

PICA		PICA	
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> DOD/DoD	<input type="checkbox"/> Member ID#
			<input type="checkbox"/> DOD
		GROUP HEALTH PLAN	FICA EXEMPTION (ROW)
		<input type="checkbox"/>	4 <input type="checkbox"/> (DOD)
138739400101059			

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HARWELL, DANIELLE	08 29 1980	M <input type="checkbox"/> F <input checked="" type="checkbox"/>	HARWELL, DANIELLE

5. PATIENT'S ADDRESS (No., Street)	PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
56 BEREHAVEN DR LEFT	Spoouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	56 BEREHAVEN DR LEFT

CITY BUFFALO	STATE NY	CITY BUFFALO	STATE NY
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951	ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N.A.	10. IS PATIENT'S CONDITION RELATED TO N	11. INSURED'S POLICY GROUP OR FICA NUMBER N
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	b. OTHER CLAIM ID (Designated by NUCC) I
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME I
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLM# CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the agency who accepts assignment below.

SIGNATURE ON FILE

03 07 2016

SIGNATURE ON FILE

SIGNED _____ DATE _____ SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE MM DD YY
10M 3P 2015 QM 1431 QM17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN ERIN LEONE RPA-C 17a. 17b. FROM MM DD YY TO MM DD YY
NPI 811909518

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24e) ICD IND
M7989 A L B I C L D L E F G L H K L J L

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMR	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS MODIFIER POINTERS	F. CHARGES \$ AMOUNT OF UNITS	G. H. I. J. AMOUNT PER UNIT ID QUAM RENDERING PROVIDER ID #
--	----------------------------	---	--------------------------------------	-------------------------------------	---

1 02 25 16 11 73221 LT A 706.26 1 -- 1831148832 --

2. NPI

3. NPI

4. NPI

5. NPI

6. NPI

25. FEDERAL TAX ID NUMBER 262448643	SSN SSN X X X X X X X X	26. PATIENT'S ACCOUNT NO. 88430	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 706.26	29. AMOUNT PAID \$ 0.00	30. Rcv'd for NUCC Use --
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements made on this form apply to this bill and are made a part hereof.) Winter, Steven W, MD	32. SERVICE FACILITY LOCATION INFORMATION BUFFALO DIAGNOSTIC IMAGIN 4925 MAIN STREET AMHERST NY 14226-4081	33. BILLING PROVIDER INFO & PH# (716) 839-3933 BUFFALO DIAGNOSTIC IMAGING, P BUFFALO MRI 4925 MAIN ST AMHERST NY 14226-4081
03 07 16	a. b. c. d.	e. f. g. h. i. j.

SIGNED DATE PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim or claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal or punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, ability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 3 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE exception case, the physician agrees, except the change of termination of the Medicare carrier or TRICARE lessor to lessor by the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if it is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain allowances with the Uniformed Services. Information on the patient's spouse should be provided in those items captioned in "Insured"; i.e., items 4, 6, 7, 9 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-Fraud Statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, its identity (legal name and NPI, license # or SSN) of the primary individual rendering such service is reported in the designated section For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee; 2) they must be an integral, although incidental part of a covered physician service; 3) they must be of kinds commonly furnished in physician offices; and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government, either civilian or military prior to 8 USC 5326. For Black Lung claims, I further certify that the services performed are not for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless the form is returned as required by existing law and regulations (42 CFR 424.32).

NOTICE. Any one who misrepresents or violates essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENTS ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS TRICARE and OWC to use you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(p) 1882, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.50(i) (8), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 5501 et seq; 50 USC 901 et seq; 8 USC 6104, E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-10-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Yea Sept. 12, 1990, as updated and re-published.

FOR OWC CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See E&A-6, E&A-6, E&A-12, E&A-13, E&A-50, as updated and re-published.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from clients and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions to the Internal Revenue Service, private collection agencies, and consumer reporting agencies, in connection with recoupment claims, and to Congressional Offices in response to requests made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, could delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-623, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

REBILLED PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost sharing charge.

SIGNATURE OF PHYSICIAN (OR STAFF MEMBER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Privacy Act Regulation of 1974, no person is 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 0938-1397. This has been reviewed and determined that this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, get information from other records and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please mail to CMS, 7500 Security Boulevard, Attn: PRA Regis Clearance Officer, Mail Stop C4-05-05, Baltimore, Maryland 21244-1000. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

ERIN LEONE, RPAC
 192 PARK CLUB LANE
 BUFFALO, NY 14221

Patient: DANIELLE HARWELL
 DOB: 8/29/1980
 ID: RAM1965183
 DOS: 2/25/2016 1:39:21 PM

MRI SHOULDER W/O CONTRAST LT 25MIN

REASON FOR STUDY AND CLINICAL INFORMATION: Left shoulder pain. Patient was in motor vehicle accident, and was a driver of a van.

IMAGING SEQUENCES: Multiplanar 3-T MR imaging of the left shoulder is performed.

FINDINGS: The components of the rotator cuff are unremarkable in size, morphology and signal characteristics, showing no tendinosis or tear. The long head of the biceps is also unremarkable, as is the short head.

Acromioclavicular alignment is satisfactory without arthrosis. There is no compromise of the subacromial space. A type 1 acromion is present.

Glenohumeral alignment is satisfactory. There is no capsule or labral defect. There is no synovial effusion or soft tissue mass. There is no bursitis. There are a few scattered ovoid axillary lymph nodes, the majority of which are fatty replaced. These have benign features but clinical correlation would be advised given the number of lymph nodes that are present.

There is a tiny subcortical cyst at the lateral margin of the humeral head, benign in appearance.

IMPRESSION:

1. THERE IS NO ROTATOR CUFF TEAR OR TENDINOSIS, OR ANY INTERNAL DERANGEMENT OF THE SHOULDER.
2. TINY SUBCORTICAL CYSTS LATERALLY AT THE HUMERAL HEAD.
3. MULTIPLE LYMPH NODES WHICH HAVE BENIGN FEATURES BUT CLINICAL CORRELATION WOULD BE ADVISED.

Thank you very much for referring this patient to us.

Sincerely,

Signed by STEVEN WINTER, M.D. at 2/28/2016 6:40:39 PM

HEBA ATEF 2/27/2016 5:51:56 AM

Buffalo Diagnostic Imaging, PLLC

Snyder Place
 4925 Main Street
 Amherst, NY 14226

P: 716.839.3333

F: 716.839.3338

Toll-Free 888.MRI.3939

buffalomri.com

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammo

Bone Density/DEXA

ERIN LEONE, RPAC
 192 PARK CLUB LANE
 BUFFALO, NY 14221

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buffalomri.com

03-14 16

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Buffalo MRI



Made easy for you.

4925 Main Street
Amherst, NY 14226

EX-FF-40

147 2424

09 MAR '16

PM 1 L



22403952607

Receive Date: 3/18/2016

Front End

Region 2: NY PIP MAIL**Indexing Category:**

- | | |
|--|--|
| <input checked="" type="checkbox"/> NY FPM Bills | <input type="checkbox"/> Unreadable Original |
| <input type="checkbox"/> PIP SHQ | <input type="checkbox"/> Notary Seal |
| <input type="checkbox"/> NY FPM PSR Provider Letters | <input type="checkbox"/> Box Work |
| <input type="checkbox"/> NY FPM PL Peer Response | <input type="checkbox"/> No Date Sheet
Needed |

Sorted by U62:

Tip Date: 3/21

#21 Pink



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIGA													
1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TICARE <input type="checkbox"/> Ticare	CHAMPVA <input type="checkbox"/> Member ID#	GROUP HEALTH PLAN <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP <input type="checkbox"/> OTHER	FED BOXING <input type="checkbox"/> INDIVIDUAL <input checked="" type="checkbox"/> GROUP <input type="checkbox"/> OTHER	1a. INSURED'S ID NUMBER 013873940-0101-055	(For Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BARWELL, DARICE L.			3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - SAME -						
5. PATIENT'S ADDRESS (No., Street) 56 BERMUDAVENT DR			6. PATIENT RELATIONSHIP TO INSURED Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)						
CITY AMBERT		STATE NY	8. RESERVED FOR NUCC USE X				CITY		STATE				
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE		TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER													
b. RESERVED FOR NUCC USE													
c. RESERVED FOR NUCC USE													
d. INSURANCE PLAN NAME OR PROGRAM NAME													
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>PLACE (State)</small> NY													
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
11. INSURED'S POLICY GROUP OR FED NUMBER													
a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>													
b. OTHER CLAIM ID (Designated by NUCC)													
c. INSURANCE PLAN NAME OR PROGRAM NAME													
12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 10, and 13													
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below													
SIGNED - ON FILE -			DATE 01-06-2016										
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			SIGNED - ON FILE -										
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 31 2015 QUAL:			15. OTHER DATE QUAL:			MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a McVIGE, JENNIFER, M.D. 17b NPI							18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD 10: _____													
A. <u>L1G44.309</u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	22. RESUBMISSION CODE ORIGINAL REF NO									
E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	23. PRIOR AUTHORIZATION NUMBER									
I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE INRG. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPTHOPCS			E. DIAGNOSIS MODIFIER POINTERS	F. \$ CHARGES	G. DAYS ON UNITS	H. CHARGE PER UNIT	I. ID QUAM	J. RENDERING PROVIDER ID #	
1 03 08 16	03 08	16	11	97140				55.00	3		NPI	1144462011	
2 03 13 16	03 12	16	11	97140			A	55.00	3		NPI	1144462011	
3 												NPI	
4 												NPI	
5 												NPI	
6 												NPI	
25. FEDERAL TAX I.D. NUMBER 099606323				SSN BIN <input checked="" type="checkbox"/>			26. PATIENT'S ACCOUNT NO HARWELL, D	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 110.00	29. AMOUNT PAID \$ 0.00	30. Rev'd for NUCC Use 110.00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			33. BILLING PROVIDER INFO & PH # (716) 725-0264						
COLSEN MARK, LMT SIGNED DATE				1144462011			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043						

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency chosen. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e., items 1a, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, when submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral Law (commonly known as Stark Law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SBN) of my primary individual rendering each service is reported in the designated section. For services to be considered incident to a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral although incidental part of a covered physician's professional services, 3) they must be of little commercial value in physician's office, and 4) the services of non-physician must be indicated on the physician's bills.

For TRICARE claims, I further certify that I (or my employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 10 USC 5330). For Black Lung claims, I further certify that the services performed were not for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who represents or misrepresents information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCW to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2052(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(e)(8) and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1076 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 813; E.O. 13937.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if no services and supplies you received are covered by these programs and to insure that proper payment is made.

This information may also be given to other providers of services, consumer organizations, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosure are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 02-70-0501, titled, "Cancer Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37510, Wed Sept 12, 1990, as updated and republished.

FOR OWCW CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb. 28, 1990. See ESA-5, EBA-6, EBA-12, EBA-13, EBA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

BOUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, or matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLAIMER: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the incident services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1120B of the Social Security Act and 31 USC 3811-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the "Ch�rester Martin and Privacy Protection Act of 1986," permits the government to verify information by way of computer inquiries.

Medicaid Payments (Provider Certification)

I hereby agree to keep track records in an ordinary manner to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services or the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of uninsured deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary in the health of this patient and were personally furnished by me or my employee under my personal direction.

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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 0238-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-26-05, Baltimore, Maryland 21204-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0894

Fax: (716) 725-0365

Client Name: Danielle Howell Date: 3/12/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliqes ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: *(Whether feeling has gotten better or worse from*

heat/ice. Spasms persist throughout (L) but (S)

Major Ache/s present & more tender today.

Action/s Applied: (Check All that Apply) *throughout C-T spine*

- Heat Packs Cold Packs Sombra/Biofreeze Musculature
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

Danielle Howell *Signature*

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0894

Fax: (716) 725-0365

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 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

_____</p

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office (716) 725-0264

Fax: (716) 725-0265

CMV

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 3/4/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Front right shoulder/beneath AT's. Under a lot of stress lately. Neck remains the same.

Started PT: 3/4/16 Shoulder. Adhesions present.

- Actions Applied: (Check All that Apply) Heat/Cold/Promber Light Pressure Massage Mod Pressure Massage Friction Deep Tissue Massage Myofascial Release Friction Manual Traction Stretching Range-of-Motion Stripping Compression Lymph Drainage Well

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretch Can't Meds Ice / Heat

Therapist: Danielle Howell ATClient Name: Danielle Howell Date: 3/8/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

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 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has spasms in R shoulder/AT/cervical region. All almost TRPs present throughout cervical + trapezius muscles.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretch Can't Meds Ice / Heat

Therapist: Danielle Howell AT

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03 18 16

Great Lakes Therapeutic Massage

Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14243



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

224035525 ECR



GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

PICA

<input type="checkbox"/> MCA																
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA						
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> DOD/DoD		<input type="checkbox"/> Member ID		<input type="checkbox"/> DOD		<input type="checkbox"/> DOD						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		(For Program in Item 1)								
HARWELL, DANIELLE		MM DD YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		HARWELL, DANIELLE		013873940011059								
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)												
56 BEREHAVEN DR. LEFT		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		56 BEREHAVEN DR. LEFT												
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE		CITY AMHERST		STATE NY								
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER												
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH												
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY												
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated by NUCC)												
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		PLACE (State) NY												
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME												
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		GEICO												
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?												
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d												
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																
SIGNED SIGNATURE ON FILE DATE						SIGNED SIGNATURE ON FILE										
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION												
MM DD YY 103115		QUAL. 431		MM DD YY 454 111215		MM DD YY										
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. <input type="checkbox"/> NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
17b. <input type="checkbox"/> NPI				MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																
20. OUTSIDE LAB? \$ CHARGES																
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD-9-CM A. M50.22 B. M51.26 C. M51.27 D. M54.12 E. I52.3 XXXA F. M99.01 G. M99.03 H. M99.02 I. M99.05 J. M54.2 K. M54.5 L. M54.6																
22. RESUBMISSION CODE		ORIGINAL REF. NO.														
23. PRIOR AUTHORIZATION NUMBER																
24. A. DATE(S) OF SERVICE		B. RAZOR SERVICE		C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS FOOTNOTE		F. \$ CHARGES		G. DAYS OR HOURS PER PAY PER	H. ID CUAL	I. ID CUAL	J. RENDERING PROVIDER ID #	
1	03032016	03032016	11	98941				ABCD	32 28	1			NPI	1710014188		
2	03032016	03032016	11	97010				ABCD	10 53	1			NPI	1710014188		
3													NPI			
4													NPI			
5													NPI			
6													NPI			
25. FEDERAL TAX ID NUMBER		SSN EN		26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT BY 3RD PARTY PAYOR YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE		29. AMOUNT PAID		30. Paid for NUCC Use				
364500165		<input type="checkbox"/> <input type="checkbox"/> X		343821013		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		\$ 421.81		\$ 0						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If only the statements on the reverse side apply, initial here and sign there.) PETER GOZINSKE DC												33. BILLING PROVIDER INFO & PH # (716) 681-3333				
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849												CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849				
SIGNED 03152016		DATE		# 1235256546 ^b		# 1235256546 ^b										

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
March 15, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday March 3, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain remains the same. Patient started PT yesterday for the shoulder. Follow up with the orthopedist will be on March 16, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches remain the same about 2 x a week. She states that the duration varies, sometimes they last all day. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck

Encounter dated 03/03/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/15/2016

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 80/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

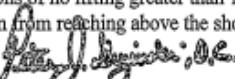
Encounter dated 03/03/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/15/2016

Thoracic assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (supine mobilization); C6 left lateral flexion restriction (supine mobilization); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); Left SI left (prone mobilization). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform broom stick elevations 2 sets of 10 daily. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

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Fredericksburg, VA 22403

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CITY OF BUFFALO
345 Dick Rd
Depew, NY 14244



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/13

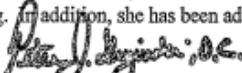
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PO BOX 9507
FREDERICKSBURG VA 22403-9526

20

1 MEDICARE (Medicare)	2 MEDICAID (Medicaid)	3 TRICARE (DOD/DoD)	4 CHAMPVA (Member ID#)	5 GROUP HEALTH PLAN (GHP) (LWV)	6 FECA BUILDING (BOM) (BOM)	7 OTHER	8 INSURED'S ID NUMBER 013873940011059	9 FOR Program in Item 1	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			3 PATIENT'S BIRTH DATE MM DD YY 08291980			SEX M	4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
5 PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT			6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY AMHERST	STATE NY	8 RESERVED FOR NUCC USE			CITY AMHERST	STATE NY			
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951			
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 08291980			
b RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NY			b. OTHER CLAIM ID (Designated by NUCC)			
c RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
d INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below									
SIGNED SIGNATURE ON FILE			DATE			SIGNED SIGNATURE ON FILE			
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) 103115			15 OTHER DATE QUAL 454 MM DD YY 111215			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE JUL			17a. NP			18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20 OUTSIDE LABS \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate A-L to service line below (24)) ICD-9-CM A I50.22 B I55.26 C I51.27 D I54.12 E I82.3 XXXA F I99.01 G I99.03 H I99.02 I I99.05 J I54.2 K I54.5 L I54.6									
22 RESUBMISSION CODE ORIGINAL REF. NO									
23 PRIOR AUTHORIZATION NUMBER									
A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B FACILITY HOSP/SPNS/EMG	C CPT/HCPCS	D PROCEDURES, SERVICES, OR SUPPLIES (Specify Universal Crosswalk)	E MODIFIER	F DIAGNOSIS CODE \$ CHARGES	G DAYS ON UNITS	H PMT Per Unit	I ID # QMB	J RENDERING PROVIDER ID #
02222016	02222016	11	98941		ABCD	32	28	1	NPI 1710014188
02252016	02252016	11	98941		ABCD	32	28	1	NPI 1710014188
02252016	02252016	11	97010		ABCD	10	53	1	NPI 1710014188
02292016	02292016	11	98941		ABCD	32	28	1	NPI 1710014188
02292016	02292016	11	97010		ABCD	10	53	1	NPI 1710014188
26 FEDERAL TAX ID NUMBER 364500165	SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>	26 PATIENT'S ACCOUNT NO. 343821712	27 ACCEPT ASSIGNMENT PBM GENCO GENCO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28 TOTAL CHARGE \$ 117.90	29 AMOUNT PAID \$ 0	30 Paid for NUCC Use 0			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made under threat of PETER GOZINSKI DC)			32 SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			33 BILLING PROVIDER INFO & P.M.A. (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			

Encounter dated 02/29/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/15/2016

home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform broom stick elevations 2 sets of 10 daily. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

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345 Dick Rd
Depew, NY 14244

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
March 15, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday February 22, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain remains the same. Patient seeing Dr. Ostempowski on Wednesday. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, tingling, shooting, numb; level: 5/10. **Pain is constant.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that her headaches are no longer daily but every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient has not experienced as much dizziness with the headaches. **Recent medical treatment for this condition:** Massage therapy. **Prior chiropractic treatment for this condition:** None.

Thoracic: Patient stated that her left middle back pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, shooting; level: 3/10. **Pain is constant.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. Left foot numbness continues to come and go. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** improving. **since last visit.** **Pain:** achy, dull, shooting, tingling, numb; level: 3/10. **Pain is constant.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck

**Encounter dated 02/22/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/15/2016**

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 80/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

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Thoracic assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Stopped decompression due to lack of improvement at this time. *Patient treated to:* relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient referred to:* Dr. Ostemponski for and orthopedic consult. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform broom stick elevations 2 sets of 10 daily. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 29, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday February 25, 2016 Provider: Peter Guzinski DC

Encounter dated 02/25/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/15/2016

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been better since last visit. Patient saw Dr. Ostempowski who ordered a shoulder MRI which will be performed this afternoon. She also stated that she has been advised to perform PT. Follow up will be on March 16, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, *since* last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches have been "pretty good, maybe 2 x a week." She states that the duration varies, sometimes they last all day. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition:* None.

Thoracic: Patient stated that her left middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, *since* last visit. *Pain:* achy, dull, shooting; level: 4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, *since* last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Encounter dated 02/25/2016 for Danielle Harwell #3438
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Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 80/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, less frequent headaches. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens thecal sac.

Thoracic assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

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Treatment & Plan

Stopped decompression due to lack of improvement at this time. *Patient treated to:* relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform broom stick elevations 2 sets of 10 daily. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Monday February 29, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been better since last visit. Patient saw Dr. Ostempowski who ordered a shoulder MRI which was performed on February 25, 2016. She also stated that she has been advised to perform PT. Follow up will be on March 16, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches remain the same about 2 x a week. She states that the duration varies, sometimes they last all day. *Recent medical treatment for this condition:* Massage therapy. *Prior chiropractic treatment for this condition*

Encounter dated 02/29/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/15/2016

None.

Thoracic: Patient stated that her left middle back pain remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, shooting; level: 4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain is "probably a 3". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 80/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending:

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25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily;

Receive Date: 03/21/2016

Front End

Region 2: NY PIP MAIL**Indexing Category:**

- | | |
|--|--|
| <input checked="" type="checkbox"/> NY FPM Bills | <input type="checkbox"/> Unreadable Original |
| <input type="checkbox"/> PIP SHQ | <input type="checkbox"/> Notary Seal |
| <input type="checkbox"/> NY FPM PSR Provider Letters | <input type="checkbox"/> Box Work |
| <input type="checkbox"/> NY FPM PL Peer Response | <input type="checkbox"/> No Date Sheet
Needed |

#21 Pink

Sorted by U62: 6b
Tip Date: 03/22

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

NUCC PICA

PICA

1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TRICARE <input type="checkbox"/> DOD/DoD	CHAMPVA <input type="checkbox"/> Member DOD	GROUP HEALTH PLAN <input type="checkbox"/> DOD	FECA EXCLUSIVE <input checked="" type="checkbox"/> DOD	OTHER <input type="checkbox"/> DOD	14. INSURED'S I.D. NUMBER 0138739400101059 (For Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY 08 29 80		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARRELL, DANIELLE							
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DRIVE							
CITY AMHERST	STATE NY	8. RESERVED FOR NUCC USE		CITY AMHERST	STATE NY	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							
ZIP CODE 14228	TELEPHONE (Include Area Code) ()			ZIP CODE 14228	TELEPHONE (Include Area Code) ()	a. OTHER INSURED'S POLICY OR GROUP NUMBER							
b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME Geico		e. OTHER INSURED'S POLICY OR GROUP NUMBER							
e. RESERVED FOR NUCC USE		f. INSURANCE PLAN NAME OR PROGRAM NAME Geico		g. OTHER INSURED'S POLICY OR GROUP NUMBER		h. OTHER INSURED'S DATE OF BIRTH MM DD YY 08 29 80 M <input type="checkbox"/> F <input checked="" type="checkbox"/>							
i. RESERVED FOR NUCC USE		j. INSURANCE PLAN NAME OR PROGRAM NAME Geico		k. OTHER INSURED'S DATE OF BIRTH MM DD YY 08 29 80 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		l. OTHER CLAIM ID (Designated by NUCC) Y4 0138739400101059							
m. RESERVED FOR NUCC USE		n. INSURANCE PLAN NAME OR PROGRAM NAME Geico		o. OTHER INSURED'S DATE OF BIRTH MM DD YY 08 29 80 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		p. INSURANCE PLAN NAME OR PROGRAM NAME Geico							
q. RESERVED FOR NUCC USE		r. INSURANCE PLAN NAME OR PROGRAM NAME Geico		s. INSURANCE PLAN NAME OR PROGRAM NAME Geico		t. INSURANCE PLAN NAME OR PROGRAM NAME Geico							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
Signature On File		DATE 3/15/2016		Signature On File		DATE 3/15/2016							
SIGNED		SIGNED		SIGNED		SIGNED							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 31 15		15. OTHER DATE QUAL 439 MM DD YY 10 31 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN J JAMES PANZARELLA							
17a. 17b. NPI 1518964204		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (S4E) ICD Ind. O		22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER NOT REQUIRED		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 02 24 16 02 24 16							
B. PLACE OF SERVICE EMG		C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES G. DAYS OR UNITS H. HCPCS Family Plan I. L. ID J. RENDERING PROVIDER ID. # K. L.						
							OB 200802 NPI 1972515740						
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							NPI						
25. FEDERAL TAX ID NUMBER 201149005		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 60409		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 83 71		29. AMOUNT PAID \$ 0 00		30. Ready for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) THADDEUS E. SEARANOWICE SIGNED 3/15/2016		32. SERVICE FACILITY LOCATION/INFORMATION BUFFALO ORTHOPAEDIC GROUP, LLP 192 PARK CLUB LANE SUITE 100 WILLIAMSVILLE, NY 14221-5242		33. BILLING PROVIDER INFO & P# (716) 204-1101 BUFFALO ORTHOPAEDIC GROUP, LLP PO BOX 8000 DEPT. 422 BUFFALO, NY 14267-8000									
DATE		a. 1144284464		b. 200802		a. 1144284464		b.					

Date: 02/24/16
Name: Danielle Harwell

Buffalo Orthopaedic Group LLP
DOB: 08/29/1980 Sex: F Age: 35 yrs Acct#: 60409

CC: Left shoulder pain

HPI: Danielle presents to the office today in regards to her left shoulder. She is a 35-year-old female who was involved in a motor vehicle accident on 10/31/2015. She states she was a belted driver when she was stopped on Stain in North Buffalo. She was rear-ended by another vehicle. She states she saw the vehicle coming in her rear view mirror and tensed up gripping the steering wheel. She injured her left shoulder. She was also noted to have some wisp/injury to the neck. She was seen and immediate care and had x-rays. At that time her neck and back were more symptomatic. She followed up with Dr. Pollina for this. She states she has had an MRI of her cervical spine. Dr.Pollina also recommend she see someone for her continued left shoulder pain. She has weakness in her left arm. She does get pain at night and pain with overhead activities. She has been seeking chiropractic treatment with some relief. She is right-hand dominant. She does sometimes get some numbness and tingling down the arm. She denies any fevers, chills or any constitutional symptoms.

Meds Prior to Visit:

Allergies:

PMH:

Medical Problems:

Shoulder Pain, Anemia, Arthritis, Asthma, Bronchitis, Hernia, Migraines, Miscarriage, Pneumonia, Tonsillitis, GERD

Accidents:

Rear Ended By 3 Cars

Surgical Hx:

Tonsils & Adnoids 1990, D&C 2012, Endoscopy & Colonoscopy 2016
(Anesthesia Complication)

(Assistive Device)

Reviewed, no changes.

FH:

Father:

Strokes, Diabetes, High Cholesterol.

Mother:

Asthma, Allergies, Diabetes.

Reviewed, no changes.

ROS:

Const: Denies symptoms other than stated above.

CV: Denies cardiovascular symptoms.

GI: Denies gastrointestinal symptoms.

Musculo: Denies symptoms other than stated above.

Skin: Denies skin, hair and nail symptoms.

Neuro: Denies symptoms other than stated above.

Reviewed, no changes.

PHYSICAL EXAMINATION: The patient is a well developed well nourished person, in no acute distress. The patient appears as stated age, is alert and oriented x 3 and is cooperative and interactive.

Musculoskeletal Exam:

Left shoulder

Skin: Intact throughout.

Inspection/Palpation/Swelling: She is no gross swelling or deformity throughout the shoulder. She is non tender throughout the shoulder. She does have some tenderness in the trapezial region.

ROM: She can forward elevate the shoulder to approximately 150° with pain. Internal rotation is to the LS junction. External rotation is 70°.

Stability: No gross instability.

Strength: 5 minus/5 abduction and external rotation strength.

Special Tests: Positive Hawkins and impingement testing. She does have some discomfort with Spurling's is well.

Neurovascular: Sensation is intact throughout the upper extremity in all dermatomes. Pulses palpable in the wrist.

Dx Studies:

Radiographs of the left shoulder were taken in the office today for the purposes of evaluating shoulder pain. Glenohumeral joint space is well-maintained. No acute fracture is evident.

Assessment:

1. M25.512 Pain in left shoulder
2. M75.42 Impingement syndrome of left shoulder

Care Plan:

Comments : Treatment was discussed with Danielle in the office today. We discussed her situation. She does see to have some mild symptoms of impingement in the left shoulder. I do think some of her symptoms are likely coming from her cervical spine. She states she was told she does have 2 herniated disks in her neck. Dr. Pollina has been managing this. I do think a course of physical therapy for her shoulder and neck will be beneficial. I have also discussed a cortisone injection in the shoulder with her. Unfortunately she is allergic to a lot of things and she does not have her EpiPen with her today. I would like to obtain an MRI scan of the left shoulder for further evaluation. If she does have findings on the MRI of the shoulder we can consider the injection. She is going to bring her EpiPen to the next appointment. She states she is not specifically allergic to cortisone but she just knows she is very sensitive to a lot of medications. For now she will begin a course of therapy and proceed with MRI of the shoulder. I would like to see her back in 4 weeks to review the MRI and to see how she is done with physical therapy. She was agreeable with the above treatment plan. She will continue management of her cervical spine with Dr.Pollina.

Xray : Shoulder Complete Min 2 Views LT
MRI Shoulder W/O Contrast Left

Therapy : Physical Therapy


Seen by: Electronically signed by Erin Leone, RPA-C on 02/29/2016

03 21 16

Danielle Harwell DOB 08/29/1980 BUFFALO ORTHOPAEDIC GROUP LLP

Page #3

Organization Manifest

BUFFALO ORTHOPAEDIC GROUP, LLP(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01387394001010591		HARWELL, DANIELLE	02/24/2016	02/24/2016

03 21 16

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

PCA

Date: 02/24/16
Name: Danielle Harwell

Buffalo Orthopaedic Group LLP
DOB: 08/29/1980 Sex: F Age: 35 yrs Acct#: 60409

CC: Left shoulder pain

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PMH:

Medical Problems:

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Accidents:

Rear Ended By 3 Cars

Surgical Hx:

Tonsils & Adenoids 1990, D&C 2012, Endoscopy & Colonoscopy 2016
(Anesthesia Complication)
(Assistive Device)

Reviewed, no changes.

FH:

Father:

Strokes, Diabetes, High Cholesterol.

Mother:

Asthma, Allergies, Diabetes.

Reviewed, no changes.

ROS:

Const: Denies symptoms other than stated above.

CV: Denies cardiovascular symptoms.

GI: Denies gastrointestinal symptoms.

Musculo: Denies symptoms other than stated above.

Skin: Denies skin, hair and nail symptoms.

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Xray : Shoulder Complete Min 2 Views LT

MRI Shoulder W/O Contrast Left

Therapy : Physical Therapy

Seen by: Electronically signed by Erin Leone, RPA-C on 02/29/2016



03 21 16

Danielle Harwell DOB 08/29/1980 BUFFALO ORTHOPAEDIC GROUP LLP

Page #3

03 21 16



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO
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FREDERICKSBURG VA 22403

CARRIER

PICA												PICA
1. MEDICARE <input type="checkbox"/> (Medicare)	2. MEDICAID <input type="checkbox"/> (Medicaid)	3. TRICARE <input type="checkbox"/> (DOD/DoD)	4. CHAMPVA <input type="checkbox"/> (Member Only)	5. GROUP HEALTH PLAN <input type="checkbox"/> (DVA)	6. FECA <input type="checkbox"/> (VET)	7. OTHER <input type="checkbox"/> (DVA)	8. INSURED'S ID NUMBER 0138739400101059 (For Program In Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE						
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVENDR		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVENDR								
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY						
ZIP CODE 14228		TELEPHONE (Include Area Code) ()		ZIP CODE 14228		TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE								10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME INDEPENDENT HEALTH								11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below				
SIGNED SIGNATURE ON FILE								DATE 03/18/16				
SIGNED SIGNATURE ON FILE								DATE 03/18/16				
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL:		15. OTHER DATE QUAL: MM DD YY 03 02 16		16. COTIS PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. MICHAEL J OSTENPOWSKI MD		17a. NPI 17b. NPI 3447262209		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer A-L to service line below (24e)) A. M25512 B. L. C. L. D. L. E. L. F. L. G. L. H. L. I. L. J. L. K. L.								22. RESUBMISSION CODE ORIGINAL REF. NO.				
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMR C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER								E. DIAGNOSIS POINTERS F. \$ CHARGES G. DOTS OR UNITS H. DRG FAC RTE I. L. ID QUAL J. RENDERING PROVIDER ID #				
1	03 15 16	03 15 16	11	97110	A	24	61	1	NPI	1922108281		
2	03 15 16	03 15 16	11	97110	A	24	61	1	NPI	1922108281		
3									NPI			
4									NPI			
5									NPI			
6									NPI			
25. FEDERAL TAX ID NUMBER 201325251	SSN/BN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO HARDA001	27. DOB/AGE/SEGMENT 85395 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 4922	29. AMOUNT PAID \$	30. Reserved for NUCC Use						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Copy the statement on the reverse apply to this bill and are made a part thereof.)								32. SERVICE FACILITY LOCATION INFORMATION BUFFALO PT SPORTS REHAB PC 192 PARK CLUB LANE SUITE 110 WILLIAMSVILLE NY 14221-5242				
SIGNATURE ON FILE								33. BILLING PROVIDER INFO & PH# THOMAS F ZDROJEWSKI PT 192 PARK CLUB LANE SUITE 110 WILLIAMSVILLE NY 14221-5242				
SIGNED 03/18/16 DATE 1958739401408								# 1922108281				

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

NICEDARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.3(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary to pay the full charge and the patient is responsible only for the deductible, coinsurance and non-contracted services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items explained in Item 1(e), items 1a, 2, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to account the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedures and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (HEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form are medically necessary and personally furnished to me or were furnished pursuant to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered pursuant to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section for services to be considered "incident to" a physician's professional services; 7) they must be rendered under the physician's direct supervision by his/her employee; 2) they must be an integral, although incidental part of a physician's professional service; 8) they must be of kinds commonly furnished in physician's offices; and 9) the services of non-physicians must be included on the physician's bill.

For TRICARE claims: I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, Civilian or military (refer to 5 USC 5508). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 422.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF HEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1882, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(b) and 424.3(a) (b), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1088, 5 USC 8101 et seq; and 30 USC 901 et seq, 38 USC 613, E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs and as otherwise necessary to administer those programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See 'An notice modifying system No. 09-70-0991, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Sept. 19, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, 'Reputation of Notice of Systems of Records' Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice in representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with retrospective claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on issues relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLAIMERS: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3301-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to fully disclose the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

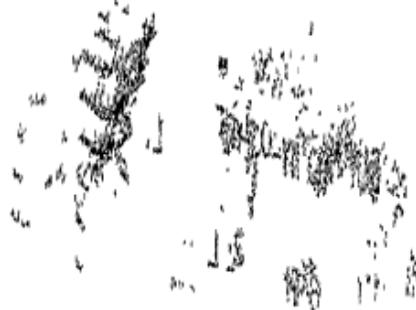
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under this program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Rm. PRPA Reports Clearance Officer, Mail Stop C4-20-06, Baltimore, Maryland 21244-1860. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

03 21 16



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032116

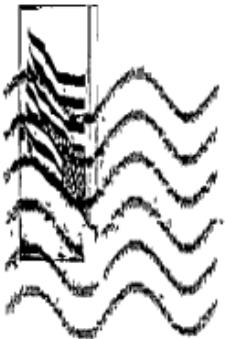
01 22406552607

151

35 Main Street PM 61

BUFFALO NY 14212

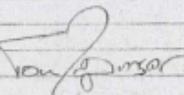
BUFFALO PHYSICAL THERAPY
& SPORTS REHABILITATION, P.C.
192 Park Club Lane Suite 110
Williamsville, NY 14221



03 21 16

DATE	TREATMENT	DAILY/PROGRESS NOTES
3/15/16	Con'st -	1 1/2 year old ADD from -1 for ant. 64 It - She notes VT & I am improving 4/10/16 - Eat all food - constipation prevents her number has to too

3/17/16 D/C pt 1 MD to HEP


John J. Binsar



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA											
1 MEDICARE (Medicare)	MEDICAID (Medicaid)	TRICARE (DOD/DoD)	CHAMPVA (Master ID#)	GROUP HEALTH PLAN (ID#)	FICA NUMBER (SSN) <input checked="" type="checkbox"/>	OTHER (ID#) <input checked="" type="checkbox"/>	1a. INSURED'S ID NUMBER 013873940-0101-059	(For Program in Item 1)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY			SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4 INSURED'S NAME (Last Name, First Name, Middle Initial) - same -				
HARMELE, DANIELLE			08 29 1980								
5 PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7 INSURED'S ADDRESS (No., Street)				
56 BERESBEN DR			X								
CITY AMHERST		STATE NY		8 RESERVED FOR NUCC USE			CITY		STATE		
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X			ZIP CODE		TELEPHONE (Include Area Code) ()		
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO,			11 INSURED'S POLICY GROUP OR FICA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> M <input checked="" type="checkbox"/> F					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <u>UNK</u>			b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10e. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED <u>ON FILE</u>			DATE 01-06-2016			SIGNED <u>ON FILE</u>			DATE		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 1-0 8-1 2-0-5 QUAL			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE MCVIGIL, JENNIFER, M.D. 17a. NP			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			22. OUTSIDE LABS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			23. RESUBMISSION CODE			24. PRIORITY NUMBER		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-L to service line below (24E) ICD Ind			25. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS			F G H I J S CHARGES DATES OF UNITS ID QRS R MODIFIER			ORIGINAL REF NO		
A <u>L44.309</u>	B <u>L</u>	C <u>L</u>	D <u>L</u>	E <u>L</u>	F <u>L</u>	G <u>L</u>	H <u>L</u>	I <u>L</u>	J <u>L</u>	K <u>L</u>	L <u>L</u>
26. DATE(S) OF SERVICE From MM DD YY To MM DD YY	27. PAYOR EMD	28. PATIENT'S ACCOUNT NO HARMELE, D	29. ACCEPT/ASSIGNMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	30. TOTAL CHARGE \$ 55.00	31. AMOUNT PAID \$ 0.00	32. RENDING PROVIDER ID # NPI 1144662011					
1 03 17 16 03 17 16 11		97140		55.00	0.00						
2						NPI					
3						NPI					
4						NPI					
5						NPI					
6						NPI					
25. FEDERAL TAX ID NUMBER 099606323	SSN BIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO HARMELE, D	27. ACCEPT/ASSIGNMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 55.00	29. AMOUNT PAID \$ 0.00	30. RENDING PROVIDER ID # NPI 1144662011					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			33. BILLING PROVIDER INFO & PH# 716 725-0264							
COLBEN MARX, LMFT SIGNED 03-17-2016 DATE	a. <u>1144662011</u>			b. <u>1144662011</u>							

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided is accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, auto, life, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.2(b)(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation plans, a physician's agreement to accept the charge determination of the Medicare center or TRICARE fiscal intermediary is less than full charge submitted. TRICARE is not a health insurance program but makes payment for health services provided through certain clinicians within the Uniformed Services. Information on the provider's sponsor should be provided if the items captioned as "listed", i.e., items 1a, 4, 6, 7, 8, and 13.

BLACK LUNG AND TRICARE CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnostic coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE, 6) for each service rendered incident to a physician's professional services: 1) they must be rendered under the physician's direct supervision by his/her employee; 2) they must be an integral, although incidental part of a covered physician service; 3) they must be of little concern furnished in physician's office; and, 4) the services of non-physician must be indicated on the physician's bill.

For TRICARE claims, I further certify that I (or my employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (41 CFR 5 USC 5336). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless the form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(e), 1982, 1972 and 1974 of the Social Security Act as amended, 42 CFR 411.26(a) and 424.5(a) (6) and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other programs of service, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying System No. 16-70-0301, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 86 No. 177, page 37519 Wed. Sept. 12, 1990, as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, 50 FR P-5A-6, ESA-6, ESA-12, ESA-13, ESA-22, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSES: To validate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/benefits rendered are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory authorities to conduct audits, under TRICARE/CHAMPVA to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the General Revenue Service, private collection agencies, and consumer reporting agencies in connection with recuperable claims; and to Congressional Offices in response to inquiries made at request of the person to whom a claim is made or to whom a payment is made; aggregate disclosures may be made to other Federal, state, local, foreign government agencies, private businesses, other, and individual providers of care, or matters relating to entitlement, claims adjudication, fraud programs, etc., unless otherwise prohibited by law; peer review, program integrity, third-party liability coordination of benefits, and civil and criminal legal actions related to the operation of TRICARE.

RIGHTS/OPPORTUNITY FOR VOLUNTARY RELEASE: Voluntary release, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amounts charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an admission.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1120B of the Social Security Act and 31 USC 3801-0812 provide penalties for furnishing this information.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I have agreed to keep such records as are necessary to describe fully the extent of services provided to individuals under this State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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03 28 16 Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14203
Office: (716) 725-0334 Fax: (716) 725-0355

CH

Client Name: Danielle Harwell Date: 3/12/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (radiating/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Score
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Right hip flexor tight yesterday & is still from

mainly Spasms persist throughout BUT IS

Action: Adhesions present & more tender today

Action's Applied: (Check All that Apply) Throughout C-T spine

Heat Packs Cold Packs Sombra/Biofreeze myofascial

Light Pressure Massage Mod Pressure Massage

Deep Tissue Massage Myofascial Release Friction

Manual Traction Stretching Range-of-Motion

Slipping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.

Follow-up w/ PT Stretch Can't Meds Ice / Heat

Therapist: Allen Maye

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0334 Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 3/17/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (radiating/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Score
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Right leg pts improvement, less for 16-7 hrs p.m.t.

Slo/s sharp pain down lateral aspect of humerus.

Surfboard she states shoulder pain is coming down neck.

Action's Applied: (Check All that Apply) Large adhesion noted in R Sabs

Heat Packs Cold Packs Sombra/Biofreeze Capital ridge chick

Light Pressure Massage Moderate Pressure Massage Capital ridge chick

Deep Tissue Massage Myofascial Release Friction Capital ridge chick

Manual Traction Stretching Range-of-Motion Capital ridge chick

Slipping Compression Lymph Drainage Capital ridge chick

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.

Follow-up w/ PT Stretch Can't Meds Ice / Heat

Therapist: Allen Maye

03 28 16

100 100 100 100 100 100

03 28 16



FREDERICKSBURG, VA 22403
P.O. BOX 9507
GEICO INS CO of NY



Great Lakes Therapeutic Massage
Colleen Martz, LMT
375 Dixie Road, Suite #2
Buffalo, NY 14243
19 MAR 2016 PM 4:11



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

01387394001059

PICA

1. MEDICARE (Medicare)		MEDICAID (Medicaid)		TRICARE (DADsD4)		CHAMPVA (Member D2M)		GROUP HEALTH PLAN (NA)		FEEA BASIC SCHLNG (NA)	OTHER (DID)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		3. PATIENT'S BIRTH DATE MM DD YY 08291980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT				
CITY AMHERST		STATE NY		CITY AMHERST		STATE NY												
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716 536 0951												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FEEA NUMBER b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/> NY				
b. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE												e. INSURANCE PLAN NAME OR PROGRAM NAME GEICO		f. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete lines 3, 8a, and 9d				
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115		15. OTHER DATE QUAL 431 454		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY 111215 TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI												17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20. CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (3ME))												22. RESUBMISSION CODE ORIGINAL REF. NO.						
A M50.22		B M51.26		C M51.27		D M54.12		E M99.02		F M99.03								
e. I2.3.3XXA		f. M99.01		g. M99.03		h. M99.02		i. M99.05		j. M54.2								
k. M54.5		l. M54.6																
24. A DATE(S) OF SERVICE From MM DD YY 03102016		B To MM DD YY 03102016		C PLACE OF SERVICE EMR 11		D PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) CPT/HCPCS 98941		E MODIFIER DIAGNOSIS CODER POINTERS ABCD		F \$ CHARGES 32.28		G \$ DAYS OR H HRS IN AMOUNT OR QUAN. 1	I L ID QUAN. NPI	J RENDERING PROVIDER ID # 1710014188				
2		2		2		2		2		2		2						
3		3		3		3		3		3		3						
4		4		4		4		4		4		4						
5		5		5		5		5		5		5						
6		6		6		6		6		6		6						
25. FEDERAL TAX ID. NUMBER 364500165		SSN EIN <input type="checkbox"/> X		26. PATIENT'S ACCOUNT NO. 3438Z1Z14		27. ACCEPT ASSIGNMENT? For Govt. claims see above <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 54.44		29. AMOUNT PAID \$ 1		30. Rcvd for NUCC Use 1						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in my behalf.) PETER GOZINSKI DC												32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849				
SIGNED 03282016 DATE 1235256546												34. PLEASE PRINT OR TYPE 1235256546		APPROVED OMB-0938-1197 FORM 1500 (02-12)				

Cichocki & Cichocki LLP
345 Dick Road
Depew, NY 140431849
716-681-3333
March 28, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday March 10, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain remains the same. Follow up with the orthopedist will be on March 16, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches remain the same about 2 x a week. She states that the duration varies, sometimes they last all day. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* Yes: patient currently wearing a heart monitor due to chest pain. Patient also going for a stress test on Friday.

Thoracic: Patient stated that her left middle back pain remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 60/80 with pain neck and upper back; right rotation: 60/80 with pain neck

Encounter dated 03/10/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/28/2016

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 5/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Upper Extremity: *Left shoulder ROM (active):* flexion: 90/180 pain left shoulder; extension: 15/40 pain left shoulder; adduction: 10/30 pain left shoulder; abduction: 80/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain. *Left shoulder ROM (passive):* flexion: 160/180 pain left shoulder; extension: WNL 40/40 pain left shoulder; adduction: WNL 30/30 pain left shoulder; abduction: 120/180 pain left shoulder; internal rotation: WNL 80/80 with no pain; external rotation: WNL 90/90 with no pain.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Left Moderate; Thoraco-Lumbar Muscle Group Right Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: 25/25 with pain lower back; right lateral bending: 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Sensation:* left L5 decreased sensation Pin prick; left S1 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving, left deltoid was stronger and graded 5/5. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Encounter dated 03/10/2016 for Danielle Harwell #3438
DOB:08/29/1980 Last 4 digits SS#: Today's date: 03/28/2016

Thoracic assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (supine mobilization); C6 left lateral flexion restriction (supine mobilization); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (anterior); T7 (anterior); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); Left SI left (prone mobilization). *Physical Modalities:* bilateral cervical moist heat pack while seated (15 minutes); bilateral lumbar moist heat pack while seated (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform broom stick elevations 2 sets of 10 daily. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days.

Additional instructions: Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

04 01 16



Item# 43568
Patent Pending



04 01 16



Geico
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

AMMENDED BY NATIONAL UNI-OMH CLAIM COMMITTEE (NUCC) 10/19

EXODUS

PICA 203

1. MEDICARE	MEDICARE (Medicare)	TRICARE (Medicare)	CHAMPVA (Medicare)	GROUP HEALTH PLAN (Medicare)	FPCA (Medicare)	OTHER (Medicare)	1a. INSURER ID NUMBER 0138739400101059	(or Program in Box)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			3. PATIENT'S BIRTH DATE 08 29 1980 M			4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR.			6. PATIENT'S RELATIONSHIP TO INSURED Snl <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR.		
CITY AMHERST		STATE NY	8. RESERVED FOR NUCC USE			CITY AMHERST		STATE NY
ZIP CODE 14228		TRI-PHONE (Include Area Code) ()				ZIP CODE 14228		TRI-PHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 								
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) Y <input type="checkbox"/> YES N <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? Y <input type="checkbox"/> YES N <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? Y <input type="checkbox"/> YES N <input checked="" type="checkbox"/> NO								
11. INSURED'S POLICY GROUP OR FPCA NUMBER DOT 10/31/15								
12. INSURED'S DATE OF BIRTH 08 29 1980 M								
13. OTHER CLAIM ID (Designated by NUCC) 								
14. INSURANCE PLAN NAME OR PROGRAM NAME 								
15. HEAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE								
SIGNED			DATE 02 09 16					
16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUA. MM DD YY QUA.								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI 17a. IG U62607 17b. 1710014188								
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Release A-L to Doctor box below (A-L)) ICD-9-CM 0								
22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY OUTSIDE U.S. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO S CHARGE 								
23. PHRCH AUTHORIZATION NUMBER 								
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B. PLACE OF SERVICE ENCL 11 C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CH-NCPS 20553 M-NCPS-H E. DIAGNOSIS Y-N-I-H F. CHANGES G. D. AMOUNT H. H-CHARGING PROVIDER ID. # 161582336 1649596495								
25. PTIN/RAIL TAX ID. NUMBER 161582336 SSN CN X								
26. PATIENT'S ACCOUNT NO. 1344316								
27. ACCEPT ASSIGNMENT I hereby assign my rights under this claim to the above named provider Y <input checked="" type="checkbox"/> YES N <input type="checkbox"/> NO								
28. TOTAL CHARGE \$ 95.74								
29. AMOUNT PAID 0.00								
30. Reason for NUCC Use 								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this file and am making a photocopy.) JENNIFER W MCVIGEL, MD								
32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727								
33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT' NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002								



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Linda Meltzer, MD, Director

Jennelle W. McGuire, MD
Nicole Sankal, MD

Kathy A. Beaman, PA-C
Robert Butzolo, PA-C
Sydney B. Grabau, PA
Lauren Jendrak, PA-C
Megan Kochis, PA-C
Colin T. McLeary, PA-C

Kathryn L. Murphy, FNP-C
Maria Rizzo, PA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Ganzola, FNP-C
Christopher Zukowski, FNP-C

Sydney B Grabau, PA

Procedure Note

Date: 04/01/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Trigger Points

History of Present Illness

General:

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Danielle states the trigger point injections have been moderately helpful. She has seen the effects wear off after about 1 month. She has continued with PT, massage and chiropractic adjustment regularly. She has continued with magnesium oxide daily, which has been helpful both for muscle relaxation and sleep issues.

Current Medications

- Taking Vitamin D2 50,000 intl units capsule 1 cap(s) 2 times a week
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) pm headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-3045

ADMINISTRATIVE SUPPORT

Brown Fager, Chris Manager
Arianna McElroy
Eileen Rose
Alice Trzaski

INFUSION CENTERS

Barbara McElroy, RN, Manager

- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Ilicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband, Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 110/61, HR 66, RR 16, Ht 63, Wt 150, BMI 26.57, BSA 1.74.

Examination

NEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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ADMINISTRATIVE SUPPORT
 Shawn Kugler, Office Manager
 Amanda McFayden
 Karen Stutz
 Alice Truskali

INFUSION CENTERS
 Barbara Malding, RN, Manager

points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 6 weeks

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 04/01/2016.

Diet: Patient counseled on Importance of lowering sugar intake, sodium and fats. 04/01/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 04/01/2016.

Follow Up

6 weeks

Electronically signed by Sydney Grabau , PA on 04/01/2016 at 12:01 PM EDT

Sign off status: Completed

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Shawn Fagan, Clinic Manager
 Amanda McPherson
 Silvana Siles
 Alice Trzasko

INFUSION CENTERS

Barbara Meldberg, RN, Manager



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

<input type="checkbox"/> PICA										PICA	
1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA		GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		14 INSURED'S I.D. NUMBER		(For Program in Item 1)					
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER		<input type="checkbox"/> BULKING <input type="checkbox"/> NAMY <input type="checkbox"/> DOWM <input type="checkbox"/> DOWM		013873940-0101-059							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 PATIENT'S BIRTHDATE		4 INSURED'S NAME (Last Name, First Name, Middle Initial)							
HARWELL, DANIELLE		MM DD YY		HARWELL, DANIELLE							
5 PATIENT'S ADDRESS (No., Street)		6 PATIENT RELATIONSHIP TO INSURED		7 INSURED'S ADDRESS (No., Street)							
56 BERBACHEN DR		Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY AMHERST		STATE NY		CITY		STATE					
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		ZIP CODE		TELEPHONE (Include Area Code)					

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO:		11 INSURED'S POLICY GROUP OR FECA NUMBER	
a OTHER INSURED'S POLICY OR GROUP NUMBER		a EMPLOYMENT? (Current or Previous)		a INSURED'S DATE OF BIRTH	
		<input type="checkbox"/> YES <input type="checkbox"/> NO		MM DD YY	
b RESERVED FOR NUCC USE		b AUTO ACCIDENT?		SEX	
		<input type="checkbox"/> YES <input type="checkbox"/> NO <u>LNY</u>		M <input type="checkbox"/> F <input type="checkbox"/>	
c RESERVED FOR NUCC USE		c OTHER ACCIDENT?		d OTHER CLAIM ID (Designated by NUCC)	
		<input type="checkbox"/> YES <input type="checkbox"/> NO			
d INSURANCE PLAN NAME OR PROGRAM NAME		10d CLAIM CODES (Designated by NUCC)		d INSURANCE PLAN NAME OR PROGRAM NAME	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED <u>ON</u> <u>PTLR</u>		DATE <u>01-06-2016</u>		SIGNED <u>ON</u> <u>PTLR</u>		DATE									
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
MM DD YY		QUAL MM DD YY		FROM MM DD YY											
10-31-2015 C/M				TO MM DD YY											
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
HARWELL, JENNIFER, M.D.				FROM MM DD YY											
17b. NPI				TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?		\$ CHARGES											
		<input type="checkbox"/> YES <input type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (24e))		22. RESUBMISSION CODE		ORIGINAL REF. NO.											
A <u>L44.4-309</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>										
E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>	J <u> </u>										
I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>	M <u> </u>	N <u> </u>										
24 A DATE(S) OF SERVICE		B PLACE OF SERVICE		C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		D CPT/HCPCS		E MODIFIER		F		G DAYS OR UNITS	H DROPOFF TIME	I ID	J RENDERING PROVIDER ID #
From MM DD YY	To MM DD YY	EMR													

1	<u>03-29-16</u>	<u>03-22-16</u>	<u>03-31-16</u>	<u>03-29-16</u>	<u>03-31-16</u>	<u>97140</u>	<u> </u>	<u>55.00</u>	<u>3</u>	<u>NPI</u>	<u>1144462011</u>				
2	<u>03-29-16</u>	<u>03-25-16</u>	<u>03-31-16</u>	<u>03-29-16</u>	<u>03-31-16</u>	<u>97140</u>	<u> </u>	<u>55.00</u>	<u>3</u>	<u>NPI</u>	<u>1144462011</u>				
3	<u>03-29-16</u>	<u>03-28-16</u>	<u>03-31-16</u>	<u>03-29-16</u>	<u>03-31-16</u>	<u>97140</u>	<u> </u>	<u>55.00</u>	<u>3</u>	<u>NPI</u>	<u>1144462011</u>				
4	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u>NPI</u>	<u> </u>				
5	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u>NPI</u>	<u> </u>				
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25. FEDERAL TAX ID NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. RWD FOR NUCC USE
099606323	x	HARWELL, D	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ 165.00	\$ 0.00	165.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If copy of the statements on the reverse apply to this bill and one made a part thereof)						
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043						
COLLEEN MARX, LMFT	03-29-2016	SIGNED	DATE	a 1144462011	b 1144462013	y 716 725-0264

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

WITERS TO CONGRESS ON PENSIONS/ 175 0917

BR-303: 1990-07-23 09:02:28

2024 RELEASE UNDER E.O. 14176 - 2024 RELEASE UNDER E.O. 14176 - 2024 RELEASE UNDER E.O. 14176 - 2024 RELEASE UNDER E.O. 14176

In a breaking news development, I am required to issue a formal statement. I confirm that: 1) The information on the form is accurate to my knowledge; 2) All my family had tested with an applicable test, and I am aware of the results; 3) I am not currently infected with COVID-19 or have been within 6 feet of someone who has; 4) I have no symptoms of COVID-19; 5) I have not traveled outside the United States in the last 14 days; 6) I have not been exposed by me or my contacts to anyone confirmed to be carrying COVID-19; 7) I have not had any recent interactions with healthcare providers or facilities; 8) I am not currently asymptomatic or experiencing any symptoms, physically or mentally, which may be related to my professional service as my employer would reasonably suppose; 9) I have no known or suspected COVID-19 exposure or infection in my household; 10) I have not been diagnosed with COVID-19; 11) I have not been in close contact with anyone who has COVID-19; 12) I have not been in a healthcare facility or a long-term care facility; 13) I have not been in a public space or a public gathering; 14) I have not been in a place where COVID-19 has been reported; 15) I have not been in a place where COVID-19 has been reported; 16) I have not been in a place where COVID-19 has been reported; 17) I have not been in a place where COVID-19 has been reported; 18) I have not been in a place where COVID-19 has been reported; 19) I have not been in a place where COVID-19 has been reported; 20) I have not been in a place where COVID-19 has been reported; 21) I have not been in a place where COVID-19 has been reported; 22) I have not been in a place where COVID-19 has been reported; 23) I have not been in a place where COVID-19 has been reported; 24) I have not been in a place where COVID-19 has been reported; 25) I have not been in a place where COVID-19 has been reported; 26) I have not been in a place where COVID-19 has been reported; 27) I have not been in a place where COVID-19 has been reported; 28) I have not been in a place where COVID-19 has been reported; 29) I have not been in a place where COVID-19 has been reported; 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62) I have not been in a place where COVID-19 has been reported; 63) I have not been in a place where COVID-19 has been reported; 64) I have not been in a place where COVID-19 has been reported; 65) I have not been in a place where COVID-19 has been reported; 66) I have not been in a place where COVID-19 has been reported; 67) I have not been in a place where COVID-19 has been reported; 68) I have not been in a place where COVID-19 has been reported; 69) I have not been in a place where COVID-19 has been reported; 70) I have not been in a place where COVID-19 has been reported; 71) I have not been in a place where COVID-19 has been reported; 72) I have not been in a place where COVID-19 has been reported; 73) I have not been in a place where COVID-19 has been reported; 74) I have not been in a place where COVID-19 has been reported; 75) I have not been in a place where COVID-19 has been reported; 76) I have not been in a place where COVID-19 has been reported; 77) I have not been in a place where COVID-19 has been reported; 78) I have not been in a place where COVID-19 has been reported; 79) I have not been in a place where COVID-19 has been reported; 80) I have not been in a place where COVID-19 has been reported; 81) I have not been in a place where COVID-19 has been reported; 82) I have not been in a place where COVID-19 has been reported; 83) I have not been in a place where COVID-19 has been reported; 84) I have not been in a place where COVID-19 has been reported; 85) I have not been in a place where COVID-19 has been reported; 86) I have not been in a place where COVID-19 has been reported; 87) I have not been in a place where COVID-19 has been reported; 88) I have not been in a place where COVID-19 has been reported; 89) I have not been in a place where COVID-19 has been reported; 90) I have not been in a place where COVID-19 has been reported; 91) I have not been in a place where COVID-19 has been reported; 92) I have not been in a place where COVID-19 has been reported; 93) I have not been in a place where COVID-19 has been reported; 94) I have not been in a place where COVID-19 has been reported; 95) I have not been in a place where COVID-19 has been reported; 96) I have not been in a place where COVID-19 has been reported; 97) I have not been in a place where COVID-19 has been reported; 98) I have not been in a place where COVID-19 has been reported; 99) I have not been in a place where COVID-19 has been reported; 100) I have not been in a place where COVID-19 has been reported.

For Plaintiff's claim 1, I further certify that I am a supervisor who performed services as an independent member of the Unarmed Services or a civilian employee of the United States Government or its contractors employed in the United States Government, its civilian or military functions, 46 USC 2303. For Plaintiff Lung-bien, I further certify that the services performed in connection with Plaintiff's claim 1 were performed as a supervisor.

Eligible PFR beneficiaries can now be paid under a new benefit structure as required by existing law, in regulations 45 CFR 20.20.

NOTICE: This is a draft version, subject to change. It is not intended to be relied on as a definitive statement of law or legal advice.

We are saddened by GUS' TPCAMP and CHOCO's decision to withdraw from the administration of the Merger, TPCAMP, FEDA, and Black Lung programs. Autonomy will result in significant savings of \$1.1 billion, 10% and 10% of the Social Security Act, respectively, 42 CFR 411.210(a) and 421 Subtitle B, and 44 CFR 3101.01 CPH 101 of seq and 10 HSC 1705 and 1035 USC Subtitle C and 40 CFR 100.10(b) CPC 1001 CPH 2 339.

The information is objective for complaints, claims under the law, and other purposes, but it is not intended to be a substitute for legal advice. It is not used to create a relationship between you and your attorney.

The information may also go on to outline members of staff, roles, responsibilities, management systems, health plans, welfare arrangements, or other arrangements for staff who work at home. It may also include details of any training or support available to staff, as well as details of any relevant legislation or codes of practice. It may also include details of any relevant regulations or standards, such as the Health and Safety at Work Act.

FOR INFORMATION: The CWA/IDC: See the notice modifying 34 CFR Part 300.1(d)(1) ("General Allocation Criteria Standard," published in the Federal Register, Vol. 55, No. 177, page 37948, June 12, 1990, or as amended and restated).

FOR TRICART CLAIMS, PLEASE USE THIS FORM TO REQUEST TO ENROLL OR DEENROLL FOR MEDICAL CARE PROVIDED BY OUTSIDE SOURCES AND TO ISSUE PAYMENT UPON APPROVAL OF CLAIMS.

Digitized by srujanika@gmail.com on 2016-07-06 10:00:00 by srujanika@gmail.com

On January 1, 2013, the Department of Justice (“DOJ”) issued a “Dear Colleague” letter to all state and local law enforcement agencies, including tribal law enforcement agencies, in the hope of “encouraging” them to adopt a policy of “no consent decrees.” The letter states that such decrees are “unnecessary, burdensome, and counterproductive.”

IFPAC DISBURSES VOLUNTARY LENDER PAYMENTS To prevent information disclosed in dispute or payment in many result in demand of claim. When the case is resolved, if disputed, there are no procedures available to require information. "Failure to furnish information regarding the services rendered or the amount charged would, if given payment, or would render these payment. Failure to furnish any other information, such as name or date or day number, would delay payment of the claim. Failure to provide medical information may result in denial of payment.

It is mandatory that you will tell us if you know it'd another party is responsible for paying for your treatment. Sections 1128B of the Social Security Act and 31 U.S.C. 3801(g)(2) provide penalties for withholding this information.

You should let us know if we can help you with your request or if you would like to speak with someone about your request.

NONCASH PAYMENTS-EXHIBIT C CERTIFICATION

I hereby agree to keep such records as are necessary in disorderly, fully the extent of services provided to individuals under the State's Title XXI plan and to furnish information regarding any payments claimed for providing such services as the Blue Agency or Dept. of Health and Human Services may require.

The number of days in each month during which the amount paid by the Medicaid program for their claims submitted for payment under that program, with the exception of such medical services, transportation, co-payment or similar co-dealing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing statement is true, accurate and complete. I understand and agree that each of the claims will be from Federal and State funds and will not contain any false claims, statements, or documents, or certifications as a false fact, may be proposed under applicable Federal or State laws.

According to the D.C. parole Recidivism Act of 1995, no person is entitled to respond to a collection of information unless it displays a valid CIBR control number. The valid CIBR control number for this inmate can be located at 053-1995. This law requires to complete this information collection in up to 30 minutes, per request. Including the CIBR control number, you may request to receive the data record(s) and compare and review the information contained in this form. If you have any comments concerning the accuracy of the information contained in this form, please write to: CIBR, 7000 Security Boulevard, APT 1700, Hanover, Maryland 21076-3800. Please include the CIBR control number in your correspondence.

04 07 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office (716) 725-4204

Fax (716) 725-0265

D.H.

Client Name: Danielle Harwell Date: 3/28/11Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client of TUSP 2° compensating for hyperback

+ tick @ DUE getting stronger, however, @ remains

the same. Has migraines confined to Client Head

Action's Applied: (Check All that Apply) It's from TRP in @ url's

- Heat Packs Cold Packs Sombra/Biofreeze vibration
 Light Pressure Massage Mod Pressure Massage Client felt better
 Deep Tissue Massage Myofascial Release Friction ↑
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

John Wayne

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office (716) 725-0394

Fax (716) 725-0265

Client Name: _____ Date: _____

Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
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 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

04 07 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14205
Office: (716) 725-0324 Fax: (716) 725-2025

Client Name: Danielle Harwell Date: 3/22/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 (8) 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Score
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obligues ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client is straining arm muscles in Escalator/lift LS region while packing. Spasm present throughout neck. Headache continue in B rhomboid/upper trapezius.

Actions Applied: (Check All that Apply) Heat Felt better to fx.
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0324 Fax: (716) 725-2025

Client Name: Danielle Harwell Date: 3/25/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 (6) 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Score
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obligues ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports shoulder region is better on ①.

Sales P.T. thinks R/EP is from RTC tear? No

Don't let this happen to you again

Actions Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

BUFFALO NY 142



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

224039526 8086

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PIKA

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> ELLINGSON <input type="checkbox"/> OTHER (Medicare) (Medicaid) (DOD) (Member DOD) (DOD) (DOD) (DOD) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/> PATIENT'S BIRTH DATE <input type="checkbox"/> SEX HARWELL, DANIELLE 08 29 80 M <input checked="" type="checkbox"/> F <input type="checkbox"/> 3. PATIENT'S ADDRESS (No., Street) <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER 56 BEREHAVEN DRIVE CITY STATE ZIP CODE TELEPHONE (Include Area Code) AMHERST NY 14228 ()												1a. INSURED'S I.D. NUMBER (For Program Item 1) 0138739400101059 4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE 6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DRIVE CITY STATE ZIP CODE TELEPHONE (Include Area Code) AMHERST NY 14228 ()							
8. RESERVED FOR NUCC USE 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of guaranteed benefits either to myself or to the party who accepts assignment before.												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> NO <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) Y4 0138739400101059 c. INSURANCE PLAN NAME OR PROGRAM NAME Geico 12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 6a, and 6d							
SIGNED Signature On File DATE 3/29/2016												SIGNED Signature On File							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 15 QUAL: 431												15. OTHER DATE MM DD YY 10 31 15 QUAL: 439				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DM J JAMES PANZARELLA												17a. MM DD YY 170 NPI 1518964204				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0												22. RESUBMISSION CODE ORIGINAL REF. NO							
A. M25.512 B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>				23. PRIOR AUTHORIZATION NUMBER NOT REQUIRED															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 16 16 03 16 16				B. PLACE OF SERVICE EMR EMR				C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) CPT/HCPCS E. MODIFIER 11				F. G. H. I. J. RENDING PROVIDER ID. # \$ CHARGES 08 200802 51 54 1 NPI 1972515740 NPI NPI NPI NPI NPI NPI							
25. FEDERAL TAX ID. NUMBER 201149005				SSN EIN XX				26. PATIENT'S ACCOUNT NO. 60409				27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO S 51 54 \$ 0 00							
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof. THADDEUS E. SZARZANOWICK				29. SERVICE FACILITY/LOCATION INFORMATION BUFFALO ORTHOPAEDIC GROUP, LLP 192 PARK CLUB LANE SUITE 100 WILLIAMSVILLE, NY 14221-5242				30. TOTAL CHARGE S 51 54 \$ 0 00				31. BILLING PROVIDER INFO & PH# (716) 204-1101 BUFFALO ORTHOPAEDIC GROUP, LLP PO BOX 8000 DEPT. 422 BUFFALO, NY 14267-8000							
SIGNED 3/29/2016 DATE				a. 1144284464				b. 200802				c. 1144284464							

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

Date: 03/16/16
Name: Danielle Harwell

Buffalo Orthopaedic Group LLP
DOB: 08/29/1980 Sex: F Age: 35 yrs Acct#: 60409

CC: Follow-up left shoulder

HPI: Danielle returns to the office today to her left shoulder. At her last visit I sent her for an MRI of her left shoulder for further evaluation. I also recommended she states that a course of physical therapy for her shoulder. Her cervical spine. In review she was in a motor vehicle accident and has been having neck and shoulder pain since. She's been seeing Dr. Pollina for her neck. She continues to have pain in the neck that radiates down her arm. She is here today to review the results of the MRI.

Meds Prior to Visit:

Allergies:

ROS:

Const: Denies symptoms other than stated above.

CV: Denies cardiovascular symptoms.

GI: Denies gastrointestinal symptoms.

Musculo: Denies symptoms other than stated above.

Skin: Denies skin, hair and nail symptoms.

Neuro: Denies symptoms other than stated above.

Reviewed, no changes.

PHYSICAL EXAMINATION: The patient is a well developed well nourished person, in no acute distress. The patient appears as stated age, is alert and oriented x 3 and is cooperative and interactive.

Musculoskeletal Exam:

Left shoulder

Skin: Intact no ecchymosis

Inspection/Palpation/Swelling: She has no gross deformity or swelling throughout the shoulder.

ROM: She has full range of motion of the shoulder with mild pain in the upper arm.

Stability: No gross instability

Strength: 5/5 supraspinatus strength

Special Tests: Negative Hawkins and impingement testing today.

Neurovascular: Sensation is intact throughout the upper extremity. Pulses palpable in the wrist.

Dx Studies: 02/25/16 - MRI Report LT Shoulder

[]

Assessment:

1. M25.512 Pain in left shoulder

Care Plan:

Comments: Treatment was discussed as Danielle in the office today. I reviewed her MRI with her. Her MRI was essentially unremarkable. At this time we discussed that her symptoms

are likely coming from her cervical spine. Her rotator cuff is intact with no evidence of inflammation on the MRI. She is going to continue a course of physical therapy as I do think that this will be helpful for her neck and trapezial region. She will continue to follow up with Dr.Pollina. In regards to her shoulder at this time we'll see her back on an as-needed basis. She is going to switch physical therapy centers due to personal reasons.



Seen by: Electronically signed by Erin Leone, RPA-C on 03/22/2016

Organization Manifest

BUFFALO ORTHOPAEDIC GROUP, LLP(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01387394001010591		HARWELL, DANIELLE	03/16/2016	03/16/2016

04 07 16





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NE

NY PIP CLAIMS

8080X 9507

FREDERICKSBURG, VA 22403

BECAUSE THIS FORM IS USED BY VARIOUS COMMISSIONS AND AUTHORITIES IN THE STATE OF CALIFORNIA, IT IS RECOMMENDED THAT IT BE SIGNED AND FILED IN THE OFFICE OF THE COMMISSIONER OR AUTHORITY WHICH ISSUED IT.

NOTICE: Any person who knowingly, but without intent to commit a felony, makes or causes to be made any statement which is false or misleading with respect to a criminal act, grants SCA, and/or law and may be subject to a fine of up to \$10,000.

REF ID: A64561D9-1A2B

MEDICARE AND TRICARE PAY-GO - Medicare and TRICARE pay-go are programs that provide the information provided in Block 10 above, as well as information on medical services and nonmedical information and usually no personal care giving services which are provided by the VA or the Department of Defense. The VA provides medical services for which the VA is responsible to the VA. TRICARE pay-go is provided by the Department of Defense. In Med care, except for TRICARE pay-go, there is nothing else to do. In TRICARE pay-go, the patient can go to any provider who is contracted with TRICARE pay-go.

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The premarket option to sell is a valuable right that can be exercised at any time before or on the day of the auction.

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In submitting this document, we respectfully request that it be made available to the public, and that it be used to inform the Office of Personnel Management, the Office of the White House, and Congress of the need for extensive regulation of prescription drugs, and to encourage the public to support such regulation.

For TRICARE claims, claim file copies will be sent to the TRICARE contractor. Government to contractor assignments are made by the Defense Health Agency (DHA) Contracting Division.

No Part B participation fee levies may be placed on any item, other than the \$10.00 per day, per person, per night, or \$100.00 per week, per person, per night, or \$1000.00 per month, per person, per night.

NOTICE: If you've taken any of our tests, it's important that you don't share your answers or results with anyone else. Doing so is illegal and can result in severe consequences.

NOTICE TO PATIENT: DO NOT TAKE THIS MEDICATION IF YOU ARE ALLERGIC TO IT. IF YOU HAVE ANY QUESTIONS, CALL YOUR DOCTOR OR PHARMACIST.

We are authorized by City of IRVING and City of DALLAS to accept information in Person, U.S. Mail, Email and FAX to The Secretary, City of Irving, 100 W. Spring Street, Suite 100, Irving, Texas 75060 or to The Secretary, City of Dallas, 1701 Main Street, Suite 1000, Dallas, Texas 75201.

To summarize, we observe no significant differences between the two groups in terms of the number of patients who responded to these treatments. This is in contrast to the results of the study by Goss et al.

The information contained herein is not necessarily current as of the date of this document. The information contained herein is not necessarily current as of the date of this document.

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FOR TABACARE CLIENTS: PRINCIPLE PART 6&C: *Healthcare clients - smoking cessation services* (see also Part 6&B: *Healthcare clients - smoking reduction services*)

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As recomendações da OMS para a vacinação contra a rotavírus devem ser seguidas de forma estrita, com base no calendário de vacinação estabelecido.

You should be over 4'8.5", 100-160 lbs. Genetics of height vary greatly, but on average, men are taller than women by about 2 inches.

Thereby, as of 6/30/2013, the Company has no cash or cash equivalents.

SIGNATURE OF INVESTIGATOR OR SUPERVISOR: _____

NOTICE: This system contains neither recommendations nor conclusions of the Environmental Protection Agency. It has been developed solely by EPA staff in performing their assigned duties.



DENT

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HEADACHE & NEURO-ONCOLOGY CENTER

Laszlo Mészáros, MD, Director

Jennifer W. McGivigan, MD
Nicholas Sakkas, MDKarly A. Benassi, RPA-C
Rebecca Battocchio, PA-C
Sydney B. Grabau, PA
Lauren Jendrzejek, RPA-C
Megan Kuechle, PA-C
Celia T. Maloney, PA-CKathryn L. Murphy, ENP
Marie Rizzo, RPA-C
Elizabeth D. Smith, CNP, ANP
Andrea Consalvi, FNP-C
Christopher Zielinski, FNP-C**Sydney B Grabau, PA****Procedure Note****Date: 04/01/2016****Patient Name: Harwell, Danielle**

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Trigger Points

History of Present Illness**General:**

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Danielle states the trigger point injections have been moderately helpful. She has seen the effects wear off after about 1 month. She has continued with PT, massage and chiropractic adjustment regularly. She has continued with magnesium oxide daily, which has been helpful both for muscle relaxation and sleep issues.

Current Medications

- Taking Vitamin D2 50,000 int'l units capsule 1 cap(s) 2 times a week
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) pm headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

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ADMINISTRATIVE SUPPORT

Shawn Ferger, Case Manager
 Amanda McPadden
 Eileen Scott
 Alice Trzeciak

INFUSION CENTERS

Barbara Mulderig, RN, Manager

- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking: Patient is a non smoker

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies

Resides with:

Spouse: Husband. Children: Yes, x3

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 110/61, HR 66, RR 16, Ht 63, Wt 150, BMI 26.57, BSA 1.74

Examination

NEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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ADMINISTRATIVE SUPPORT
 Shawn Ferger, Clinic Manager
 Amanda McFaydes
 Ellem Stote
 Alice Trzcienski
INFUSION CENTERS
 Barbara Meldeng, RN, Manager

points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 6 weeks

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle:-04/01/2016

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats 04/01/2016.

Exercise Patient counseled on importance of moderate physical activity daily 04/01/2016.

Follow Up

6 weeks

plans for me

J

Electronically signed by Sydney Grabau , PA on 04/01/2016 at 12:01 PM EDT

Sign off status: Completed

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Edrea State
Alice Trzcińska

INFUSION CENTERS
Barbara Mulhern, RN, Manager



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APRIL 5, 2016

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

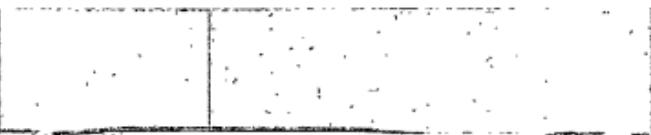
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DIAGNOSTICS & SERVICES

MR/CT	Neurophysiology
EEG	Paranography
Baker	Sleep Studies
Doppler/TCD	SPECT
EMG	Ultrasound
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**INSURANCE CLAIM
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNI-OHM CLAIM COMMITTEE (NOC) ON 10/1/01

GEICO INSURANCE - NF
 NY PIP CLAIMS
 POBOX 9507
 FREDERICKSBURG VA 22403

PICA 2000

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		CREDIT HEALTH PLAN		FCA DISLUND (EM)		OTHER (EM)		1a. INSURED'S ID. NUMBER 0138739400101059		(For Progress in Bars 10)	
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> CREDIT HEALTH PLAN		<input type="checkbox"/> FCA DISLUND (EM)		<input type="checkbox"/> OTHER (EM)		1a. INSURED'S ID. NUMBER 0138739400101059		(For Progress in Bars 10)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE				3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980				4. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				5. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		6. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR.		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR.	
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: b. OTHER INSURED'S POLICY OR GROUP NUMBER c. RESERVED FOR NUCC USE d. RESERVED FOR NUCC USE e. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FCA IN IMFR DOI 10/31/15		12. EMPLOYMENT (Current or Previous) f. EMPLOYMENT g. AUTO ACCIDENT? h. OTHER ACCIDENT? i. CLAIM CODES (Designated by NUCC)		13. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980		14. OTHER CLAIM ID (Designated by NUCC)	
15. SIGNATURE ON FILE SIGNED		16. DATE 02 09 16		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. IS THERE ANOTHER HEALTH BENEFIT PLAN? j. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If "NO", complete items g, h, and i. k. INSURED'S PATIENT NUMBER TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY l. OUTPATIENT m. CHARGES n. CHARGES o. CHARGES p. CHARGES q. CHARGES r. CHARGES s. CHARGES t. CHARGES u. CHARGES v. CHARGES w. CHARGES x. CHARGES y. CHARGES z. CHARGES		20. PATIENT'S PATIENT NUMBER FROM MM DD YY TO MM DD YY 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to section later below (24)) a. ICD-9 b. ICD-10 c. ICD-10 d. ICD-10 e. ICD-10 f. ICD-10 g. ICD-10 h. ICD-10 i. ICD-10 j. ICD-10 k. ICD-10 l. ICD-10 m. ICD-10 n. ICD-10 o. ICD-10 p. ICD-10 q. ICD-10 r. ICD-10 s. ICD-10 t. ICD-10 u. ICD-10 v. ICD-10 w. ICD-10 x. ICD-10 y. ICD-10 z. ICD-10 22. MEDICAL/PROFESSION CODE 23. PHARM AUTHENTICATION NUMBER 24. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances) From MM DD YY To MM DD YY Place of Service E/M 25. A. DATE OF SERVICE From MM DD YY To MM DD YY 26. B. CHARGES 27. C. CHARGES 28. D. CHARGES 29. E. CHARGES 30. F. CHARGES 31. G. CHARGES 32. H. CHARGES 33. I. CHARGES 34. J. CHARGES 35. K. CHARGES 36. L. CHARGES 37. M. CHARGES 38. N. CHARGES 39. O. CHARGES 40. P. CHARGES 41. Q. CHARGES 42. R. CHARGES 43. S. CHARGES 44. T. CHARGES 45. U. CHARGES 46. V. CHARGES 47. W. CHARGES 48. X. CHARGES 49. Y. CHARGES 50. Z. CHARGES 51. H-PROVIDER PROVIDER ID # 161582336 52. NPI 53. NPI 54. NPI 55. NPI 56. NPI 57. NPI 58. NPI 59. NPI 60. NPI 61. NPI 62. NPI 63. NPI 64. NPI 65. NPI 66. NPI 67. NPI 68. NPI 69. NPI 70. NPI 71. NPI 72. NPI 73. NPI 74. NPI 75. NPI 76. NPI 77. NPI 78. NPI 79. NPI 80. NPI 81. NPI 82. NPI 83. NPI 84. NPI 85. NPI 86. NPI 87. NPI 88. NPI 89. 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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1. MEDICARE <input type="checkbox"/> Medicare		MEDICAID <input type="checkbox"/> Medicaid		TRICARE <input type="checkbox"/> DOD/DoD		CHAMPVA <input type="checkbox"/> Member ID#		GROUP PECA <input type="checkbox"/> FECA <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> INDIV		OTHER <input type="checkbox"/> INDIV		1a INSURED'S ID NUMBER 01387394001059 (For Program Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08291980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE				CITY AMHERST		STATE NY							
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR PECA NUMBER 08291980			
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY		c. INSURED'S DATE OF BIRTH MM DD YY 08291980			
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. OTHER CLAIM ID (Designated by NUCC) GEICO			
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Boxes 9, 9a, and 9d		e. SIGNATURE ON FILE SIGNED			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below.		f. SIGNATURE ON FILE			
SIGNED SIGNATURE ON FILE DATE																	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 QUA 431												15. OTHER DATE MM DD YY 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. <u>M50.22</u> B. <u>M51.26</u> C. <u>IM51.27</u> D. <u>M54.12</u> E. <u>I82.3.3XXA</u> F. <u>IM99.01</u> G. <u>M99.03</u> H. <u>M99.02</u> I. <u>M99.05</u> J. <u>IM54.2</u> K. <u>M54.5</u> L. <u>M54.6</u>			
24. A. DATE(S) OF SERVICE MM DD YY		B. TO MM DD YY		C. DURATION HRS/ENGL		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS		E. DIAGNOSIS CODE MODIFIER		F. CHARGES		G. BILLS DUE UNITS	H. EXPEND ITEM PER UNIT	I. ID QUAM	J. RENDERING PROVIDER ID #		
1	03192016	03192016	11	99212	25			ABCD		20 29	1	NPI			1710014188		
2	03192016	03192016	11	98941				ABCD		32 28	1	NPI			1710014188		
3	03192016	03192016	11	97010				ABCD		10 53	1	NPI			1710014188		
4	03242016	03242016	11	98941				ABCD		32 28	1	NPI			1710014188		
5	03242016	03242016	11	97010				ABCD		10 53	1	NPI			1710014188		
6												NPI					
25. FEDERAL TAX ID NUMBER	SSN EN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT FOR MED. BILLING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Revd for NUCC Use											
364500165	<input type="checkbox"/> <input checked="" type="checkbox"/>	3438Z1215		\$ 105.91	\$ 0												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made in my name.) PETER GUZINSKI DC												32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			
SIGNED 04042016 DATE 1235256546												34. PLEASE PRINT OR TYPE 1235256546		APPROVED OMB-0938-1197 FORM 1500 (02-12)			

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345 Dick Rd.
Depew, NY 14043

Geico
P.O. BOX 9507
Fredericksburg, VA 22103

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 4, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Saturday March 19, 2016 Provider: Peter Guzinski DC RE-EXAM

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights, she has slight headaches which come infrequently, she cannot perform her usual work, her normal sleep has been moderately disturbed (2-3 hrs. sleepless) and she is able to engage in most, but not all of her usual recreational activities. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving. *since onset.* *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week as opposed to daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. In addition, light no longer bother her. *Cervical Disability Index:* 38%. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back and left anterior chest pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving. *since onset.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates*

Encounter dated 03/19/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 04/04/2016

symptoms: nothing. *Numbness:* none. *Weakness:* none. *Oswestry score:* 26%. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. Due to the pain, she is unable to lift heavy weights and she is only able to sleep comfortably for 4 hours. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 24%. *The Keele STarT Back Screening Tool:* Medium risk. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Activity of Daily Living Form Bending forward/backward: mild impairment; Buttoning shirt: moderate impairment; Driving: moderate impairment; Drying Hair: moderate impairment; Household chores: moderate impairment; Laundry: moderate impairment; Lifting more than 10 lbs: moderate impairment; Kneeling: mild impairment; Making Meals: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: severe impairment; Restful night's sleep: moderate impairment; Seated to standing position: mild impairment; Squatting: moderate impairment; Taking out the trash: severe impairment; Tying shoes: moderate impairment; Walking: mild impairment.

Objective

Physical exam: Ht: 5' 3" Never smoker; Ht: 5' 3" Wt: 150lbs. BMI: 26.6 Never smoker Temp: 98.8 BP (left): 110/70.

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck; right shoulder depression: Negative for right lower neck pain; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral.

Encounter dated 03/19/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/04/2016

Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Reflexes:* bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Ely's Heel to Buttock: Negative bilateral; Minor's sign: Negative; Nachlas: Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Hibbs test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-evaluation on January 15, 2016, Mrs Harwell has made favorable improvement with chiropractic treatment. Her VAS score improved from a 7 to 5 out of 10 and her Neck Disability Index score improved from 48% to 38%. In addition, she is now able to read for longer durations with less pain and her headaches are no longer moderate but now slight in intensity. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADLs. **Diagnosis:** M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Lumbar assessment: Mrs. Harwell has made favorable improvement with chiropractic treatment since her initial evaluation on November 12, 2015. Her VAS score improved from 7 to 5 out of 10 and her pain is no longer constant but now frequent. In addition, she no longer has severe but now moderate pain while lifting objects greater than 10 lbs and while sleeping. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to reach, sleep and lift with less pain. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural

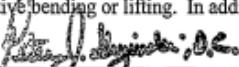
Encounter dated 03/19/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/04/2016

foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday March 24, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain continues to remain the same. Patient started physical therapy this week on the left shoulder. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last week:* *Pain:* achy, dull, tingling, shooting, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week as opposed to daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. In addition, light no longer bother her. *Cervical Disability*

Encounter dated 03/24/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/04/2016

Index: 48%. Recent medical treatment for this condition: None. Changes in past medical history: None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last week.* *Pain:* achy, dull, shooting; level: 7/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* foward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate to Severe. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left

Encounter dated 03/24/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/04/2016

gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), MS4.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: slightly worse. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: worse. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease

Encounter dated 03/24/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/04/2016

hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Peter J. Guzinski, D.C.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS Visual Analog Scale
WNL: within normal limits

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Item# 43568
Patent Pending



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 1540 MAPLE ROAD PO BOX 8000 DEPT 042
 WLMSSVILLE, NY 142213647 BUFFALO, NY 142670002
 7168597200 161533232 032316 032316

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HARWELL, DANIELLE

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GEICO
 GEICO
 PO BOX 9507
 FREDERICKSBURG, VA 224039526

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REF ID	REF NUMBER	HS REF ID - HIPS COAL	HS ENTRY DATE	HS ENTRY STATUS	HS ROWS GRANULS	HS REMAINING GRANULS
0420	PHYSICAL THERP	G8984CJ	032316	1	0 01	
0420	PHYSICAL THERP	G8985CH	032316	1	0 01	
0424	PHYS THERP/EVAL	97001GP	032316	1	351 76	

PLEASE PROCESS IN ACCORDANCE
 WORKERS COMPENSATION
 NO FAULT FREE SCHEDULE

MEDICAL RECORDS TO FOLLOW

Please pay attention
 due in 60 days

1001 PAGE 1 OF 1

CREATION DATE 040516 TOTALS 351 78

DISPNAME	TSID	Y	Y	1053441907
GEICO	98919	Y	Y	64.40
HA GOVT PROGRAMS	95308	Y	Y	161533232
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DISPNAME	TSID	LAST	LAST
ARWELL, DANIELLE	18	0138739400101059	LAWRA WILDER
ARWELL, DANIELLE	18	DBD16761Q00	60000S

DISPNAME

CREATION DATE

LAST

M5412 M7552

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LAST OSTEMPOWSKI

LAST MICHAEL

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LAST MICHAEL

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THE CLAIMS ON THIS FORM APPLY TO THE STATE AND ARE UNDER A PART OF THE

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EW-SNS 22403



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Patient Financial Services
76 Exchange Street Suite 300
Burlington, Vermont 05401

Kaleida Health
www.kaleidhealth.org



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA													
1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEGLI	OTHER	14 INSURED'S ID. NUMBER	(For Program Id Item 1)					
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2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE		SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
HARWELL, DANIELLE				MM DD YY	MM DD YY	SEX	HARWELL, DANIELLE						
5 PATIENT'S ADDRESS (No., Street)				6 PATIENT RELATIONSHIP TO INSURED						7 INSURED'S ADDRESS (No., Street)			
56 BERKHAVEN DR.				<input checked="" type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other						
CITY	STATE	8. RESERVED FOR NUCC USE						CITY	STATE				
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9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
10. IS PATIENT'S CONDITION RELATED TO													
a. EMPLOYMENT? (Current or Previous)													
b. AUTO ACCIDENT?													
c. OTHER ACCIDENT?													
d. INSURANCE PLAN NAME OR PROGRAM NAME													
10d. CLAIM CODES (Designated by NUCC)													
11. INSURED'S POLICY GROUP OR PICA NUMBER													
a. INSURED'S DATE OF BIRTH													
b. OTHER CLAIM ID (Designated by NUCC)													
c. INSURANCE PLAN NAME OR PROGRAM NAME													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
SIGNED - ON FILE - DATE 01-06-2016													
SIGNED - ON FILE -													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)				15. OTHER DATE		QUAL	MM	DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
MM DD YY				QUAL			MM	DD	YY	FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES						
McVIE, JENNIFER, M.D.				17b. NPI			FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
20. OUTSIDE LAB?													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24e)													
22. RESUBMISSION CODE ORIGINAL REF NO													
23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE		C. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F	G.	H.	I.	J.	
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25. FEDERAL TAX ID NUMBER				BBN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT		28. TOTAL CHARGE	29. AMOUNT PAID	30. Rcv'd for NUCC Use		
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)													
32. SERVICE FACILITY LOCATION INFORMATION													
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043													
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043													
COLLEEN MARX, TMS 04.08.2016 DATE 11-11-11 b 11-11-11 p													

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offence under the Health Insurance Act.

PIECES TO COMPLETE YOUR GRAVES OR X

TRICARE AND MEDICARE PAYMENT. As the claim's provider, you request that payment be made and authorize release of any information necessary to process the claim and certify that the information provided in Block 14 is true, accurate and complete. In the case of Medicare claims, the provider's signature authorizes any entity to release an Medicare medical record and nonmedical information, and where the person has given his/her power of attorney, liability waiver, waiver, other written or other instrument which is responsible in law for the release of the medical record. See 42 CFR 411.24(a). If item 14 is completed, the provider's signature authorizes release of the information to the health plan or agency within the Medicare program or to TRICARE plus plan(s), as applicable, the payor agrees to accept full charge as payment in full for the services rendered. Insurance is not considered as seen in Contract 14, and the deductible may be used upon the charge determination as the Medicare carrier. TRICARE plus plans are subject to the charge submitted by TRICARE or to their established program. If the provider is a member of the Uniform Data System, information in the patient's records should be available at 703-842-5000 or 1-800-444-8987. Payment for health care is processed through vendor billings. See 42 CFR 411.24 and 14.

REFERENCES AND NOTES

This non-peer-reviewed document is provided for reference only. See [NIH Line and ReCA instructions](#) regarding consensus and disclaimer coding systems.

DISMANTLED BY THE SUPPLIER (MEDICAL TRICARE, PFC6 AND BLACK LUMPS)

In submitting this claim for payment from federal funds, I certify that: 1) my information on this form is true, accurate, and complete; 2) I have informed myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have earned or will provide services, documents required to allow the government to make an advance payment or pay my bill; 4) I do, either by statute or by my employer, my employer's health benefit plan, or my employer's third party administrator, comply with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited in the Federal one-month statute and Physician Self-Referral law (commonly known as Stark); 5) I practice on this form if it is medically necessary and properly furnished by me or someone I have lent my medical credential to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by 42 U.S.C. § 13957(l)(6); 6) each service rendered incident to my professional service are identified (legal name and NPI, license #, or SBN# of the primary individual rendering such service); 7) no conflict of interest exists between the physician and the non-physician services to be rendered; 8) I am not a subscriber to professional services; 9) they must be rendered under the physician's direct supervision by his/her employee; 10) my agent is an integral, direct, and integral part of a non-physician service; 11) they must be of high quality and furnished in a timely manner.

For TCREC claims: I further certify that for my employment with rendered services, I am not an active member of the United States Army or a civilian employee of the United States Commission or a contract employee of the United States Government, either civilian or military (refer to UMC 3526). For Black Lung claims, I further certify that the services performed were not in a mine or coal-related industry.

In Part B, Sections B.3(b)(1)-(3) may be used unless the firm is required to use such law and regulations (42 CFR 104(e)).

NOTICE: Any person who knowingly makes or transmits false information to law enforcement agencies shall be held liable. Persons found guilty of this offense may upon conviction be subject to fine and/or imprisonment under applicable State and Federal laws.

NOTICE TO PATIENTS ABOUT THE COLLECTION AND USE OF GENOTYPE, TRIGRAGE, FECO, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

NOTICE TO PATIENTS This document from Aetna is for educational purposes only. It does not contain medical, legal or other professional advice. It is not intended to be relied upon as a substitute for consultation with your physician or attorney. We are authorized by CMS, TRICARE and OIGP to ask you for information needed in the administration of the Programs. TRICARE, FECA, and Black Lung programs. Authority to collect information is in 45 CFR 160.101, 1620.101, 1872 and 1874 of the Social Security Act as amended, 42 CFR 111.2(a) and 21.6(a), (b), and 44 USC 3101 et seq. 10 USC 1078 and 1083, 5 USC 8101 et seq., and 30 USC 811 et seq.; 58 USC 813 F.O. 8397.

This information we obtain to complete our needs for these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that your payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0601, titled, 'Corrrr Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OFFICE OF COMPTROLLER OF THE CURRENCY: Department of Labor, Privacy Act of 1974 ("Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wednesday Feb. 28, 1990, See E&A-5, E&A-6, E&A-12, E&A-13, E&A-30, or its updated and reauthorized)

PURSUE UNICARE CLAIMS: PRINCIPLE PURPOSE: To control eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services supplied received are authorized by law.

10/10/2011 LEGISLATIVE INFORMATION: False claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation along with their statutory adviser in the appropriate agency (e.g., VA/HHS/DOT) or to the Dept. of Justice (for representation of the Secretary of Defense) and in addition to the Internal Revenue Service, private citizen litigants, and consumer protection agencies in connection with equipment claims, and to Congress and OIGs in response to inquiries; in addition, the names of the persons to whom a claim was submitted, and pertinent information concerning the claim, may be made to other Federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on entities subject to regulation, licensure, audit, review, audit, regulatory, quality assistance, peer review, program integrity, third-party liability, promulgation of standards, and used cases of similar nature, as required by law, including the False Claims Act.

ENROLLED/EMPLOYED: However, failure to provide information will result in delay in payment or may result as denial of claim. With the one exception discussed below, there are no penalties similar to the HIPAA programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under the FECA program. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be denied as non-merit.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1991," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services, may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

According to the Paperwork Reduction Act of 1995, no burdens are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0334

Fax: (716) 725-1025

Client Name: Danielle Howell Date: 4/18/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specify: Client reports being frustrated w/ 1) shoulder/armstill being very tight. No disc/lumbar priorCervical pain, Adhesions & severe hypertrophy

Actions Applied: (Check All that Apply) Continue.

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Blood Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: MLW/HK TPB

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0334

Fax: (716) 725-0335

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office (716) 725-0324

Fax (716) 725-0365

Client Name: Danielle Harrell Date: 3/28/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Otiquies ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client to TLP 2° complaining in upper back & neck. DUE getting stronger; however, C remains the same. HAs/migraines continue & Client thinks

- Action's Applied: (Check All that Apply) It's from TrPs in @ cutts
 Heat Packs Cold Packs Somora/Biofreeze V/Fjan.
 Light Pressure Massage Mod Pressure Massage Client felt better
 Deep Tissue Massage Myofascial Release Friction tx.
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

Cheri Mary

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office (716) 725-0324

Fax (716) 725-0365

Client Name: Danielle Harrell Date: 4/15/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Otiquies ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client to Scapula & cervical 2°

TrPs/tension last week. Darn still sore but slowly getting better. No Δ in hypo sensitivity this

- Action's Applied: (Check All that Apply) Heat Pack Cold Pack Somora/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:

Cheri Mary

041216

100% 200%

041216

224039552607

FREDERICKSBURG, VA 22403
P.O. BOX 9507
GEICO INS CO of NY



99 APR 2006 PM21
ROCHESTER NY 14611

Great Lakes Therapeutic Massage
4 Bodgework Practitioners
375 Dixie Road, Suite #2
Dixie, NY 14043
Anne C. Myers

NF GEICO
PO BOX 9507

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

PIGA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BOXING <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (I&M) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (I&M) <input type="checkbox"/> (I&M)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial)													
HARWELL, DANIELLE 08 29 1980 <input checked="" type="checkbox"/> HARWELL, DANIELLE													
5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED													
56 BEREHAVEN DRIVE Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>													
CITY STATE ZIP CODE TELEPHONE (Include Area Code)													
AMHERST NY 14228 (716)-536-0951													
7. INSURED'S ADDRESS (No., Street)													
56 BEREHAVEN DRIVE CITY STATE ZIP CODE TELEPHONE (Include Area Code)													
AMHERST NY 14228 (716)-536-0951													
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
HARWELL, DANIELLE													
9. OTHER INSURED'S POLICY OR GROUP NUMBER													
DRDL6761000													
10. IS PATIENT'S CONDITION RELATED TO:													
a. EMPLOYMENT? (Check or Uncheck) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)													
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
11. INSURED'S POLICY GROUP OR FECA NUMBER													
12. IS THERE ANOTHER HEALTH BENEFIT PLAN?													
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Items B, G, and H.													
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNATURE ON FILE 04 14 2016													
SIGNED DATE													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATES MM DD YY MM DD YY													
10 31 2015 QUA 431													
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY													
FROM TO													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. G2													
17b. NPI # 1710014188													
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY													
FROM TO													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (ME)) ICD Ind: 0													
a. IM51 b. IM5116 c. IM5020 d. e. f. g. h. i. j. k. l. l.													
22. RESUBMISSION CODE ORIGINAL REF. NO.													
23. PRIOR AUTHORIZATION NUMBER													
F. G. H. I. J. RENDERING PROVIDER ID. #													
\$ CHARGES DATES OR UNITS EXP'D PER UNIT QTY ID. #													
1	04	11	16		11	99214			ABC	74	79	1	G2
2													NPI
3													NPI
4													NPI
5													NPI
6													NPI
25. FEDERAL TAX ID. NUMBER SSN/NIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENTS? (Check or Uncheck and Sign Below)													
030445678 <input checked="" type="checkbox"/> 102251 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO													
28. TOTAL CHARGE 29. AMOUNT PAID 30. Rate for NUCC Use													
\$ 74.79 \$ 0.00													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)													
UNIVERSITY AT BUFFALO NEU 3980A SHERIDAN DRIVE UB NEUROSURGERY, INC													
3980A SHERIDAN DRIVE PO BOX 8000 DEPT 883													
AMHERST NY 14226-1727 BUFFALO NY 14267-0002													
POLLINA, JOHN, MD * 1740266048 G2													
SIGNED 04 14 16 DATE 306896220													

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

April 11, 2016

Peter Guzinski DC
345 Dick Road
Depew, NY 14043

Patient Name:	Danielle Harwell
Date of Birth:	08/29/1980
No-Fault Carrier:	NF Geico
CL#:	0138739400101059
Date of Injury:	10/31/15
Date of Exam:	04/11/16

Dear Dr. Guzinski:

I had the pleasure of seeing Danielle Harwell in the office today.

History: We saw Ms. Harwell in the office today for follow-up after continued conservative treatment. As you are aware, she was involved in a motor vehicle accident in October of 2015, when she was rear-ended and she has been having ongoing neck and low back pain since then. She has noticed an improvement of her neck pain with the combination of physical therapy, chiropractic therapy and massage therapy, but is still noticing low back pain with some left sided radicular symptoms. She does obtain some short term relief with the physical therapy, chiropractic therapy and massage therapy, but she is not seeing the same results as she is seeing with her neck. She is here to discuss further treatment recommendations at this point in time.

Medications: Voltaren

Physical Examination: Ms. Harwell is a 35-year-old female in no acute distress, pleasant and cooperative, oriented to person, place, and time. Coordination is within normal limits. They have a normal gait and station. Upper and lower extremity reflexes are intact and symmetrical bilaterally. Sensation to pinprick is intact and symmetrical bilaterally. They have 5/5 strength in all muscle groups in the upper and lower extremities bilaterally. No tenderness on palpation of cervical spine, paraspinal muscles, lumbar spine or paraspinal muscles. She has decreased range of motion in the left shoulder with abduction and internal and external rotation secondary to pain within her shoulder. Negative straight leg raise and Patrick's maneuver bilaterally. Negative Hoffman's sign bilaterally. No evidence of myelopathy, fasciculations, clonus, or edema.

Danielle Harwell DD 04/11/2016

Page #2

Medical Decision Making: Danielle has cervicalgia and low back pain with cervical and lumbar radiculopathy in addition to having suboccipital headaches as a result of the motor vehicle accident in October of 2015. She has disk herniations at C4-C5 and C5-C6 along with lumbar disk herniations on the left at L5-S1 and a central disk herniation at L4-L5. At this time, we do encourage her to continue with conservative treatment since she has been making some slow and steady improvements. She can continue with the physical therapy, chiropractic therapy and the massage therapy. In addition, we would like to introduce Voltaren gel. She cannot take any oral NSAIDS due to significant reflux. We will see her back in the office in three months time to continue following her progress. If she has any increased pain, questions or concerns, she can contact the office back at that time.

The patient and proposed treatment plan was discussed with Dr. Pollina.

Thank you very much for allowing me to participate in the ongoing care of this patient.

Diagnosis: Headache, Intervertebral disc disorders with radiculopathy, lumbar region, Other cervical disc displacement, unspecified cervical region

Sincerely,

Electronically signed by Cheryl L. Owczarzak, PA-C on 04/12/2016 at 11:55 am
Cheryl Owczarzak, PA-C in conjunction with Dr. Pollina
Physician Assistant
UB Neurosurgery

Electronically signed by John Pollina, MD
John Pollina, Jr., M.D.
Clinical Vice Chairman
Director of Spine Surgery
Assistant Professor of Neurosurgery
WC#: CNS/201503
CO/JP/dlp



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PIRA

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PIRA

1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BUILDING (IND)		OTHER (IND)		1a INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)											
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> GROUP HEALTH PLAN (IND)		<input type="checkbox"/> FECA BUILDING (IND)		<input type="checkbox"/> OTHER (IND)		1a INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)											
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08291980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE											
5 PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT												6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT													
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE				CITY AMHERST		STATE NY		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER 14228 (716) 536 0951		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 08291980											
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		PLACE (State) NY		b. OTHER CLAIM ID (Designated by NUCC)		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F																	
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO																			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10e. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, complete items 8, 9a, and 9d.																	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below															
SIGNED SIGNATURE ON FILE DATE												SIGNED SIGNATURE ON FILE															
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (IMP) MM DD YY 103115 QM 431												15. OTHER DATE MM DD YY 454 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI												17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e)												ICD Int. 0		22. RESUBMISSION CODE ORIGINAL REF NO													
A M50.22		B M51.26		C M51.27		D M54.12		E M99.05		F M99.01		G M99.03		H M99.02		I M54.5		J M54.6									
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY 03282016 03282016 11												B. PLACE OF SERVICE E/M 98941		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS ABCD		E. MODIFIER		F. CHARGES		G. DAYS OR UNITS		H. EXPENSE PER UNIT		I. ID CODE NPI		J. RENDERING PROVIDER ID # 1710014188	
1	03282016		03282016		11		98941				ABCD		32.28		1		NPI		1710014188								
2	03282016		03282016		11		97010				ABCD		10.53		1		NPI		1710014188								
3																			NPI								
4																			NPI								
5																			NPI								
6																			NPI								
25. FEDERAL TAX ID NUMBER 364500165		SSN EN		26. PATIENT'S ACCOUNT NO 343821216		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 42.81		29. AMOUNT PAID \$		30. Row for NUCC Use															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made on my behalf.) PETER GUZINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849																							
SIGNED 04132016 DATE 1235256546																											

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 13, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday March 28, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with continued left side of neck and shoulder pain. "I feel about the same". **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, tingling, shooting, numb; level: 7/10. **Pain is constant.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week as opposed to daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. In addition, light no longer bother her. **Cervical Disability Index:** 48%. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Thoracic: Patient stated that her middle back pain has not been as intense. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** improving. **since last visit.** **Pain:** achy, dull, shooting; level: 5/10. **Pain is constant.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has not been as intense but still radiates down the left thigh. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** improving. **since last visit.** **Pain:** achy, dull, shooting, tingling, numb; level: 5/10. **Pain is constant.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain

Encounter dated 03/28/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2016

with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Sensation:** all upper extremity sensory exams (C5-T1) were WNL to Pin prick. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Reflexes:** bilateral upper extremity reflexes (C5, C6, C7) 2+. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Sensation:** left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident.

Encounter dated 03/28/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2016

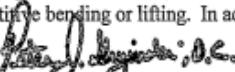
Lumbar assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain.

Long term goals: decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

04 18 16



04.18.16

\$2.83 0
US POSTAGE
FIRST CLASS
06250007459001 14043


345 Dick Rd.
Depew, NY 14043

Geico
P.O. BOX 9507
Fredericksburg, VA 22403

首先，我們要了解的是，當我們說「一個國家」的時候，我們其實是在說一個社會。這是一個由許多不同的人、家庭、組織和團體組成的複雜系統。每個人都有自己獨特的背景、經驗和價值觀。因此，當我們說「一個國家」的時候，我們其實是在說一個社會。

Subtracting the above expression from the first, the following moment equation is obtained: $M_{AB} = -M_{BC} + M_{AC}$. Then the value of M_{AB} is $M_{AB} = \frac{1}{2}(M_{BC} + M_{AC})$.

2. In the event of a fire or explosion, the following steps should be taken:
a) Evacuate the building as quickly as possible.
b) Call 911 and report the fire or explosion.
c) Follow the instructions of the emergency responders.

3. Physician's view on medical treatment and family by cultural & religious orientation.
 4. Religious belief and its influence on medical decision-making and its effect on family.
 5. Signature of consent form, the extent of the information contained in the informed consent form, the extent of the information given to the patient, the extent of the information given to the family, the extent of the information given to the physician, the extent of the information given to the hospital.
 6. The extent of social support given by the family in the form of emotional, physical, financial, and informational support.
 7. Religious belief and its influence on the extent of social support given by the family.
 8. Religious belief and its influence on the extent of social support given by the physician.
 9. Religious belief and its influence on the extent of social support given by the hospital.
 10. Religious belief and its influence on the extent of social support given by the physician and the hospital.

(b) The minimum age of service for a member of the Royal Canadian Air Force is 18 years. The maximum age limit for a member of the RCAF is 32 years. The maximum age limit for a member of the Canadian Forces is 35 years.

KALEIDA
HEALTH

- Buffalo General Hospital
 DeGraff Memorial Hospital
 Millard Fillmore Gates Circle Hospital
 Millard Fillmore Suburban Hospital
 Women & Children's Hospital of Buffalo
 Others: _____

Patient ID Area

HARWELL DANIELLE

PT- 3890065

MR- 1000780250

DOB- 08/29/80

AGE- 035Y

SEX- F

ATT- REFERRING DOC

PCP- PANZARELLA JAMES J

FC- THP

R

ADM DT- 03/23/16

MILLARD FILLMORE SUBURBAN

NF

FACE SHEET 1 of 1

MEDICAL RECORD NO 1000780250	PATIENT NUMBER 3890085	PATIENT NAME (LAST, FIRST, MIDDLE) HARWELL DANIELLE		SVC AREA THP	LOCATION RMWPT	ROOM NO BED					
STREET ADDRESS, CITY, STATE ZIP CODE 56 BEREHAVEN DR LEFT			COUNTY 14	SOCIAL SECURITY NO NOT DISPLAYED	BIRTHDATE 08/29/80	AGE 035Y					
SEX F	MAJ STAT M	RACE W	RELIGION CRI	ADMIT TYPE PHYS THERA	ADMIT PRIORITY ELECTIVE	ADMIT SOURCE NONHLT FAC	HIPAA Y	MODE OF ARRIVAL	ADMIT DATE 03/23/16	ADMIT TIME 08:10	
HEALTH CARE AGENT			LASUP 001			ENGLISH			VIP		
PRIOR STAY LOCATION	PRIOR STAY DATES		HOME PHONE 716-536-0951	ALTERNATE PHONE 716-536-0951	HOSPICE N	HL CONSENT Y	ORGAN DONOR N	VISIT TYPE R			
ATTENDING PHYSICIAN REFERRING DOC	REFERRED PHYSICIAN OSTEMPOWSKI MICHAEL J					ADMIT BY (LOGIN ID) dmm172	RECEIVED BILL OF RIGHTS? YES				
PRIMARY CARE PROVIDER PANZARELLA JAMES J	STREET ADDRESS, CITY, STATE ZIP CODE TONAWANDA					OFFICE PHONE 716-833-2200	OFFICE FAX 716-332-0797				
EMERGENCY CONTACT 1 SHAWN HARWELL	REL SPOUSE	HOME PHONE --	WORK PHONE --	CELL PHONE 716-604-7208	PAGER NUMBER --						
EMERGENCY CONTACT 2 DIANE TOTARO	REL PARENT	HOME PHRSE --	WORK PHONE --	CELL PHONE 716-507-4308	PAGER NUMBER --						
ADMITTING DIAGNOSIS (CODE & VERBAGE) VMS412 RADICULOPATHY CERVICAL REGION			CHIEF COMPLAINT CURTIS CERVICAL/SHOULDER								
LAST NAME, FIRST, MI HARWELL, DANIELLE,			STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTY 56 BEREHAVEN DR LEFT SIDE			W AMHERST, NY 142280000					
SOCIAL SECURITY NO. NOT DISPLAYED	TELEPHONE NUMBER 716-536-0951		RELATIONSHIP OF GUARANTOR SELF	EMPLOYER			EMPLOYER TELEPHONE NUMBER --				
COMMENTS											SMOKING CESSATION INFORMATION PROVIDED TO-PATIENT-CAREGIVER: YES
INSURANCE CARRIER NO FAULT	PLAN NAME GEICO		CERTIFICATE/POLICY NO 0138739400101059			SECOND POLICY NUMBER 4			EFFECTIVE DATE 10/31/2015		
INSURED NAME DANIELLE HARWELL	DATE OF BIRTH 08/29/1980		REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER					
INSURANCE CARRIER IHA GOVT PROGRAMS	PLAN NAME MEDISOURCE		CERTIFICATE/POLICY NO DBD16761Q00			SECOND POLICY NUMBER DB16761Q			EFFECTIVE DATE //		
INSURED NAME DANIELLE HARWELL	DATE OF BIRTH 08/29/1980		REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER					
INSURANCE CARRIER SELF PAY	PLAN NAME SELF PAY		CERTIFICATE/POLICY NO			SECOND POLICY NUMBER 10/25			EFFECTIVE DATE		
INSURED NAME	DATE OF BIRTH		REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT	AUTHORIZATION NUMBER					
INSURANCE CARRIER	PLAN NAME		CERTIFICATE/POLICY NO			SECOND POLICY NUMBER 10/25			EFFECTIVE DATE		
INSURED NAME	DATE OF BIRTH		REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT	AUTHORIZATION NUMBER					
ISOLATION INDICATOR 1	ISOLATION INDICATOR 2	ISOLATION INDICATOR 3	ISOLATION INDICATOR 4			ISOLATION INDICATOR 5			ISOLATION INDICATOR 6		
PRINCIPAL DIAGNOSIS											
SECONDARY DIAGNOSIS											
PROCEDURES											
ATTENDING PHYSICIAN				DATE							

03/16/16

BUFFALO ORTHOPAEDIC GROUP LLP
Patient Therapy Order Requisition

Page 1

Harwell, Danielle
56 Berchaven Drive
Amherst, NY 14228

M-Phone: (716) -536-0951 DOB : 08/29/1980
W-Phone: (716) - - -
C-Phone: (716) - - -
Race : Unknown Sex : F
Account: 60409 Chart:

Co#: 28 Policy#: 0138739400101059
Geico
PO Box 9507
Fredericksburg, Va 22403

PRIMARY INSURANCE

Insured Name: Danielle Harwell
Group Number:
Plan Name :
Expired Date: 00/00/00

SECONDARY INSURANCE

Insured Name: Danielle Harwell
Group Number: 60000S
Plan Name :
Expired Date: 00/00/00

THERAPY ORDER

Status : Open Sent to *Michael Ostrowski*
Doctor : Erin Leone, RPA-C NPI : 1811909518
Address : 192 PARK CLUB LANE, SUITE 100 LIC : 009109
Address2 : WILLIAMSVILLE, NY 14221-5383
Address3 :
Phone : (716) -204-1101 Fax: (716)-204-0914
Therapist:
Address1 :
Address2 :
Phone : Fax:

Ordered Date: 03/16/16
Start Date : 00/00/00
End Date : 00/00/00
Duration : 6 Weeks

Therapy Frequency
PHYSICAL THERAPY 2x week

Diagnosis: M54.12 Radiculopathy, cervical region
Diagnosis: M75.52 Bursitis of left shoulder

INSTRUCTIONS

Evaluate and treat. Cervical radiculopathy trapezial spasm/shoulder pain

Peter Guzniski DC
345 Dick Rd
Depew NY 14043

Ordering Physician's Signature:



Kaleida Health

BUFF THERAPY SERVICES
 705 Main Street, Williamsville, NY 14221
 Phone (716) 590-7369 • Fax (716) 585-7296
DEGRAFF THERAPY SERVICES
 415 Veterans Street, West Seneca, NY 14219
 Phone (716) 693-2031 • Fax (716) 693-2160



HARWELL, DANIELLE

MR- 1000780250 PT- 3890065
 DOB-08/29/80 AGE-35Y SEX-F
 ATT- REFERRING DOC
 PCP- PANZARELLA JAMES
 FC- THP R ADM DT- 03/23/16
 Patient ID Area MILLARD FILLMORE SUBURBAN

DAILY PROGRESS NOTE

*Billing Guidelines For Medicare (CCI edits hi-lited). 1 unit = 8-23 2 units = 24-38 3 units = 39-53 4 units = 54-68 5 units = 69-82 minutes Cannot bill until less than 8 minutes. For other payers use CPT 15 rule for timed services (T) when each min=1 unit

Date	Visit #	Start	Stop	Total Time	Treatment Provided
3/23/16		8:16:00		1:00	CPT-Description ICD-10 CM UNITS

SUBJECTIVE: Palpitations (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse

See DE

OBJECTIVE:**ASSESSMENT:**

Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem(s)/x → Recommendation for future treatment →**PRESENT TREATMENT/PLAN:** On Exercise/Treatment Card

Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code: G-3 - Sp-8-4 f Goal G-code: CM - 84-2-5 DIC G-Code:

PROVIDER SIGNATURE

SUBJECTIVE: Palpitations (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse

OBJECTIVE:**ASSESSMENT:**

Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem(s)/x → Recommendation for future treatment →**PRESENT TREATMENT/PLAN:** On Exercise/Treatment Card

Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code: Goal G-code: DIC G-Code:

PROVIDER SIGNATURE

SUBJECTIVE: Palpitations (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse

OBJECTIVE:**ASSESSMENT:**

Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem(s)/x → Recommendation for future treatment →**PRESENT TREATMENT/PLAN:** On Exercise/Treatment Card

Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code: Goal G-code: DIC G-Code:

PROVIDER SIGNATURE



GBCO
P.O. BOX 9527
FREDERICKSBURG, VA
22403-9527

Express Envelope



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> ERCA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> WORKING <input type="checkbox"/> <input type="checkbox"/> ADM <input type="checkbox"/> <input type="checkbox"/> ADM												1a. INSURED'S ID NUMBER (For Program Item 1) 013873940-0101-059						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARRELL, DANIELLE												MM <input type="text"/> DD <input type="text"/> YY	M <input type="checkbox"/> F <input type="checkbox"/>	- 8-8111 -				
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)			
56 BERBEHAVEN DR												Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE			CITY		STATE									
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X			ZIP CODE		TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR PIKA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH SEX			
b. RESERVED FOR NUCC USE												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	MM <input type="text"/> DD <input type="text"/> YY	M <input type="checkbox"/> F <input type="checkbox"/>				
c. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)					
d. INSURANCE PLAN NAME OR PROGRAM NAME												c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	c. INSURANCE PLAN NAME OR PROGRAM NAME					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			e. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												SIGNED - ON PTI.R - DATE 01-06-2016			SIGNED - ON PTI.R - DATE 01-06-2016			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below																		
SIGNED - ON PTI.R - DATE 01-06-2016																		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)												15. OTHER DATE (QUAL) MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
MM DD YY 1-1-2015 GUA												17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> 17b. <input type="checkbox"/> NPI MCY LOS, JENNIFER, M.D.			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-I to services listed below (24E) ICD IND. <input type="checkbox"/>			
A. LG44-30.9 B. L C. L D. L												22. RESUBMISSION CODE ORIGINAL REF. NO.						
E. L F. L G. L H. L												23. PCPR AUTHORIZATION NUMBER						
I. L J. L K. L L. L																		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service I.M.C. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS D. MODIFIER												E. DIAGNOSIS POINTER F. \$ CHARGES G. DUE OR UNITS H. PAYOR/PAID I. ID. CODE J. RENDERING PROVIDER ID #						
1	04	24	16	04	24	16	11	97140	X	55	1.00	3	NPI	1344462011				
2													NPI					
3													NPI					
4													NPI					
5													NPI					
6													NPI					
25. FEDERAL TAX ID NUMBER	SSN	BIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. REB'D FOR NUCC USE											
099506323	<input type="checkbox"/>	<input type="checkbox"/>	HARRELL, D	<input type="checkbox"/>	\$ 55.00	\$ 0.00	\$ 55.00											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH#			
COLLEEN MARX, INT 04.14.2016 SIGNED												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			(716) 725-0264			
DATE 11/1/2015												a. 1144462011 b. 1144462011						

EBCAN THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.
NOTICE: Any person who fraudulently files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a

ПОСТРОЕНИЕ ВАРИАНТОВ ОЦЕНКИ

MEDICARE AND TRICARE PAYMENTS: A patient's separate payment is the payment he or she makes and suffuses a release of any information necessary to prevent the claim and continue the release from prior paid in Block 1. Because it is his, doctors and hospitals. In the case of a hospital claim, the patient's separate payment may apply to release in Medicare medium and maximum, as well as to the other parts of the hospital group, to both inpatient, outpatient, and emergency care. See 19 CFR 111.11. Take 19 CFR 111.11, the provider statement, and the information of the insurance which is responsible in part for the payment of the hospital claim. The information to the health care or agency where the Medicare payment is made by the hospital, as well as the physician, agrees to release all the information of the hospital claim or TRICARE health insurance, in the full amount and in full responsibility for the individual, as well as one or more hospital claims. Contractors and subcontractors are bound upon the TRICARE health insurance, in the full amount and in full responsibility for the individual, as well as one or more hospital claims. Contractors and subcontractors are bound upon the TRICARE health insurance, in the full amount and in full responsibility for the individual, as well as one or more hospital claims.

BLACK AND WHITE

The procedure enables to assess the amount held by the Government as payment in kind. See Black Line and EBCA in sections regarding mineral resources and diamonds under section 2.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, PICA AND BLACK LUNG)

In submitting the claim for payment from Federal funds, I certify that: 1) the information on the item is true, accurate, and complete; 2) I have compensated myself fairly and appropriately, in accordance with applicable law, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim is either submitted by me or on my behalf by my designated billing company, compliant with all applicable Medicare laws, regulations, and program instructions for payment, including but not limited to the Federal Anti-kickback Statute and Physician Self-Referral law (commonly known as Stark law); 5) the services in the form were medically necessary and personally furnished by me or were reasonably incident to my professional service under my decimal code description except as otherwise expressly permitted by law; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, if applicable) of the primary individual rendering my service is included in the itemized action for services to be rendered ("incident to"), physician professional services; 7) they must be rendered under the physician's direct supervision by his/her employee(s); 8) they must be an integral, although incidental part of a covered physician service; 8) they must be of items commonly furnished in a physician's office; and 9) the amount of non-passive items must be included on the physician's bill.

For TRICARE drama, I further certify that I (or my employee) who furnished services am not an active-duty member of the Uniformed Services or a civilian employee of the U.S. Government or a contractor employee of the United States Government. Other than a military spouse (as defined in 10 USC 853(b)), I do not have a Black-Lynn status. I further certify that the services furnished were not for a Black-Lynn related disorder.

Mr. Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 434 series).

NOTICE. Any one who misrepresents or falsifies proposed information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CHS, TRICARE and CMCPC to ask you for information needed in the administration of the Medicare, TRICARE, PECRA and Black Lung programs. Authority to collect information in this letter is under 10 U.S.C. 1621 and 1074 of the *Post-9/11 Security Act* as amended, 42 CFR 111.24(n) and 124(a)(2), and 44 USC 3101.41 (4 CFR 101 et seq and 10 USC 1709 and 1806; 5 USC 801 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 13887).

The information we obtain to contact you directly under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to assure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the specific claim-related or Federal provisions that require other third parties pay to give priority to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you are paid in a hospital or doctor. Adverse medical disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70 0601, titled, 'Corner Medicare Claims Record,' published in the Federal Register, Vol. 65 No. 177, page 37349, Wed. Sep. 12, 1990, as updated and republished.

FOR OWCP CLAIMS: Department of Labor Privacy Act of 1974, "Regulation of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 25 1990, SFR-ESA-8 ESA-6 ESA-12 ESA-11 ESA-10, as updated and re-published.

FOR TRICARE CLAIMS: PRINCIPLE PURSE (a). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of liability and determination that the "incident" happened, neither of which is sufficient below:

For more information from claims and related documents, may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation or related units their disability administrative units or the Office of the Inspector General of the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation.

length of the person's life where it is most appropriate or desired. Many benefits in medical care, health, health insurance systems, personal finance, values, and inherited powers of care, can be best realized within these values, objectives, focus, program design, selection criteria, quality insurance, peer review, program intensity, third-party liability, coordination of benefits, and cost and limited litigation reflected in the acronym of "FIREBEE".

Healthcare providers should be encouraged to report adverse events to the manufacturer or distributor, and to advise patients, under license provisions for reporting, to supply information regarding the medical services received or the amount charged if there would potential liability of claim(s) in those products. Failure to furnish any other information, such as names or client numbers, could delay payment of the claim. Failure to provide financial information, e.g., FICA code, could also delay payment.

If you're already on your feet or you know that another party is responsible for paying for your treatment, Section 114(b) of the Social Security Act and 31 CFR 380.4-6(d) provides procedures.

You should be aware that it is illegal to copy or distribute copyrighted material without permission from the copyright owner.

Medicaid Payment Provider Certification
fills the intent of a grace period to educate us in

Payments received by health care providers for services furnished under the SGR will be paid at rates determined by the Secretary of Health and Human Services.

standard rights, as may be set forth in the relevant part of the licensing program or other laws established by a given state that prohibit, with the exception of statutory or common law, concurrent or parallel or similar cost sharing charges.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete. I understand the payment of a portion of this claim will be from Federal and State funds, and that

Act 43 items in the Assessment: Reduce an Act 43% non-patient rate and/or respond to a collection of information unless it displays a valid O&B control number. For valid O&B control numbers for the information, see collection on p. 033-197. The non-patient to complete the information collection in a timely manner, up to 10 minutes per response, including the time to review insurance, session history data resources, gather the G-3, G-4, G-5, and complete and review the information collection. If you have any concerns concerning the accuracy of the time estimates or suggestions for improving this item, please write to: UCM, 7560 Serpent, Brookhaven, AL, PRA 120007, Cleo J. O'Brien, Comm. Stat. 04-56-26, Maryland 21234-1050. This subsection is for emergency, office, non-emergency, DOD/MHTR, CNA, ELD/CLIA, 180B/ABX, and/or CACB.

Great Lakes Therapeutic Message & Bodywork Practitioners
313 Dick Rd Depew, NY 14204
Office: (716) 725-0234 Fax: (716) 725-0235

Client Name: Danielle Howell Date: 4/18/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy _____ Anxiety _____ Burning _____ Depressed _____ Fatigued _____
- Low Energy _____ Pain _____ Restlessness _____ Restricted _____ Sore _____
- Numbness _____ Tingling _____ ↓ Strength _____ Inability to Sleep _____
- Headaches/Migraines _____ Spasms _____ Swelling _____

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head _____ Jaw _____ Sinus/Eye Pressure _____
- Cervical (Posterior) Cervical (Anterior) _____
- Upper Thoracic (Anterior) Upper Thoracic (Posterior) _____
- Mid Thoracic Ribs Scapula (R) Scapula (L) _____
- Abdomen/Obliges ASIS PSIS _____
- Lumbar _____ Sacrum _____ Coccyx _____ Hips _____ Glutes (R?) (L?) _____
- IT Band _____ Quads _____ Hamstrings _____ Knee (R) _____ Knee (L) _____
- Calf Muscles (R) _____ Calf Muscles (L) _____
- Ankle (R) _____ Ankle (L) _____ Foot (R) _____ Foot (L) _____
- Shoulder (R) _____ Shoulder (L) _____
- Upper Arm (R) _____ Upper Arm (L) _____
- Forearm (R) _____ Forearm (L) _____ Hand (R) _____ Hand (L) _____

Specific: Client reports feeling frustrated w/ [unclear] shoulder/arm

still being very mindfull. No Disc/Lumbar prior or

Cervical pain. Adhesive & Severe hypertonicity

Actions Applied: (Check All that Apply) Continue.

- Heat Packs _____ Cold Packs _____ Sombra/Biofreeze _____
- Light Pressure Massage _____ Mod Pressure Massage _____
- Deep Tissue Massage _____ Myofascial Release _____ Friction _____
- Manual Traction _____ Stretching _____ Range-of-Motion _____
- Stripping _____ Compression _____ Lymph Drainage _____

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D. _____
- Follow-up w/ PT _____ Strategies _____ Con't Meds _____ Ice / Heat _____

Therapist:

Great Lakes Therapeutic Message & Bodywork Practitioners

313 Dick Rd Depew, NY 14204

Office: (716) 725-0234

Fax: (716) 725-0235

Client Name: Danielle Howell Date: 4/14/16

Client Status: (Circle) Better Progressing Worse Same/No Change Plateauing

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy _____ Anxiety _____ Burning _____ Depressed _____
- Low Energy _____ Pain _____ Restlessness _____ Restricted _____ Sore _____
- Numbness _____ Tingling _____ ↓ Strength _____ Inability to Sleep _____
- Headaches/Migraines _____ Spasms _____ Swelling _____

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head _____ JAW _____ Sinus/Eye Pressure _____
- Cervical (Posterior) Cervical (Anterior) _____
- Upper Thoracic (Anterior) Upper Thoracic (Posterior) _____
- Mid Thoracic Ribs Scapula (R) Scapula (L) _____
- Abdomen/Obliges ASIS PSIS _____
- Lumbar _____ Sacrum _____ Coccyx _____ Hips _____ Glutes (R?) (L?) _____
- IT Band _____ Quads _____ Hamstrings _____ Knee (R) _____ Knee (L) _____
- Calf Muscles (R) _____ Calf Muscles (L) _____
- Ankle (R) _____ Ankle (L) _____ Foot (R) _____ Foot (L) _____
- Shoulder (R) _____ Shoulder (L) _____
- Upper Arm (R) _____ Upper Arm (L) _____
- Forearm (R) _____ Forearm (L) _____ Hand (R) _____ Hand (L) _____

Specific: Client is being stressed therefore cervical

Thoracic. No Disc/muscular hypertonicity

This session, felt better & more relaxed

Actions Applied: (Check All that Apply)

- Heat Packs _____ Cold Packs _____ Sombra/Biofreeze _____
- Light Pressure Massage _____ Moderate Pressure Massage _____
- Deep Tissue Massage _____ Myofascial Release _____ Friction _____
- Manual Traction _____ Stretching _____ Range-of-Motion _____
- Stripping _____ Compression _____ Lymph Drainage _____

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro _____ Follow-up w/ M.D. _____
- Follow-up w/ PT _____ Stretches _____ Con't Meds _____ Ice / Heat _____

Therapist:

04-19 16

04 19 16

224093287

FREDRICKSBURG, VA 22403

P.O. BOX 907

GEICO INS CO of NY

Great Lakes Therapeutic Massag
e Bodywork Practitioners
375 Black Rock Road, Suite #2
Dover, VT 05443
Anne C. Mox





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

PICA

1 MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TRICARE <input type="checkbox"/> (DOD/DIA)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP <input type="checkbox"/> (N/A)	FECA <input type="checkbox"/> (N/A)	LONG <input type="checkbox"/> (N/A)	OTHER <input type="checkbox"/> (N/A)	1a INSURED'S ID NUMBER 013873940011059	(For Program In Item 1)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE				3 PATIENT'S BIRTH DATE MM DD YY 08291980				4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE				
5 PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR LEFT				6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT				
CITY AMHERST	STATE NY	8 RESERVED FOR NUCC USE				CITY AMHERST	STATE NY					
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951					ZIP CODE 14228	TELEPHONE (Include Area Code) (716 536 0951					
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980				
				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NY				c. OTHER CLAIM ID (Designated by NUCC) GEICO				
c. RESERVED FOR NUCC USE				d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				e. INSURANCE PLAN NAME OR PROGRAM NAME GEICO				
d. INSURANCE PLAN NAME OR PROGRAM NAME				12d CLAIM CODES (Designated by NUCC)				f. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.												
SIGNED SIGNATURE ON FILE DATE												
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 103115				15. OTHER DATE MM DD YY 454 111215				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) A. M50.22 B. M51.26 C. M51.27 D. M54.12 E. I22.3 XXXA F. M99.01 G. M99.03 H. M99.02 I. M99.05 J. M54.2 K. M54.5 L. M54.6				22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04122016 04122016				B. PLACE OF SERVICE EMR 11	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 98941	D. MODIFIER ABCD	E. DIAGNOSIS CODE 32 28	F. \$ CHARGES 32 28 1	G. DAYS ON UNIT NPI	H. HOSP. PAYEE PER UNIT 1710014188	I. ID # NPI	J. RENDERING PROVIDER ID # 1710014188
1	04122016	04122016	11	98941		ABCD	32 28 1	NPI	1710014188			
2	04122016	04122016	11	97010		ABCD	10 53 1	NPI	1710014188			
3	04152016	04152016	11	98941		ABCD	32 28 1	NPI	1710014188			
4	04152016	04152016	11	97010		ABCD	10 53 1	NPI	1710014188			
5												
6												
25. FEDERAL TAX ID NUMBER 364500165	SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO 3438Z1217	27. ACCEPT ASSIGNMENTS I HEREBY AUTHORIZE THE PAYOR TO BILL ME DIRECTLY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 85.62	29. AMOUNT PAID \$	30. Reserved for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am making a copy thereof.) PETER GOZINSKI DC				32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849				33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849				
SIGNED 04272016 DATE				# 1235256546				# 1235256546				

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 27, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday April 12, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain has not been as intense. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 1-2 x a week as opposed to daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. In addition, light no longer bother her. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper

Encounter dated 04/12/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/27/2016

back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Sensation:** left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving. VAS score improved from a 7 to 5 out of 10 and her headache frequency improved from a 2 to 3 to 1 to 2 out of 10. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens thecal sac.

Thoracic assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the

Encounter dated 04/12/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/27/2016

radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 right (diversified prone); T3 right (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 (manual traction); L5 (manual traction); SI left PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Friday April 15, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain remains the same. Patient saw Dr. Pollina who recommended continued chiropractic treatment. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck**

Encounter dated 04/15/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 04/27/2016

pain: none. *Changes in this condition:* no change. *since* last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 1-2 x a week as opposed to daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. In addition, light no longer bother her. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since* last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Pain radiates to:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain continues as well. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since* last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* foward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending:

Encounter dated 04/15/2016 for Danielle Harwell #3438
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WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 right (diversified prone); T3 right (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 (manual traction); L5 (manual traction); SI left PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB

Encounter dated 04/15/2016 for Danielle Harwell #3438
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soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2016 with the restrictions of no lifting greater than 15lb and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits



Item# 43568
Patent Pending



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DEPT OF DEFENSE~~
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

Geico

P O Box 9507
Fredericksburg VA 22403

CARRIER

PIRA											
1 MEDICARE <input type="checkbox"/> (Medicare #)	2 MEDICAID <input type="checkbox"/> (Medicaid #)	3 TRICARE <input type="checkbox"/> (DOD/DoDHS)	4 CHAMPVA <input type="checkbox"/> (Member ID)	5 GROUP HEALTH PLAN <input type="checkbox"/> (DME)	6 FECA <input type="checkbox"/> BIL LUNG <input type="checkbox"/> (DME)	7 OTHER <input type="checkbox"/> (DME)	8 INSURED'S ID NUMBER 0138739400101059 [For Program in Item 1]				
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle,			3 PATIENT'S BIRTH DATE MM DD YY 08 28 1980M			4 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	5 INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle,				
5 PATIENT'S ADDRESS (No., Street) 1131 Cleveland Dr			6 PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7 INSURED'S ADDRESS (No., Street) 1131 Cleveland Dr					
CITY Cheektowaga		STATE NY	8 RESERVED FOR NUCC USE			CITY Cheektowaga		STATE NY			
ZIP CODE 14225		TELEPHONE (Include Area Code) ()				ZIP CODE 14225		TELEPHONE (Include Area Code) ()			
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11 INSURED'S POLICY GROUP OR FECA NUMBER					
b RESERVED FOR NUCC USE			b AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			12 INSURED'S DATE OF BIRTH MM DD YY 08 29 1980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		
c RESERVED FOR NUCC USE			c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13 OTHER CLAIM ID (Designated by NUCC)					
d INSURANCE PLAN NAME OR PROGRAM NAME Nationwide Insurance			14 CLAIM CODES (Designated by NUCC)			14 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			N/A yes, complete items 9, 9a and 9d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
Signature on file			DATE 04 29 2016			Signature on file					
SIGNED _____						SIGNED _____					
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (JMP) MM DD YY QUAL:			15 OTHER DATE MM DD YY QUAL:			16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DR James J Panzarella MD			17a DR James J Panzarella MD			18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			17b NPI 1518964204			20 OUTSIDE LABS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			\$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E)			22 RESUBMISSION CODE			23 PRIOR AUTHORIZATION NUMBER			ORIGINAL REF NO		
A M609	B M2653	C R51	D M6580	E	F	G	H	I	J RENDERING 203865000000 #		
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY			B RACE OF SERVICE ENG C GENDER CPT/CDX D MODIFIER			E DIAGNOSIS POINTERS F \$ CHARGES			G. DATE OF SERV E/M H I L ID QUAL		
1 04 18 2016	04 18 2016	11 N	D0160			ABCD	96 67 1		1013022888		
2									NPI		
3									NPI		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX ID NUMBER 2038650007	SSN EIN X	26 PATIENT'S ACCOUNT NO 4947	27 ACCPT ASSESSMENT (Check, claim, see back) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28 TOTAL CHARGE 96 67	29 AMOUNT PAID \$ 0.00	30. Rev'd for NUCC use 716 565.0685					
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made in my behalf.) Dr Francis P O Day DDS			32 DR Francis P O Day DDS 1110 Colvin Blvd Tonawanda NY 14223 04 29 2016	33 DR Francis P O Day DDS PC 1110 Colvin Blvd Tonawanda NY 14223	34 DR Francis P O Day DDS PC 1356532568	35 DR Francis P O Day DDS PC 1356532568					
SIGNED	DATE 04 29 2016										

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured," i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete, 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor, 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black-Lung claims, I further certify that the services performed were for a Black-Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 434.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.6(a) (5), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1080; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 513; E.O. 9397

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and documentation that the services/supplies received are authorized by law.

ROUTINE USE(S) Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlements, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

05.05.16

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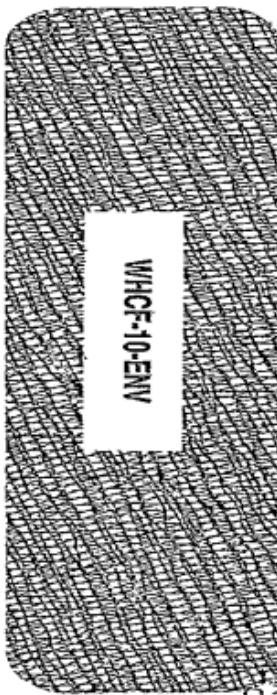
Dr. Francis P. O'Day DDS, PC
1110 Cowen Blvd
Tonawanda, NY 14223

BUFFALO NY 142

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WHCF-10-ENV



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 1540 MAPLE ROAD PO BOX 8000 DEPT 042
 WLMSSVILLE, NY 142213647 BUFFALO, NY 142670002
 7168597200 3890065-4
 1000780250 0131

PATIENT NAME		PATIENT ADDRESS		CITY STATE ZIP	
HARWELL, DANIELLE		CHEEKTONWAGA		1131 CLEVELAND DR; NY 14225	
13 TREATMENT	13 DATE	13 TYPE	13 DUE	16 CRATE	17 STAT
08291980	F 040116	1	01		
CODE	CODE	CODE	CODE	CODE	CODE
02 103115	11 103115	35 032316			

GEICO
 GEICO
 PO BOX 9507
 FREDERICKSBURG, VA 224039526

CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT	CODE	VALUE CODES AMOUNT
a	45		8.0050		4.00
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AP-REV. CODE	AP-REV.CHARGE	IN-HOSP./OUT-PAT/EMERG CODE	BL-SUPPLY/DATE	BL-SUPPLY/UNITS	BL-TOTAL CHARGES	BL-IN-HOSP/OUT-CHARGES
0420 PHYSICAL THERP		97010GP	040616	1	25 26	
0420 PHYSICAL THERP		97110GP	040616	2	234 50	
0420 PHYSICAL THERP		97110GP	041116	2	234 50	
0420 PHYSICAL THERP		97010GP	041116	1	25 26	
0420 PHYSICAL THERP		97010GP	042016	1	25 26	
0420 PHYSICAL THERP		97110GP	042016	1	117 25	

PLEASE PROCESS IN ACCORDANCE WITH
 WORKERS COMPENSATION
 NO FAULT FEE SCHEDULE

MEDICAL RECORDS TO FOLLOW

Please pay estimated amount
 due in box 55

0001 PAGE 1 OF 1	CREATION DATE	050516	TOTALS	662 03
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01 PAYOR NAME	01 PAYOR PLAN ID	01 HOSP/OUTP/EMERG	01 MED PAYMENTS	01 COST AMOUNT	01 AMT	1053441907
GEICO	98919	Y	Y			183.36
IHA GOVT PROGRAMS	95308	Y	Y			161533232
						15

01 EMPLOYEE NAME	01 PAYOR UNIQUE ID	01 GROUP NUMBER	02 PAYORNAME GROUP NO.
HARWELL, DANIELLE	18 0138739400101059		LAURA WILDER
HARWELL, DANIELLE	18 DBD16761Q00		60000S

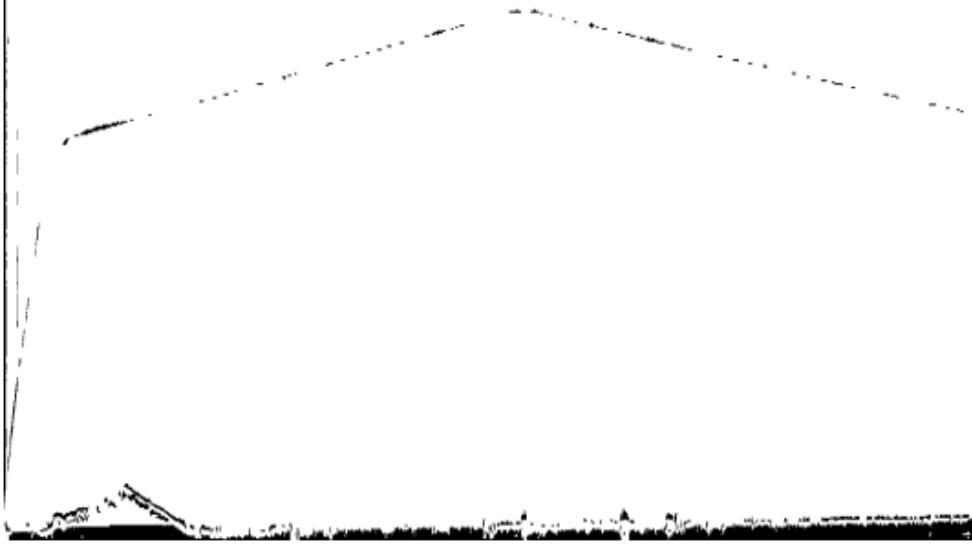
01 TREATMENT AUTHORIZATION CODES	01 DOCUMENT CONTROL NUMBER	01 EMPLOYEE NAME
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M5412 M7552				
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01 ADMIT	01 PAYOR	01 PAYOR	01 PAYOR	01 PAYOR
01 OTHER PROCEDURE CODE	01 OTHER PROCEDURE DATE	01 OTHER PROCEDURE CODE	01 OTHER PROCEDURE DATE	01 OTHER PROCEDURE CODE
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DYU-SMB 22403

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Kaleda Health
www.kaledahealth.org

Patient Financial Services
76 Exchange Street Suite 300
Buffalo, New York 14202





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

CHICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

— CARRIER —

PIRA										PIRA													
1. MEDICARE [Medicare] <input type="checkbox"/>		MEDICAID [Medicaid] <input type="checkbox"/>		TRICARE [Medicaid] <input type="checkbox"/>		CHAMPVA [Member] <input type="checkbox"/>		GROUP HEALTH PLAN [DVA] <input type="checkbox"/>		FECA BUKLINE [DVA] <input type="checkbox"/>		OTHER [DVA] <input type="checkbox"/>											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>									
HARWELL, DANIELLE										- SAME -				4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)									
56 BERKSHIRE DR					8. RESERVED FOR NUCC USE X					CITY			STATE										
CITY AMHERST		STATE NY			ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951			ZIP CODE		TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO,													
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO													
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) [NY]													
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO													
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED <u>ON</u> <u>PTLR</u> DATE <u>01-06-2016</u>													
SIGNED <u>ON</u> <u>PTLR</u> DATE <u>01-06-2016</u>					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY) MM DD YY 10 31 2015 QMUL					15. OTHER DATE MM DD YY 17a					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE NeVIGE, JENNIFER, M.D. 17b. API					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind										22. RESUBMISSION CODE ORIGINAL REF NO													
A. <u>I64.309</u>		B. <u> </u>		C. <u> </u>		D. <u> </u>		E. <u> </u>		F. <u> </u>		G. <u> </u>		H. <u> </u>									
I. <u> </u>		J. <u> </u>		K. <u> </u>		L. <u> </u>		F. <u> </u>		G. <u> </u>		H. <u> </u>		I. <u> </u>									
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE BMG		C. CPT/HCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MCDFIER		F. MCDFIER		G. CHARGE \$ CHARGE \$ CHARGE \$ CHARGE		H. PAYOR ID ID ID ID		I. PAYOR ID ID ID ID		J. RENDERING PROVIDER ID #					
04 19 16 04 19 16 11		97140										55 00 3		NPI		144462011							
04 26 16 04 26 16 11		97140										55 00 3		NPI		144462011							
04 28 16 04 28 16 11		97140										55 00 0		NPI		144462011							
05 05 16 05 05 16 11		97140										55 00 3		NPI		144462011							
																NPI							
																NPI							
25. FEDERAL TAX ID NUMBER SSN/BIN										26. PATIENT'S ACCOUNT NO. HARWELL, D						27. ADJUST ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 220 00		29. AMOUNT PAID \$ 0 00		30. RAdv for NUCC Use \$ 220 00	
099606323 <input type="checkbox"/> <input type="checkbox"/>										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043						33. BILLING PROVIDER INFO & PH # 716 725-0264		GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and we are made a part thereof.)																							

NJCC Instruction Manual available at: www.njcc.com

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made; and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participant cases, the physician signs a Release, the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible is based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain contractors with the Uniformed Services. Information on the patient's spouse should be provided in those items captioned "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor, 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-Kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (under 5 USC §3356). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.38).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1982, 1972 and 1974 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(b) (B), and 44 USC 9101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 36 USC 619; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

This information may also be given to other providers of services, carriers, insurance companies, medical review agents, health plans, and other organizations or Federal agencies for the effective administration of Federal programs that require other third parties (payers) to pay primary to Federal programs, and is otherwise necessary to administer the programs. For example, it may be necessary to disclose information about the benefits you have used to a health plan or doctor. Additional disclosure may include items resulting from information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying systems No. 08-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37579, Wed. Sept. 10, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See E&A-5, E&A-6, E&A-12, E&A-13, E&A-32, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the corresponding records are authorized by law.

ROUTINE USES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities; under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with account claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosure may be made to other federal, state, local, foreign governments, private business entities, and individual providers of care, or matters relating to entitlement, claim adjudication, fraud, program abuses, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and denial and denial of litigation related to the use of TRICARE.

DISCLOSURES: Voluntary: However, failure to provide information will result in delay in payment or may result in denial of claim. With the exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged and/or payment of claim may result in a program. Failure to furnish any other information, such as, name or claim number, would delay payment of the claim. Failure to provide medical information under FICA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1135B of the Social Security Act and 31 USC 3801-012 provides penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer match.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time for travel, to instructions, saving existing data resources, gathering the data needed, and completing and reviewing the information collection. If you have any comments concerning the economy of the information collection or suggestions for improving this form, please write to: CMS 7500 Security Boulevard, Mail PRA-Romis Clearance Officer, Mail Stop C4-20-05, Baltimore, Maryland 21201-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14245

Office: (716) 725-0334

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 4/28/16Client Status: (Check) Better Progressing/Worse Same/No Change Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Stretches
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling R/O D/C

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Otalgues ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client feels stiffness in lower back/thighs

Knee/leg pain/crepitus continue in L/L/S

Shoulder region. Client felt better w/

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: ellen harry

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14245

Office: (716) 725-0334

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 5/10/16Client Status: (Check) Better Progressing/Worse Same/No Change Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Stretches
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
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 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client %0.5 hr "locking up" in the

Abducted/LR position (ie: missing scapula) IT

Involuntary jerking/tremors in (B) Scalp region.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: ellen harry

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0684

Fax: (716) 725-0685

Client Name: Danielle Harwell Date: 4/19/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client got @ in all c-t-l musculature today. Pain shoots down @ post. humerus to middle trapezius. Adhesions continue in above muscles.

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Message Mod Pressure Message
 Deep Tissue Message Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

H2O Follow-Up w/ Cairo Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist: Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0684

Fax: (716) 725-0685

Client Name: Danielle Harwell Date: 4/21/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client states she has palpated muscle in L cs/wt region from neck to mid-HA's. It's a less frequent but more intense & chronic type of adhesion. It is supraspinous.

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze muscle & surrounding
 Light Pressure Message Moderate Pressure Message
 Deep Tissue Message Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist: Danielle Harwell

05 10 16

05 10 16

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

ROCHESTER NY 146

07 MAY 2015 PM 2 1



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403-952607

1051216 MILLARD-FILLMORE SUBURBAN 1540 MAPLE ROAD WLMSSVILLE, NY 142213647		MILLARD FILLMORE SUBURBAN PO BOX 8000 DEPT 042 BUFFALO, NY 142670002 71-68597200		38 PAT CHARGE 6 WED FEE # 6 FED TAX NO STATEMENT COVERS PERIOD FROM THROUGH	3890065-4 1000780250 161533232 040116 042016	PAT OF BILL 0131
6 PATIENT NAME HARWELL, DANIELLE		6 PATIENT ADDRESS CHEEKTONWAGA		NY STATE		
10 BIRTHDATE 11 SEX 12 GRADE 13 HT 14 WT/PW 15 SBC 16 DHR 17 STX		18 CONDITION CODES 19 COODINCE SPAN FROM THROUGH		20 ACCT/SC STATE		
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42 REV CD	43 DESCRIPTION	44 HOPD / RATE / WIPPS CODE	45 SERV RATE	46 SDW UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0420	PHYSICAL THERP	97010GP	040616	1	25.26	-
0420	PHYSICAL THERP	97110GP	040616	2	234.50	-
0420	PHYSICAL THERP	97110GP	041116	2	234.50	-
0420	PHYSICAL THERP	97010GP	041116	1	25.26	-
0420	PHYSICAL THERP	97010GP	042016	1	25.26	-
0420	PHYSICAL THERP	97110GP	042016	1	117.25	-

PLEASE PROCESS IN ACCORDANCE WITH
WORKERS COMPENSATION
NO FAULT FEE SCHEDULE

Please pay estimated amount
due in box 55

0001 PAGE 1 OF 1 CREATION DATE 05/05/16 TOTALS 562 0

SS PAYER NAME	SS HEALTH PLAN ID	10 HRD EXP	10 LSS EXP	64 PRIOR PAYMENTS	65 EST AMOUNT PAID	PAYER
GEICO	98919	Y	Y		183,36	161533232
IHA GOVT PROGRAMS	95308	Y	Y			OTHER PRV ID

SR INSURED'S NAME	SR P. RD. #3 INSURED'S SOCIAL SEC. NO.	SR GROUP NAME	SR INSURANCE GROUP NO.
HARWELL, DANIELLE	18 0138739400101059		LAWRA WILDER
HARWELL, DANIELLE	18 DBD16761000		60000S

... WILHELMINA'S ACADEMY OF ARTS AND DESIGN

00 TREATMENT RETROGRADE LOGS 04 DOCUMENT CONTROL NUMBER 05 EMPLOYER NAME

For more information about the study, please contact Dr. Michael J. Hwang at (319) 356-4000 or email at mhwang@uiowa.edu.

For more information about the study, please contact Dr. John Smith at (555) 123-4567 or via email at john.smith@researchinstitute.org.

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69 ADULT
CUE
REGISTRATION BY

74. PRINCIPAL PROCEDURE OTHER PROCEDURE 75. OTHER PROCEDURE 76. ATTENDING DOCTOR 77. DENTIST 78. OPTOMETRIST 79. NURSE

CODE DATE CODE DATE CODE DATE
1447462203

LAST **OSTREMPOWSKI** FIRST **MICHAEL**

5 EDITION NUMBER 6 OTHER PROCEDURE 7 OTHER PROCEDURES 77 OPERATING RPI QUA

LAST _____ FIRST _____

Annual Report 2000-2001, page 20

b LAST FIRST

79 OTHER
80 P
81 QNL

LAST FIRST

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART OF IT.

NUBC National Utility Billing Council 2025-0034

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT TO PERIODICALLY RELEASE INFORMATION OR ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, THE SUBMITTER MAY BE SUBJECT TO CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY BE SUBJECT TO CRIMINAL PENALTIES FOR UNDUE INPRISONMENT UNDER FEDERAL STATUTE 42 U.S.C. § 1395k.

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or fabricate or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

- If third party benefits are indicated, the appropriate assignments by the insured/beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
- If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
- Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
- For Religious Non-Medical facilities, verifications and if necessary certifications of the patient's need for services are on file.
- Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1335f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 159) and any other applicable contract regulations, is on file.
- The provider or care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such government agencies as required by applicable law.
- For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to tell Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which the Medicare claim is made.
- For Medicaid purposes: The submitter certifies that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
- For TRICARE Purposes:
 - The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

- The patient has signed a bill of lading or other document to indicate a liability to the provider for services rendered. The provider does not have authority to bill Medicare, TRICARE, or other medical insurance companies for services rendered. The submission of claims to other payers is the responsibility of the patient, the State, and/or the facility. The provider is not responsible for the denial of medical claims by other insurance companies or for amounts not available by State or Federal law.
- The patient or the patient's family, if applicable, has signed a liability to the provider for services rendered to the patient by the provider, including a non-dischargeable liability to the patient for the claim amount, even if the claim is denied or if the provider receives partial payment from the other payers.
- The amount due to TRICARE for services rendered will be paid by the provider to TRICARE, unless otherwise specified in the TRICARE contract.
- The beneficiary or patient, if applicable, has signed a liability to the provider for services rendered to the patient by the provider and, if applicable, to the State.
- Any hospital-based physician, or other health care professional, who provides service and renders a bill of lading or other document to the employee or patient, shall sign the bill of lading or other document, indicating his/her name, title, and address. This includes physician assistants, nurse practitioners, clinical pharmacists, and other health care professionals employed by the provider.
- Based on all valid State Medicaid programs and all TRICARE participating in Element 1, the provider is liable to the State or TRICARE for services rendered to the patient, even if the provider bills another entity for the services.
- "TRICARE beneficiaries" are defined as dependents of the submitter, and dependents of dependents of the submitter, who are appropriate TRICARE beneficiaries. The term "dependent" means a person related by blood, marriage, or adoption to the subscriber, or to the subscriber's spouse, and includes children, stepchildren, and other dependents of the subscriber. The term "dependent" does not include persons who are more closely related to the subscriber than the listed dependents and persons who are not entitled to be paid by TRICARE, such as persons who are not eligible to be paid as dependents from available TRICARE funds, or persons whose full payment for the services is not covered by TRICARE. The provider is not liable to the State or TRICARE for services rendered to a patient for whom the patient is not entitled to be paid by TRICARE if a medical record indicates that the patient is not eligible for payment by TRICARE, or if the provider has been advised by the provider's state or TRICARE that the patient is not eligible for payment by TRICARE.

KALEIDA
HEALTH

- Buffalo General Hospital
 DeGraff Memorial Hospital
 Millard Fillmore Gates Circle Hospital
 Millard Fillmore Suburban Hospital
 Women & Children's Hospital of Buffalo
 Others _____

Patient ID Area

HARWELL DANIELLE
 MR- 1000780250
 DOB 08/29/80
 ATT- REFERRING DOC
 PCP- PANZARELLA JAMES J

PT- 3890065
 AGE- 035Y

SEX- F

FACE SHEET 1 of 1

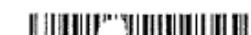
MEDICAL RECORD NO 1000780250	PATIENT NUMBER 3890065	PATIENT NAME (LAST, FIRST, MIDDLE) HARWELL DANIELLE			INCA AREA THP	LOCATION RMWPT	ROOM NO BED			
STREET ADDRESS, CITY, STATE, ZIP CODE 56 BEREHAVEN DR LEFT			COUNTY 14	SOCIAL SECURITY NO NOT DISPLAYED	BIRTHDATE 08/29/80	AGE 035Y				
SEX F	MAR STAT M	RACE W	RELIGION CRI	ADMIT TYPE PHYS THERA	ADMIT PRIORITY ELECTIVE	ADMIT SOURCE NONHILT FAC	HPI/A Y	MODE OF ARRIVAL	ADMIT DATE 03/23/16	ADMIT TIME 09:10
HEALTH CARE AGENT				LASLSP 001		ENGLISH			NP	
PRIOR STAY LOCATION		PRIOR STAY DATES		HOME PHONE 716-536-0951	ALTERNATE PHONE 716-536-0951	HOSPICE N	HL CONSENT Y	ORGAN DONOR N	VISIT TYPE R	
ATTENDING PHYSICIAN REFERRING DOC				REFERRED PHYSICIAN OSTEMPOWSKI MICHAEL J		ADMIT BY (LOGIN ID) dmm172		RECEIVED BILL OF RIGHTS? YES		
PRIMARY CARE PROVIDER PANZARELLA JAMES J				STREET ADDRESS, CITY, STATE, ZIP CODE TONAWANDA		OFFICE PHONE 716-833-2200		OFFICE FAX 716-332-0797		
EMERGENCY CONTACT 1 SHAWN HARWELL				REL SPOUSE	HOME PHONE --	WORK PHONE --	CELL PHONE 716-604-7208	PAGER NUMBER --		
EMERGENCY CONTACT 2 DIANE TOTARO				REL PARENT	HOME PHONE --	WORK PHONE --	CELL PHONE 716-507-4308	PAGER NUMBER --		
ADMITTING DIAGNOSES (CODE & VERBAGE) IM5412 RADICULOPATHY CERVICAL REGION				CHIEF COMPLAINT CURTIS CERVICAL/SHOULDER						
LAST NAME, FIRST, MI HARWELL, DANIELLE,				STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTY 56 BEREHAVEN DR LEFT SIDE		W AMHERST, NY 142280000			GUARANTOR	
SOCIAL SECURITY NO NOT DISPLAYED	TELEPHONE NUMBER 716-536-0951			RELATIONSHIP OF GUARANTOR SELF		EMPLOYER		EMPLOYER TELEPHONE NUMBER --		
COMMENTS										
SMOKING CESSATION INFORMATION PROVIDED TO PATIENT/CAREGIVER: YES										
INSURANCE CARRIER NO FAULT	PLAN NAME GEICO			CERTIFICATE/POLICY NO 0138739400101059		SECOND POLICY NUMBER		EFFECTIVE DATE 10/31/2015		
INSURED NAME DANIELLE HARWELL				DATE OF BIRTH 08/29/1980	REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER		
INSURANCE CARRIER IHA GOVT PROGRAMS	PLAN NAME MEDISOURCE			CERTIFICATE/POLICY NO DBD15761Q00		SECOND POLICY NUMBER		EFFECTIVE DATE //		
INSURED NAME DANIELLE HARWELL				DATE OF BIRTH 08/29/1980	REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER		
INSURANCE CARRIER	PLAN NAME SELF PAY			CERTIFICATE/POLICY NO		SECOND POLICY NUMBER		EFFECTIVE DATE		
INSURED NAME				DATE OF BIRTH	REL TO PT 1	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER		
INSURANCE CARRIER	PLAN NAME			CERTIFICATE/POLICY NO		SECOND POLICY NUMBER		EFFECTIVE DATE		
INSURED NAME				DATE OF BIRTH	REL TO PT 1	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER		
ISOLATION INDICATOR 1	ISOLATION INDICATOR 2	ISOLATION INDICATOR 3		ISOLATION INDICATOR 4		ISOLATION INDICATOR 5		ISOLATION INDICATOR 6		
PRINCIPAL DIAGNOSIS										
SECONDARY DIAGNOSIS										
PROCEDURES										
ATTENDING PHYSICIAN										
DATE										



BUFI THERAPY SERVICES

105 Main Street, Williamsville, NY 14221
Phone (716) 583-7360 • Fax (716) 583-7366DEGRAFF THERAPY SERVICES
415 Tremont Street, North Tonawanda, NY 14219
Phone (716) 690-2031 • Fax (716) 690-2160

Kaleida Health



HARWELL, DANIELLE

MR- 1000780250 PT- 3890065
DOB-08/29/80 AGE-35Y SEX- F
ATT- REFERRING DOC
PCP-PANZARELLA JAMES
FC- THP R ADM DT- 03/23/16

DAILY PROGRESS NOTE

Billing Guidelines For Medicare (CCI edits hi-lited): 1 unit = 8-23 2 units = 24-38 3 units = 39-53 4 units = 54-68 5 units = 69-82 minutes

Control bill unit if less than 8 minutes. For other payers use CPT 15 rule for timed services (T) where each 15 min=1 unit

Date	3/23/16	Visit #	1	Start	9:45:00	Stop	10:00	Total Time	15:00	Treatment Provided
SUBJECTIVE: Pain/symptoms (Circle)	none 0 1 2 3 4 5 6 7 8 9 10 worse									CPT-Description MINS UNITS
See DE										<input type="checkbox"/> HEAT <input type="checkbox"/> COLD 97010 1/16th
										<input type="checkbox"/> TRACTION 97012 1/16th
										<input type="checkbox"/> ESTIM (unilateral) 97014 1/16th
										<input type="checkbox"/> BAUCODR/POB* 97112 1/16th
										<input type="checkbox"/> ESTIM (bilatd) 97032 1/16th
										<input type="checkbox"/> PUNCTACTIVITY* 97030 1/16th
										<input type="checkbox"/> GAIT TRAIN 97116
										<input type="checkbox"/> MANUAL MOBL* 97140
										<input type="checkbox"/> MASSAGE 97124
										<input type="checkbox"/> DORT FIT 760-1 PRO RT 761
										<input type="checkbox"/> OTHER EXERCISE* 97110
										<input type="checkbox"/> ULTRASOUND* 97035
										<input type="checkbox"/> PT/EVAL CL R/P/EVAL 97001/02 >0:00:00
										<input type="checkbox"/> AQUATIC THER* 97113
										<input type="checkbox"/> TENNIS setup only 64550 unused
										Total timed minutes* (for Medicare unit calc only)

OBJECTIVE:



ASSESSMENT:

- Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem(s)(x) → Recommendation for future treatment →

PRESENT TREATMENT/PLAN:

- On Exercise/Treatment Card
 Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code: C3 - 84891 Goal G-code: CM - 84851 DIC G-code:

Date	4/6/16	Visit #	2	Start	9:45:00	Stop	10:15:00	Total Time	1:15	Treatment Provided
SUBJECTIVE: Pain/symptoms (Circle)	none 0 1 2 3 4 5 6 7 8 9 10 worse									CPT-Description MINS UNITS
I feel strong today										<input type="checkbox"/> HEAT <input type="checkbox"/> COLD 97010 1/16th
										<input type="checkbox"/> TRACTION 97012 1/16th
										<input type="checkbox"/> ESTIM (unilateral) 97014 1/16th
										<input type="checkbox"/> BAUCODR/POB* 97112 1/16th
										<input type="checkbox"/> ESTIM (bilatd) 97032 1/16th
										<input type="checkbox"/> PUNCTACTIVITY* 97030 1/16th
										<input type="checkbox"/> GAIT TRAIN 97116
										<input type="checkbox"/> MANUAL MOBL* 97140
										<input type="checkbox"/> MASSAGE 97124
										<input type="checkbox"/> DORT FIT 760-1 PRO RT 761
										<input type="checkbox"/> OTHER EXERCISE* 97110 2/2
										<input type="checkbox"/> ULTRASOUND* 97035
										<input type="checkbox"/> PT/EVAL CL R/P/EVAL 97001/02 >0:00:00
										<input type="checkbox"/> AQUATIC THER* 97113
										<input type="checkbox"/> TENNIS setup only 64550 unused
										Total timed minutes* (for Medicare unit calc only)

OBJECTIVE:

The ex is as outlined as well tolerated lot. fr

ASSESSMENT:

- Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem(s)(x) → Recommendation for future treatment →

PRESENT TREATMENT/PLAN:

- On Exercise/Treatment Card
 Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code: Goal G-code: DIC G-code:

Date	4/11/16	Visit #	3	Start	12:00:00	Stop	1:00:00	Total Time	1:00	Treatment Provided
SUBJECTIVE: Pain/symptoms (Circle)	none 0 1 2 3 4 5 6 7 8 9 10 worse									CPT-Description MINS UNITS
S still left. Doctor's think it's my shoulder joint.										<input type="checkbox"/> HEAT <input type="checkbox"/> COLD 97010 1/16th
										<input type="checkbox"/> TRACTION 97012 1/16th
										<input type="checkbox"/> ESTIM (unilateral) 97014 1/16th
										<input type="checkbox"/> BAUCODR/POB* 97112 1/16th
										<input type="checkbox"/> ESTIM (bilatd) 97032 1/16th
										<input type="checkbox"/> PUNCTACTIVITY* 97030 1/16th
										<input type="checkbox"/> GAIT TRAIN 97116
										<input type="checkbox"/> MANUAL MOBL* 97140
										<input type="checkbox"/> MASSAGE 97124
										<input type="checkbox"/> DORT FIT 760-1 PRO RT 761
										<input type="checkbox"/> OTHER EXERCISE* 97110 2/2
										<input type="checkbox"/> ULTRASOUND* 97035
										<input type="checkbox"/> PT/EVAL CL R/P/EVAL 97001/02 >0:00:00
										<input type="checkbox"/> AQUATIC THER* 97113
										<input type="checkbox"/> TENNIS setup only 64550 unused
										Total timed minutes* (for Medicare unit calc only)

OBJECTIVE:

The ex is as outlined as well tolerated

(+) ad r/c shoulder pain L/Hop

ASSESSMENT:

- Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem(s)(x) → Recommendation for future treatment →

PRESENT TREATMENT/PLAN:

- On Exercise/Treatment Card
 Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code: Goal G-code: DIC G-code:

CPT-Description	MINS	UNITS
<input type="checkbox"/> HEAT <input type="checkbox"/> COLD 97010 1/16th		
<input type="checkbox"/> TRACTION 97012 1/16th		
<input type="checkbox"/> ESTIM (unilateral) 97014 1/16th		
<input type="checkbox"/> BAUCODR/POB* 97112 1/16th		
<input type="checkbox"/> ESTIM (bilatd) 97032 1/16th		
<input type="checkbox"/> PUNCTACTIVITY* 97030 1/16th		
<input type="checkbox"/> GAIT TRAIN 97116		
<input type="checkbox"/> MANUAL MOBL* 97140		
<input type="checkbox"/> MASSAGE 97124		
<input type="checkbox"/> DORT FIT 760-1 PRO RT 761		
<input type="checkbox"/> OTHER EXERCISE* 97110 2/2		
<input type="checkbox"/> ULTRASOUND* 97035		
<input type="checkbox"/> PT/EVAL CL R/P/EVAL 97001/02 >0:00:00		
<input type="checkbox"/> AQUATIC THER* 97113		
<input type="checkbox"/> TENNIS setup only 64550 unused		
Total timed minutes* (for Medicare unit calc only)		



BUFI THERAPY SERVICES

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DEGRAFF THERAPY SERVICES
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 Phone (716) 656-2931 • Fax (716) 656-2930

Kaleida Health



HARWELL, DANIELLE

MR- 1000780250

PT- 3890065

DOB-08/29/80

AGE-35Y

SEX-F

ATT- REFERRING DOC

PCP-PANZARELLA JAMES

FC- THP R

ADM DT- 03/23/16

MILLARD FILLMORE SUBURBAN

Patient ID Area

DAILY PROGRESS NOTE

*Billing Guidelines For Medicare (CCI edits hi-lited) 1 unit = 8-23 2 units = 24-38 3 units = 39-53 4 units = 54-68 5 units = 69-82 minutes
 Cannot bill unit of less than 8 minutes. For other payers use CPT 15 rule for timed services (T) where each 15 min=1 unit

Date	Visit #	Visit #	Start	Stop	Total Time	Treatment Provided
						CPT-Description
						MN UNITS
4/20/16	4		9:30	10:30	1:00	<input type="checkbox"/> HEAT/COLD 97010 <small>Unmed.</small> <input type="checkbox"/> TRACTION 97012 <small>Medic.</small> <input type="checkbox"/> ESTIM (unmed) 97014 <small>Medic.</small> <input type="checkbox"/> BAL/COOR/POS 97112 <input type="checkbox"/> ESTIM (med) 97032 <input type="checkbox"/> FUNCT ACTIVITY ^T 97530 <input type="checkbox"/> GAIT TRAIN ^T 97116 <input type="checkbox"/> MANUAL MOBIL ^T 97140 <input type="checkbox"/> MASSAGE ^T 97124 <input checked="" type="checkbox"/> ORT RT-760 ^T PRO RT-761 ^T <input type="checkbox"/> OTHER EXERCISE ^T 97110 <small>LFB</small> <input type="checkbox"/> ULTRASOUND ^T 97035 <input type="checkbox"/> PT EVAL ^T R/EVAL 9700102 <small>>0:00:00</small> <input type="checkbox"/> AQUATIC THER ^T 97113 <input type="checkbox"/> TENS set-up only 84550 <small>unmed</small>

SUBJECTIVE: Pathophysios (Circle)

None 0 1 2 3 4 5 6 7 8 9 10 worse
 "My neck and (L) arm are really sore!"

OBJECTIVE:

The ex or extnd → corner st & ch
 Due pain/stress, DUE/levator stretch
 unrelaxed QOF 3/4.

ASSESSMENT:

- Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem/goal(s) → Recommendation for future treatment →

PRESENT TREATMENT/PLAN:

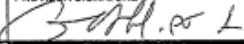
- On Exercise/Treatment Card
 Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-codes

Goal G-codes

D/C G-codes

PROVIDER SIGNATURE


 Total timed minutes*
 (For Medicare unit calc. only)

Treatment Provided

CPT-Description	MN	UNITS
-----------------	----	-------

SUBJECTIVE: Pathophysios (Circle)

None 0 1 2 3 4 5 6 7 8 9 10 worse

OBJECTIVE:

ASSESSMENT:

- Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem/goal(s) → Recommendation for future treatment →

PRESENT TREATMENT/PLAN:

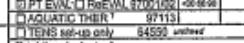
- On Exercise/Treatment Card
 Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-codes

Goal G-codes

D/C G-codes

PROVIDER SIGNATURE


 Total timed minutes*
 (For Medicare unit calc. only)

Treatment Provided

CPT-Description	MN	UNITS
-----------------	----	-------

SUBJECTIVE: Pathophysios (Circle)

None 0 1 2 3 4 5 6 7 8 9 10 worse

OBJECTIVE:

ASSESSMENT:

- Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

 New problem/goal(s) → Recommendation for future treatment →

PRESENT TREATMENT/PLAN:

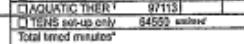
- On Exercise/Treatment Card
 Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-codes

Goal G-codes

D/C G-codes

PROVIDER SIGNATURE


 Total timed minutes*
 (For Medicare unit calc. only)

Treatment Provided

CPT-Description	MN	UNITS
-----------------	----	-------

SUBJECTIVE: Pathophysios (Circle)

None 0 1 2 3 4 5 6 7 8 9 10 worse

09 12 16



GEICO
P O BOX 9507
FREDERICKSBURG, VA
22403-9526

Express Envelope



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA

1. MEDICARE (Medicare) <input type="checkbox"/> MEDICAID (Medicaid) <input type="checkbox"/> TRICARE (DOD/DoD) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (GHP) <input type="checkbox"/> FECA (FECA) <input type="checkbox"/> OTHER (Other)												1a. INSURED'S ID. NUMBER (For Program in Item 1) 013873940-0101-059											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08 25 1980				SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) - - - - -					
5. PATIENT'S ADDRESS (No., Street) 56 BEREHEAVEN DR												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)							
CITY AMHERST			STATE NY			8. RESERVED FOR NUCC USE X			CITY STATE			ZIP CODE ()			TELEPHONE (Include Area Code) (716) 536-0951								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>PLACE (SMA)</small>				c. OTHER CLAIM ID (Designated by NUCC)							
b. RESERVED FOR NUCC USE												d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				e. INSURANCE PLAN NAME OR PROGRAM NAME							
c. RESERVED FOR NUCC USE												f. INSURANCE PLAN NAMES OR PROGRAM NAMES 906. CLAIM CODES (Designated by NUCC)				g. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, complete items 9, 9a, and 9d</small>							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
SIGNED = ON FILE = DATE 01-06-2016												SIGNED = ON FILE =											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 2015			15. OTHER DATE QUAL			MM DD YY			16. DATES PATIENT ABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE KovIGE, JENNIFER, M.D. NPI			17a. <input type="checkbox"/> NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. <input type="checkbox"/> A. <u>G44.309</u> B. <u> </u> C. <u> </u> D. <u> </u> E. <u> </u> F. <u> </u> G. <u> </u> H. <u> </u> I. <u> </u> J. <u> </u> K. <u> </u> L. <u> </u>												22. RESUBMISSION CODE ORIGINAL REF NO											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 05 10 05 16												B. PLACE OF SERVICE EMO 05 16 16				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 97140				D. MODIFIER E. DIAGNOSIS CODING POINTERS F. \$ CHARGES G. DAYS OR UNITS H. CHARGE PER UNIT I. L ID QUAL J. RENDERING PROVIDER ID # NPI			
1	05	10	05	16	05	16	11	97140								NPI	1144462011						
2	05	11	05	16	11	16	11	97140								NPI	1144462011						
3																NPI							
4																NPI							
5																NPI							
6																NPI							
25. FEDERAL TAX ID NUMBER 099606323	SSN <input checked="" type="checkbox"/>	BIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. HARWELL, D			27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. TOTAL CHARGE \$ 110.00		29. AMOUNT PAID \$ 0.00		30. Rcv'd for NUCC Use 110.00										
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMFT SIGNED DATE 05.12.2016												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043				33. BILLING PROVIDER INFO & PH# 716 725-0264 GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENT: A patient's signature means that payment will be made and otherwise releases any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient waives liability for any delay in release to Medicare in medical and non-medical information and waives the physician's group health care liability, no less, without reservation or other reservation which is responsible in full for the services furnished in the Medicare claims made. See 42 CFR 411.204(b). If item 8 is completed, it is the patient's right to have a copy of the information released to the health plan or agency shown in Medicare assigned or TRICARE participation codes. The physician agrees to accept the charge determination of the health care carrier or TRICARE local intermediary as the bill charge and the physician is responsible only for amounts deductible, reasonable and non-reasonable charges. **Consent:** And the debtor agrees on behalf of the charge determinations of the Medicare carrier or TRICARE local intermediary as the bill charge determined. TRICARE is not a health insurance program but makes payment for health benefits provided through certain suppliers with the United States. Information on the patient's sponsor should be pre-printed in block letters numbered in "Legend", i.e., items 8, 6, 7, 9, and 11.

* BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting the claim for payment from Medicare funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf to my employer's billing company, complies with all applicable Medicare and/or Medicaid laws, regulations and program instructions for payment including but not limited to the Federal and State Audit and Physician Self-Referral law (commonly known as Stark law); 5) the services on the claim were medically necessary and personally furnished to me or were furnished pursuant to my professional service by my employee under my direct supervision, except otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, I am clearly (legally and NPI) licensed if or SSI of the primary individual rendering such service as required in the designated section. For services to be considered "incident to" a physician's professional services, (i) they must be rendered under the physician's direct supervision by his/her employee, (ii) they must be integral, although incident, part of a covered physician service, (ii) they must be items commonly furnished in physician's office, and 4) the names of non-physicians must be included on the physician's bills.

For TRICARE claim: Further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government either civilian or military (refer to 5 USC 8339j). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 414.32).

NOTICE: Any one who represents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1082, 1082 and 1087 of the Social Security Act as amended, 42 CFR 411.24(a) and 421.5(a) (6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1088, 5 USC 80101 et seq, and 30 USC 901 et seq 36 USC #10: E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties pay to pay priority to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-70-0601, titled, "Gamer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 97540 Wed. Sept. 17, 1990, or as updated and republished.

FOR OWCWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, Sec EBA-5, EBA-6, EBA-12, EBA-13, EBA-30, or as updated and republished.

FOR TRICARE CLAIMS, PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the service(s) received were authorized by law.

EXEMPTIONS: (a) Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation for use in the disability adjustment, re-employment, and TRICARE/CHAMPVA; to the Dept. of Justice for investigation of the St. Louis City of Death in小麦田村; to the Dept. of Justice, the FBI, private collection agencies, and consumer reporting agencies in connection with recovery of debts, and to Congress and the Office of the Comptroller of the Currency in connection with a financial institution's examination and audit procedures. Aggregate disclosure may be made to other Federal, state, local, foreign government agencies, panels, commissions, and individual members of Congress in connection with their legislative functions. (b) Information from claims and related documents may be given to the Dept. of Health and Human Services, the Dept. of Transportation, and the Dept. of Justice in connection with the operation of TRICARE.

RIGHTS: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, this is no limitation under this program for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claim under this program. Failure to furnish any other information, such as name or doctor used, would delay payment of the claim. Failure to provide medical information under this law could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 9301-9312 provide penalties for withholding this information.

You should be aware that P.L. 100-505 (the Computer Matching and Privacy Protection Act of 1988), permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to furnish such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept the payment in full, the amount paid by the Medicaid program for these claims submitted for payment under that program, with the exception of authorized deductible, copayments, co-payments or similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically reasonable and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21244-1650. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0244

Fax: (716) 725-0265

Client Name: Daniel Hansen Date: 5/10/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Scro
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Otalgues ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Hypertonicity in Cervical, thoracic
and lumbar regions. B/c UT hypertonicity, ①

worse than right. ④ Scapula greater hypertonicity

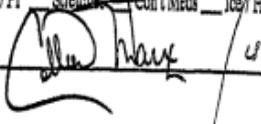
Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretching Can't Meds Ice/Heat

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0214

Fax: (716) 725-0265

Client Name: Daniel Hansen Date: 5/11/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Scro
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Otalgues ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client to ↑ Cervical P/S L/S Shoulder

Slowly feeling better. No ↑ hypertonicity
this visit.

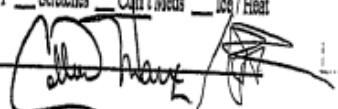
Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretching Can't Meds Ice/Heat

Therapist:



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FREDRICKSBURG, VA 22403

P.O. BOX 9507

GEICO INS CO of NY

Great Lakes Therapeutic Massage
Collie Mart, LMT
375 Dick Road, Suite #2
Buffalo, NY 14243

13 MAY 2016 PM 21
GULFPORT, MS 39082





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FEDERAL EXCLNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (TRICARE) (CHAMPVA) (Group Health Plan) (FEDERAL EXCLNG) (Other)</small>										1a. INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE										3. PATIENT'S BIRTH DATE MM DD YY 08291980		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE							
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE										6. PATIENT'S RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT							
CITY CHEEKERTOWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY AMHERST		STATE NY											
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																			
SIGNED SIGNATURE ON FILE DATE																			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 QUA1 431										15. OTHER DATE MM DD YY 111215 QUA1 454									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI: _____										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24))										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
A. M50.22		B. IM51.26		C. IM51.27		D. M54.12		22. RESUBMISSION CODE ORIGINAL REF NO											
E. IS23.3XXA		F. IM99.01		G. IM99.03		H. M99.02		23. PRIOR AUTHORIZATION NUMBER											
I. IM99.05		J. IM54.2		K. M54.5		L. M54.6													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS CODE		F. CHARGES	G. DAYS OR UNITS	H. AMOUNT PER UNIT	I. ID CODE	J. RENDERING PROVIDER ID #					
1	04222016	04222016	11	98941				ABCD	32 28	1		NPI	1710014188						
2	04222016	04222016	11	97010				ABCD	10 53	1		NPI	1710014188						
3	04292016	04292016	11	98941				ABCD	32 28	1		NPI	1710014188						
4	04292016	04292016	11	97010				ABCD	10 53	1		NPI	1710014188						
5	05052016	05052016	11	98941				ABCD	32 28	1		NPI	1710014188						
6	05052016	05052016	11	97010				ABCD	10 53	1		NPI	1710014188						
25. FEDERAL TAX ID NUMBER SSI EM 364500165										26. PATIENT'S ACCOUNT NO 343821218		27. ACCEPT ASSIGNMENTS (Check if you desire to have my bill sent to my insurance company)		28. TOTAL CHARGE \$ 128.43		29. AMOUNT PAID \$ 0.00		30. Rev'd for NUCC Use b	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to the bill and are made in my name.) PETER GOZINSKI DC										32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849							

05 19 16

Encounter dated 05/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

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05 19 16

~~11455-111-0119~~
~~11455-111-0119 PACTC~~

Geico
P.O. Box 9507
Fredericksburg, VA 22403



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Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
May 16, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday April 22, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain continues to remain sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 1-2 x a week as opposed to daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. In addition, light no longer bother her. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activites of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain continues as well. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper

Encounter dated 04/22/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Sensation:** left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident.

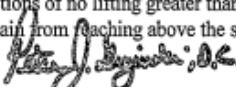
Lumbar assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet

Encounter dated 04/22/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 (manual traction); L5 (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Friday April 29, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain continues. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates*

Encounter dated 04/29/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 05/16/2016

symptoms: movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are now daily for the past week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she denies any nausea. In addition, light aggravates her headaches. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Thoracic: Patient stated that her middle back pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit:** **Pain:** achy, dull, shooting; level: 5/10. **Pain is constant.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been better. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** improving. **since last visit:** **Pain:** achy, dull, shooting, tingling, numb; level: 3/10. **Pain is constant.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: **Range of motion:** flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Shepplemans: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5.

Encounter dated 04/29/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

Sensation: left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** worse, increased headache frequency. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: improving, VAS score improved from a 5 to 3 out of 10. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. **Treatment schedule:** 2x/week for 2 weeks; Re-examination for 2 weeks. **Subluxations found on assessment and adjusted:** C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); SI left PI (prone mobilization). **Physical Modalities:** bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. **Patient given:** home exercise program: advised patient to perform active

Encounter dated 04/29/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday May 5, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain remains the same. Patient going for a MRI on the jaw later today. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also continues to experience headaches. The headaches are now every other day for the past week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she denies any nausea. In addition, light aggravates her headaches. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent*

Encounter dated 05/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

Infection or fever: No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment

Encounter dated 05/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/16/2016

without incident.

Lumbar assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 1 week; Re-examination for 1 week. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzilski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits
VAS: Visual Analog Scale



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
NY PIP
P O BOX 9507
FREDERICKSBURG VA 22403

CARRIER

NUCC										PICA								
1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP ERICA OTHER										14 BUSINESS'S ID NUMBER 0138739400101059	(For Program in Item 1)							
(Medicare) (Medicaid) (TRICARE) (Champva) (Group ID#) (Erica ID#) (Other ID#)										14 BUSINESS'S NAME (Last Name, First Name, Middle Initial)								
HARWELL, DANIELLE										HARWELL, DANIELLE								
56 BEREHAVEN DR LEFT										56 BEREHAVEN DR LEFT								
6 PATIENT'S ADDRESS AND PHONE NUMBER										6 PATIENT'S RELATIONSHIP TO INSURED								
56 BEREHAVEN DR LEFT										SEX	X							
7 PATIENT'S ADDRESS AND PHONE NUMBER										7 PATIENT'S RELATIONSHIP TO INSURED								
56 BEREHAVEN DR LEFT										SEX	F							
8 RESERVED FOR NUCC USE										8 RESERVED FOR NUCC USE								
BUFFALO NY										BUFFALO NY								
ZIP CODE 14228 TELEPHONE (Include Area Code) (716) - 536 - 0951										ZIP CODE 14228 TELEPHONE (Include Area Code) (716) - 536 - 0951								
HARWELL'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO								
DEBT 6761000										SEX	X							
a. EMPLOYMENT? (Current or Previous)										a. INSURED'S DATE OF BIRTH	07/01/1980	SEX	X					
X YES NO										PLACE (State)		M						
b. AUTO ACCIDENT?										b. OTHER CLAIM ID (Designated by NUCC)								
X YES NO										c. INSURANCE PLAN NAME OR PROGRAM NAME								
c. OTHER ACCIDENT?										d. IS THERE ANOTHER HEALTH BENEFIT PLAN?								
X YES NO										YES	NO	If yes, complete items b, ea, and fd						
d. INSURANCE PLAN NAME OR PROGRAM NAME										13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described above								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										SIGNATURE ON FILE								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process my claim or to pay benefits either to myself or to the physician or supplier mentioned below.										SIGNATURE ON FILE 05/16/2016								
SIGNED _____ DATE _____										SIGNED								
14 IN DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) 43 9 QUARTER 2										15 OTHER DATE MM DD YY								
17a DATE NAME OR REFERRING PROVIDER OR OTHER SOURCE DR FRANCIS ODAY DDS										17b 1013.02288.8	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY							
17b NPI										17 FROM MM DD YY TO MM DD YY								
18 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY								
										19 OUTSIDE LABS	\$ CHARGES							
										YES	NO							
21. DESCRIPTION OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) M2655										22 RESUBMISSION CODE	ORIGINAL REP. NO							
A L	B I	C C	D D	E F	G G	H H	I J	K L	23 PRIOR AUTHORIZATION NUMBER									
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY										B PLACE OF SERVICE EMR	C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	D MODIFIER	E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS OF UNITS	H DRAFT/READY FOR	I ID	J RENDERING PROVIDER ID #
15. 05. 16										11	70336		A	698.60	1			1942282207
NPI																		
2																NPI		
3																NPI		
4																NPI		
5																NPI		
6																NPI		
25. REFERRING PHYSICIAN'S NUMBER 262415643 SSN/INN 08430										26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENTS YES NO		28. TOTAL CHARGE	29. AMOUNT PAID	30. RPD for NUCC Use		
														\$ 698.60	\$ 0.00	b (716) - 839 - 3133		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) RAND, LAWRENCE, MD										32. SERVICE FACILITY LOCATION INFORMATION BUFFALO DIAGNOSTIC IMAGING 4925 MAIN STREET AMHERST NY 14226-4081		33. BILLING PROVIDER INFORMATION BUFFALO DIAGNOSTIC IMAGING, P BUFFALO MRI 4925 MAIN ST AMHERST NY 14226-4081						
05 16 16														1821262866				
SIGNED DATE										a b		a b						

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any false, preposterous or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS A patient's physician requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer/group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.2(b)(1). If item 8 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured", i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting the claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal self-insurance statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in its designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black Lung claims I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.82).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OIGP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2056(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(e) (6), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1078 and 1088, 5 USC 8101 et seq and 90 USC 901 et seq, 36 USC 613; E.O. 13377

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to issue the proper payment if made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay money to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system no. 09-70-0501 titled "Carmer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept. 12, 1980, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb. 28, 1980, See ESA-5, ESA-6, ESA-12, ESA-13 ESA-30, or as updated and republished

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/benefits received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in actions to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosure may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3601-3612 provides penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to discharge fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER) I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0938-1167. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-03, Baltimore, Maryland 21234-1800. This address is for comments and/or suggestions only. DO NOT MAIL COPIES OR PLATED COPIES TO THIS ADDRESS.

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammogram

Bone Density/DEXA

FRANCIS ODAY, DDS
1110 COLVIN BLVD
BUFFALO, NY 14223

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 5/5/2016 2:06:27 PM

MRI TMJ BILATERAL 40MIN

REASON FOR STUDY AND CLINICAL INFORMATION: Bilateral TMJ pain with clicking, greater on the right.

IMAGING SEQUENCES: Sagittal and proton density open and closed mouth images. Coronal proton density images. Sagittal T2 images. Sagittal proton density kinematic images.

RIGHT SIDE FINDINGS: In the closed mouth position, there is moderate anterior displacement of the right TMJ meniscus with its posterior band at 10 o'clock. There is full reduction on the second stage of mouth opening. No meniscal tear is detected. There is a minimal superior compartment effusion. No lateral displacement is detected. The condylar head appears intact.

IMPRESSION:

1. MODERATE ANTERIOR RIGHT TMJ MENISCAL DISPLACEMENT WITH REDUCTION ON THE SECOND STAGE OF MOUTH OPENING.
2. MINIMAL SUPERIOR COMPARTMENT EFFUSION.

LEFT SIDE FINDINGS: In the closed mouth position, there is normal position of the TMJ meniscus with normal translation with mouth opening. No meniscal tear is detected. No lateral displacement is detected. No effusion is detected. The condylar head appears unremarkable.

IMPRESSION:

1. NEGATIVE LEFT TMJ.

Thank you very much for referring this patient to us.

Sincerely,

Signed by LAWRENCE RAND, MD at 5/6/2016 11:55:45 AM

KK 5/6/2016 11:27:37 AM

Buffalo Diagnostic
Imaging, PLLC

Snyder Place
4925 Main Street
Amherst, NY 14226

P: 716.839.3333

F: 716.839.3338

Toll-Free 888.MRI.3939

buffalomri.com

Appointment Date: 5/5/2016 8:00:00 AM	Patient ID: RAM1965183
Study Type: MRI TMJ BILATERAL 40MIN	Patient Name: DANIELLE HARWELL
Date of Birth: 8/29/1980	Social Security #:
Phone Number: (716)536-0951	Address: 56 BEREHAVEN DR LEFT BUFFALO, NY 14228

Follow-up Appointment Date/Time and Doctor	
Referring Provider	FRANCIS ODAY, DDS
Referring Provider Address	1110 COLVIN BLVD BUFFALO, NY 14223

Primary Insurance:	GEICO	ID	0138739400101059	Group ID:	N
Secondary Insurance:	IHA MEDISOURCE	ID	DBD16761Q00	Group ID:	N
Type of fee:	<input checked="" type="checkbox"/> Copay <input type="checkbox"/> Private Pay <input type="checkbox"/> Deductible <input type="checkbox"/> Payment for CD (\$5.00) <input type="checkbox"/> Payment for Films (\$20.00) <input type="checkbox"/> Mammogram Pad (\$7.00) <input type="checkbox"/> M2S Payment (\$225.00)			Amount Due:	50 - No Fault
				Amount Paid:	
				Remaining Balance:	
				<small>*These amounts are what are known at the time of service. After the final billing process, these amounts may change.</small>	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of a summarization of the current Federal law protecting the privacy of your health information has been provided for your review. If you would like a copy of the summary of the law, please request us. We are also required by law to ask for your signature acknowledging only that you have seen a copy of the summarized law. By signing below you are acknowledging that we have given you a copy of the summarized law. I have been offered a copy of the Notice of Privacy Practices for Protected Health Information (PHI) from Buffalo Diagnostic Imaging, PLLC.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE OF RECORDS

I hereby authorize Buffalo Diagnostic Imaging, PLLC to release any information, including the diagnosis, records, and services to my doctor(s) and/or insurance company. I hereby give my authorization to release any of my medical records requested by Buffalo Diagnostic Imaging PLLC or Buffalo MRI.

I hereby authorize direct payment(s) to Buffalo Diagnostic Imaging PLLC for services rendered. I understand I am financially responsible for and guarantee payment of all charges not covered by the insurance(s) I presented at the time of study or properly authorized by my insurance.

An account referred to an outside collection agency will be charged an additional 25% collection fee on the unpaid balance. You will be responsible for additional service fees, interest and attorney's fees while your account is in collection.

MRI SAFETY

My Medical History has not changed since my Prescreening Interview performed on: _____. Please let us know if you'd like a copy.

RACE: Declined

ETHNICITY: Declined

MEANINGFUL USE:

SMOKING STATUS: Declined

Updated information in Ramssoft

I verify that the above information is accurate and confirm that I have read and agree to the statements above.

Patient/Guardian Signature

Date:

Danielle Harwell

5/5/16

OFFICIAL NEW YORK STATE PRESCRIPTION FORM

FRANCIS P O'DAY DDS
LIC: 051392
NPI: 1013022668

1110 COLVIN BOULEVARD TOWN OF TONAWANDA, NY 14223 (716) 655-0635

 PRESCRIBER'S SIGNATURE

Patient Name Danielle Hanwell Date 05/03/16
 Address 1131 Cleveland Dr.
 City Cheektowaga State NY Zip 14225 Sgn HRK
 Rx Bilateral TMJ MRI

M210.63

 REFILL REQUESTEDPrescriber Signature J. O' DayMAIL ROOM USE ONLY
DO NOT FILE

THIS PRESCRIPTION WILL BE FILLED GENERALLY UNLESS PRESCRIPTION SPECIFICS SHOWN IN THE BOX BELOW

REFILLS

Name _____

Rx# _____

BR324L 45

PHARMACIST TEST AREA	Dispenser Authorization
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DOB - 08/29/1980

#S (716) 276-9181

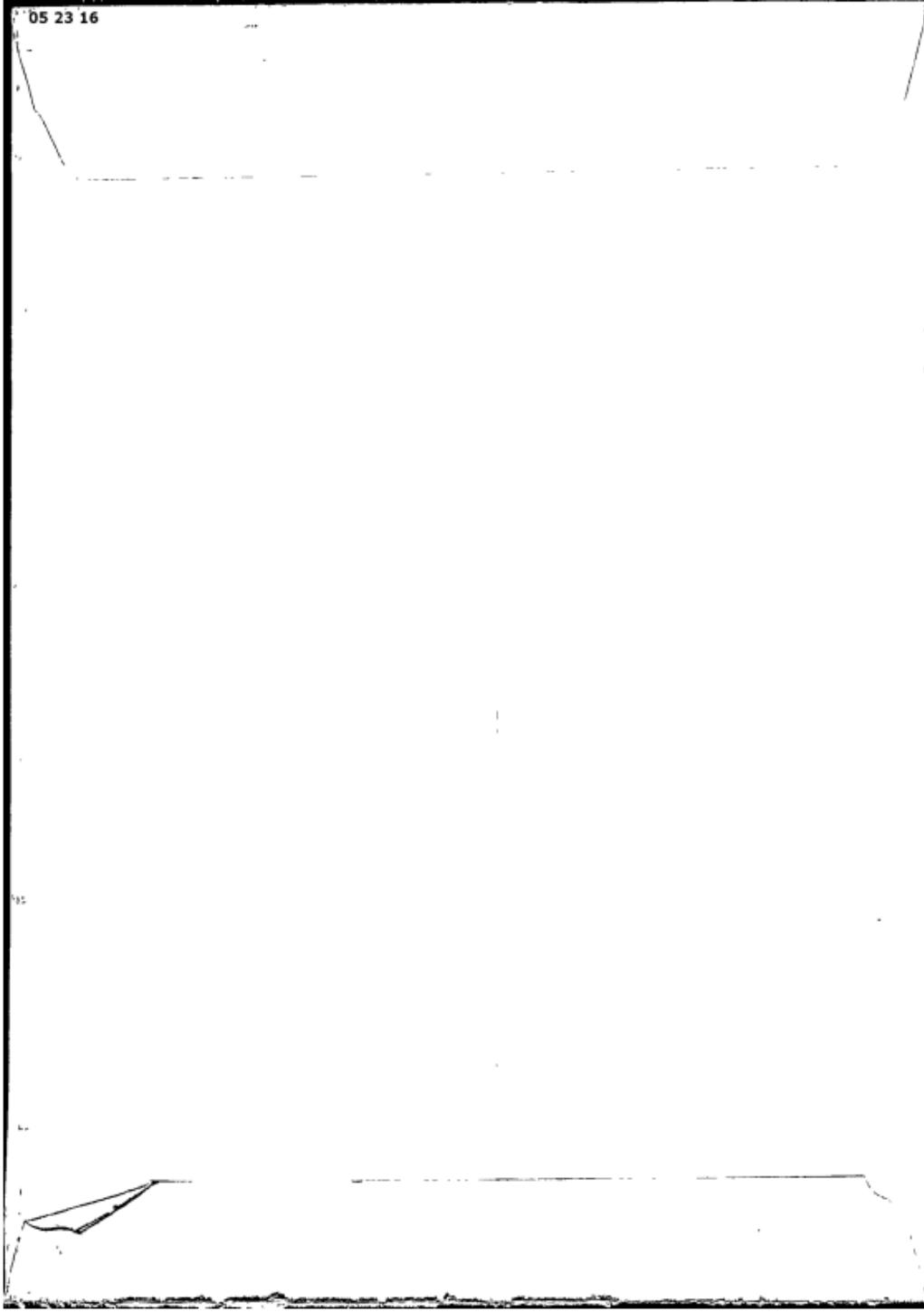
or (716) 536-0951

NO fault - Geico

DOA - 10/31/15

Claim # 0138739400101059

05 23 16



05 23 16



Buffalo MRI 
Made easy for you.
4925 Main Street
Amherst, NY 14226



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/11

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARRIER -

PI-905 PICA										PICA		
1. MEDICARE (Medicare)		MEDICAID (Medicaid)		TRICARE (NAME/DSN)		CHAMPVA (Member/DSN)		GROUP HEALTH PLAN (GHP) <input type="checkbox"/>	FECA EXCLUSIVE (FECEX) <input type="checkbox"/>	OTHER (OTH) <input type="checkbox"/>	1a. INSURED'S ID NUMBER (For Program in Item 1) 013873940-03-03-059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARMS, DONNIE L.										4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME		
5. PATIENT'S ADDRESS (No., Street) 56 BERBREAVEN DR										7. INSURED'S ADDRESS (No., Street)		
CITY AMHERST					STATE NY					CITY	STATE	
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951								ZIP CODE	TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) e. OTHER INSURED'S POLICY OR GROUP NUMBER										10. IS PATIENT'S CONDITION RELATED TO:		
b. RESERVED FOR NUCC USE										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	b. INSURED'S DATE OF BIRTH MM DD YY	SEX <input type="checkbox"/> M <input type="checkbox"/> F
c. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) INT'L	b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME		
10e. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, b, and 9d		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED 03/20/2018

DATE: 10-10-2018

SIGNER

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD YY)			15. OTHER DATE QUAL.			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
1-30	11	2015						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
			17b					
McVIGLE, JENNIFER, N.D.			17c	NPI				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB?	\$ CHARGES	
						<input type="checkbox"/> YES	<input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Refer A-L to service line below (24L)						ICD IND	22. RESUBMISSION CODE ORIGINAL REF NO	
A <u>G44.308</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>
						23. PRIOR AUTHORIZATION NUMBER		

099606323 HARMELIN, D YES NO \$ 110.00 \$ 0.00 110.00
 31 SIGNATURE OF PHYSICIAN OR SUPPLIER
 INCLUDING DEGREES OR CREDENTIALS
 (I certify that the statements on the reverse
 apply to this bill and are made a part hereof)
 32 SERVICE FACILITY LOCATION INFORMATION
 33 BILLING PROVIDER INFO & PH #
 GREAT LAKES THERAPEUTIC MASSAGE 716 725-0264
 GREAT LAKES THERAPEUTIC MASSAGE

COLLEEN MARY LINT 05-20-2016

第二部分：基础理论与方法

W. W. NORTON & COMPANY · NEW YORK · LONDON · AUCKLAND · BOSTON · CALIFORNIA · CANBERRA · DURBAN · FLORENCE · HONG KONG · KARACHI · KOLKATA · LIMA · MELBOURNE · MEXICO CITY · MUNICH · NEW DELHI · OXFORD · PERTH · PORT ELIZABETH · ROME · SINGAPORE · TORONTO · WINDHOEK

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who fraudulently files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A health care provider may request the medical and nonmedical release of this information necessary to process the claim and certify that the information provided in this form is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity in relation to Medicare to make medical and nonmedical information available to the patient's health care provider. In this, the health care provider may request any information necessary to pay for services for which the Medicare claim is made. See 42 CFR 411.24(a). If claim is completed, the individual's signature authorizes release of the information to the health plan or other payor entity. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the change determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health resource program but makes payment for health services provided through certain entities with the Uniformed Services. Information on the patient's spouse should be provided in those items concerned in "Insured," i.e., items 10, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and degree of coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or my authorized agent, is based on information furnished by my designated billing company, complete with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-fraud statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service, by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 3) they must be rendered under the physician's direct supervision by his/her employees, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices; and 4) the services of non-physicians must be included on the physician's file.

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The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services you received are covered by these programs and to insure that proper payment is made.

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06 03 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14203
Office: (716) 725-0384 Fax: (716) 725-0265

Client Name: Danielle Harvey Date: 5/17/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 (8) 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Otalgia ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client of 1 number/cervical of 1 & elbow

Pain d/t having 1 M/E yesterday & causing

further discomfort. Facial restrictions noted

Actions Applied: (Check All that Apply) throughout the neck & shoulder

- Heat Packs Cold Packs Sombra/Biofreeze Nejlon Felt Tapes
- Light Pressure Massage Mod Pressure Massage TX
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist:

1 Mary 5/16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0384

Fax: (716) 725-0265

Client Name: Danielle Harvey Date: 5/20/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 (6) 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
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- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Otalgia ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports no D/C LP. Cervical of D/C bld

Still stiff & sore esp because she was unable to attend clinic for this week.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist:

1 Mary 5/20

-06 03 16

06 03 16

Great Lakes Therapeutic Massage

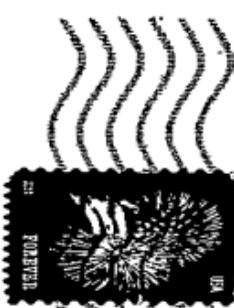
Colleen Marx, LMT

375 Dick Road, Suite #2

Buffalo, NY 14043

BUFFALO NY 142

31 MAY 2016 PM 1 L



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-952507



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIA		PICA											
1 MEDICARE	MEDICAID	TINCARE	CHAMPVA	GROUP HEALTH PLAN	FED SALARIED (ADM)	OTHER (ADM)	1a INSURED'S ID NUMBER			(For Program in Item 1)			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TINCAIR	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> Member ID#	<input type="checkbox"/> FED SALARIED (ADM)	<input type="checkbox"/> OTHER (ADM)	013879440-01-01-058						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
BARWELL, DANIELLE			MM	DD	YY	M	F	BARWELL, DANIELLE					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)								
56 BERBEEHAVEN DR			Spouse	Child	Other								
CITY		STATE		8. RESERVED FOR NUCC USE		CITY		STATE					
AMHERST		NY		X									
ZIP CODE		TELEPHONE (Include Area Code)		X		ZIP CODE		TELEPHONE (Include Area Code)		()			
14228		(716) 536-0953		X									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO										
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)										
			<input type="checkbox"/> YES	<input type="checkbox"/> NO									
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <u>X</u> PLACE (State) <u>NY</u>										
			<input type="checkbox"/> YES	<input type="checkbox"/> NO									
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <u>X</u>										
			<input type="checkbox"/> YES	<input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)										

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ON 5/16/2016DATE 05-06-2016SIGNED ON 5/16/2016IS THERE ANOTHER HEALTH BENEFIT PLAN?
 YES NO If yes, complete items 9, 9a, and 9c.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)
MM DD YY QUAL
3/01/2016 QUA
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a _____
17b. NPI _____
MARGIE JENNIFER, M.D.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A/L to service line below (24e)	ICD IND	16. OTHER DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
A <u>1G44-309</u>	B _____	C _____	D _____	16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
E _____	F. L _____	G _____	H _____	16. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		
I. L _____	J. L _____	K. L _____	L. L _____	22. RESUBMISSION CODE ORIGINAL REF. NO		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE EMR	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS	D. MODIFIER	E. DIAGNOSIS POINTER F. \$ CHARGES G. DOLLARS OR UNITS H. PAYMENT FEE PER UNIT I. ID CODE J. RENDERING PROVIDER ID #		
1 05-24-16-05-24-16-11	97140	A	55.00	3 NPI 1144462011		
2 05-27-16-05-27-16-11	97140	A	55.00	3 NPI 1144462011		
3				NPI		
4				NPI		
5				NPI		
6				NPI		
25. FEDERAL TAX ID. NUMBER	SSN/EIN	26. PATIENT'S ACCOUNT NO. BARWELL, D	27. ACCEPT ASSIGNMENT TO 3RD PARTY YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$ 110.00	29. AMOUNT PAID \$ 0.00	30. Rev for NUCC Use 110.00
47-0989449						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Indicate if the statements on the reverse apply to this bill and are made a part thereof)	32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPWA, NY 14043	33. BILLING PROVIDER INFO & PH# 716 725-0264				

COLLEEN MARX, LMT 05.28.2016 SIGNED DATE 1144462011

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO COVERED/EXEMPT PROGRAM ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests the payment to me and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any inquiry to release to Medicare medical and nonmedical information and certifies the person has employer group health insurance, liability, life, auto, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a). If Item 8 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if it is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain utilization in the Uniform Services. Information on the patient's sponsor should be provided in above items captioned as "Insurer", i.e., Items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to compensate the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedures and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

I submit this claim for payment from Federal funds. I certify that: 1) the information in this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program requirements, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-Kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering such service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's services, 3) they must be of little or no value furnished in physician's office and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I (or my employee) who rendered services, am not a active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government, either civilian or military (under 5 USC 5339). For Black Lung claims, I further certify that the services performed were for a Black Lung-eligible claimant.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any oral or written representation or false or misleading information or income statement or income payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal or state laws.

NOTICE TO PAYMENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OASFC to collect your information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(w), 1822, 1872 and 1674 of the Social Security Act as amended, 42 CFR 411.26(a) and 426(d)(6) (b), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 8101 et seq, am 30 USC 901 et seq, 34 USC 613, E.O. 13379.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, promotorships, individual health boards, health plans and other organizations or Federal agencies for the effective administration of Federal programs that require other health care programs to pay money to Federal programs and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-00-TC01 titled "Center for Medicare Claims Review" published in the Federal Register, Vol. 53 No. 177, page 37510, Wed Sept 12, 1990, as updated and republished.

FOR OASFC CLAIMS: Department of Labor, Privacy Act of 1974, "Reproduction of Notice of System of Records," Federal Register Vol. 55 No. 49, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies rendered are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory authority and responsibilities under TRICARE/Title 37 PA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recuperant claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, or entities relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and end of criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or phone number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1120B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for the claim, submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: The is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0638-1197. The time required to complete the information collection is estimated to average 10 minutes per response, including the time in review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21244-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

06 03 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14203
 Office: (716) 725-0284 Fax: (716) 725-0265

Client Name: Danielle Hanwell Date: 5/27/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Score
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client to rechedule Sxs into GLE's L/R.

Client felt the same pattern working on leggates.

No improvement by this session.

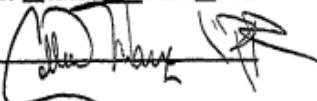
Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14203
 Office: (716) 725-0284 Fax: (716) 725-0265

Client Name: Danielle Hanwell Date: 5/27/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Score
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client repeats improvement in cervical & ROM.

Shoulder still pain radiating down arm.

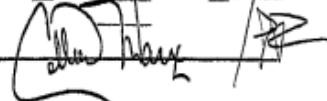
LBP ↑ lately for no apparent reason & radiates

Action's Applied: (Check All that Apply) Sxs - TRPs remain in
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage All central thoracic
 Deep Tissue Massage Myofascial Release Friction musculature.
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:



Form
 (Rev. December 2014)
 Department of the Treasury
 Internal Revenue Service

W-9

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Colleen J. Marx

2 Business name/dispersed entity name, if different from above

Great Lakes Therapeutic Massage + Bodywork Practitioners

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:

Individual/sole proprietor or C Corporation S Corporation Partnership Trust/estate

United liability company. Enter the tax classification (D=C corporation, S=S corporation, P=partnership) ►

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

Other (see instructions) ►

5 Address (number, street, and apt. or suite no.)

375 Dick Road, Suite #2

Requester's name and address (optional)

6 City, state, and ZIP code

Deerpark, New York 14043

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			-				
--	--	--	---	--	--	--	--

or

Employer identification number

4	7	-	0	9	8	9	4	1	9
---	---	---	---	---	---	---	---	---	---

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions: You must cross out Item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, Item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

**Sign
Here**

Signature of
U.S. person

Colleen J. Marx

Date ► 05-20-2016

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/w9.

Purpose of Form

An individual or entity (Form W-9 requested) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-G (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).

2. Certify that you are not subject to backup withholding.

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See What is FATCA reporting? on page 2 for further information.

06 03 16

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2, Depew, NY 14043

P: 716-725-0264 F: 716-725-0265

~ Hours By Appointment Only ~

- Private Pay - No-Fault - Worker's Compensation - Some Insurance Plans Accepted -

May 21, 2016

To Whom It May Concern:

Please note, *effective immediately* our practice will begin using our IRS assigned EIN:

47 - 0989449

Additionally, *ALL* previous addresses in your system for Colleen J. Marx, LMT (tax ID: 099606323) should be deleted.

The *only address* for use should be:

Great Lakes Therapeutic Massage

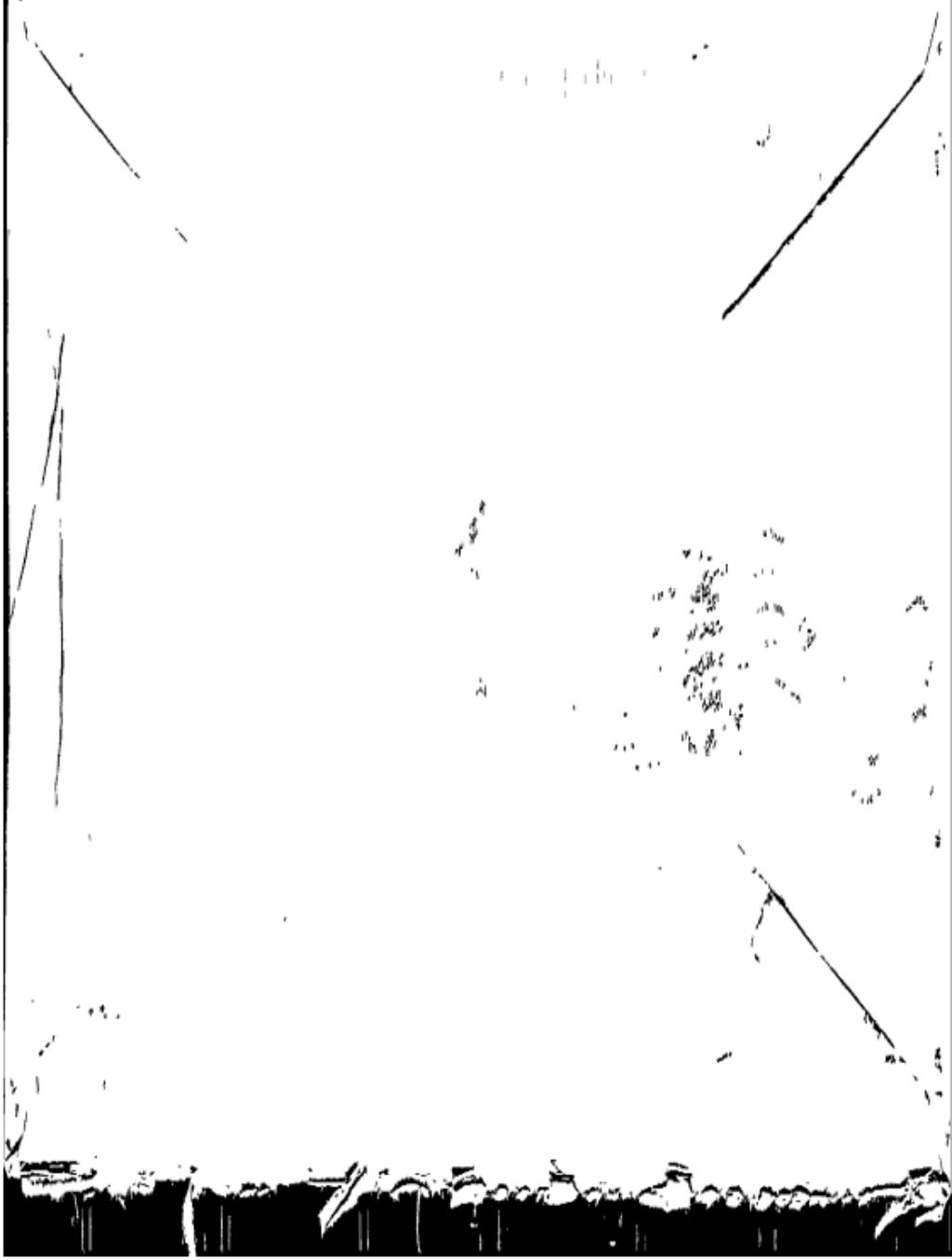
375 Dick Road

Suite #2

Depew, NY 14043

Thank you for your assistance with this change.

060316



06 03 16

22403-952607

FREDERICKSBURG, VA 22403

P.O. BOX 9507

GEICO INS CO of NY

Great Lakes Therapeutic Massage
Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14243



GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

IPIA

PICA

1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		PECA BENEFITS		OTHER		1a INSURED'S I.D. NUMBER		(For Program in Boxes 1)															
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> (Medicare & Medicaid)		<input type="checkbox"/> Member ID#		<input type="checkbox"/> (DOD)		<input type="checkbox"/> (DOD)		<input type="checkbox"/> (DOD)		013873940 0101059																	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)												3 PATIENT'S BIRTH DATE		SEX		4 INSURED'S NAME (Last Name, First Name, Middle Initial)															
HARWELL DANIELLE												MM DD YY		<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		HARWELL DANIELLE															
5 PATIENT'S ADDRESS (No., Street)												6 PATIENT RELATIONSHIP TO INSURED																			
1131 CLEVELAND DRIVE												<input checked="" type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child		<input type="checkbox"/> Other		7 INSURED'S ADDRESS (No., Street)											
CITY		STATE		ZIP CODE		TELEPHONE (Include Area Code)		8 RESERVED FOR NUCC USE		CITY		STATE		AMHERST		NY															
CHEEKERTOWAGA		NY		14225		(716) 536 0951				14228						(716) 536 0951															
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO																			
												a. EMPLOYMENT? (Current or Previous)																			
												<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH															
												MM DD YY		<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		b. OTHER CLAIM ID (Designated by NUCC)															
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT?																			
												<input checked="" type="checkbox"/> YES		<input type="checkbox"/> NO		c. OTHER ACCIDENT?															
												<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME															
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d CLAIM CODES (Designated by NUCC)																			
												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																			
												<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO		e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete Items 9, 9a, and 9d															
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below																			
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below												14 SIGNED SIGNATURE ON FILE DATE																			
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14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)												16 OTHER DATE		MM DD YY		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION															
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17 NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. _____		17b. NPI		MM DD YY		MM DD YY		MM DD YY											
18 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19 OUTSIDE LAB?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		S CHARGES															
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))												ICD IND		O		22 RESUBMISSION CODE		ORIGINAL REF. NO.													
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E I82.3 XXXA		F M99.01		G M99.03		H M99.02																									
I M99.05		J IM54.2		K M54.5		L M54.6																									
24 A DATE(S) OF SERVICE		B PLACE OF SERVICE		C		D PROCEDURES, SERVICES, OR SUPPLIES (Specify Universal Categorizations)		E MODIFIER		F		G DAYS OR UNITS		H PAY PER UNIT		I L ID QMUL		J RENDERING PROVIDER ID #													
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364500165		<input type="checkbox"/> <input checked="" type="checkbox"/>		343821219		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 42.81		\$																					
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <i>(Verify that the statements on the reverse side to this bill and are made a part thereof.)</i>												32 SERVICE FACILITY LOCATION INFORMATION																			
PETER GUZINSKI DC												CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849																			
33 BILLING PROVIDER INFO & PH#												(716) 681-3333																			
												CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849																			
SIGNED 05272016 DATE 1235256546												1235256546																			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
May 27, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday May 12, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain continues to remain the same. Patient waiting to get her TMJ MRI results. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, tingling, shooting, numb; level: 4/10. **Pain is constant.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving, lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also continues to experience headaches. The headaches are now every other day for the past week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she denies any nausea. In addition, light aggravates her headaches. **Recent medical treatment for this condition:** None. **Changes in past medical history:** Yes: patient had a chest x-ray and blood work performed.

Thoracic: Patient stated that her middle back pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, shooting; level: 5/10. **Pain is constant.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, shooting, tingling, numb; level: 3/10. **Pain is constant.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain

Encounter dated 05/12/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/27/2016

with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Sensation:** left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident.

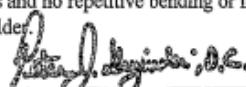
Lumbar assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet

Encounter dated 05/12/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/27/2016

arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 1 week; Re-examination for 1 week. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

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Item# 43568
Patent Pending



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INCLING 01114
C 110 O D R C T T C
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

IPIGA

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PIGA

1 MEDICARE <input type="checkbox"/> Medicare	2 MEDICAID <input type="checkbox"/> Medicaid	3 TRICARE <input type="checkbox"/> (DOD/DIA)	4 CHAMPVA <input type="checkbox"/> (Member ID)	5 GROUP HEALTH PLAN <input type="checkbox"/> (DOI) <input type="checkbox"/> (DOD)	6 PEC (PECA) <input type="checkbox"/> (DOI)	7 OTHER <input type="checkbox"/> (DOI)	8a INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			3. PATIENT'S BIRTH DATE MM DD YY 08291980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT	
CITY CHEEKETOWAGA	STATE NY	8 RESERVED FOR NUCC USE			CITY AMHERST	STATE NY	9 ZIP CODE 14225 TELEPHONE (Include Area Code) (716) 536 0951	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR PECAN NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 08291980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) b. OTHER INSURED'S POLICY OR GROUP NUMBER c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO	
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items B, Bn, and Bd.		
14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE DATE								
15. OTHER DATE MM DD YY 103115			16. OTHER DATE MM DD YY 454			17. PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24)) ICD IND A. M50.22 B. M51.26 C. M51.27 D. M54.12 E. I52.3 XXXA F. M99.01 G. M99.03 H. M99.02 I. M99.05 J. M54.2 K. M54.5 L. M54.6		
22. RESUBMISSION CODE						23. PRIOR AUTHORIZATION NUMBER		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 05232016 05232016			B. PLACER OF SERVICE EMR 11			C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 98941		
E. MODIFIER			F. MODIFIER			G. DAYS OR UNITS H. BILLS IN PAY PER UNIT I. ID QUAL L. RENDERING PROVIDER ID #		
25. FEDERAL TAX ID NUMBER 364500165			26. TOTAL CHARGE 32 28 1			27. AMOUNT PAID NPI 1710014188		
28. PATIENT'S ACCOUNT NO 343821220			29. ACCEPT ASSIGNMENT? I. AMV II. SVA III. SVA IV. SVA YES			30. Reserved for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to my bill and no one else made a copy thereof.) PETER GUZINSKI DC			32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849		
SIGNED 06022016 DATE 1235256546						1235256546		

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Item# 43568
Patent Pending



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345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PIRA

PIRA

1. MEDICARE <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (VA/DoD) <input type="checkbox"/> (Member ID#)	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	3. GROUP HEALTH PLAN <input type="checkbox"/> (HMO) <input type="checkbox"/> (PPO) <input type="checkbox"/> (POS) <input type="checkbox"/> (EVN) OTHER	4. INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)	
5. PATIENT'S ADDRESS (No., Street) 11131 CLEVELAND DRIVE		6. PATIENT'S BIRTH DATE MM DD YY 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	7. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	8. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY CHEEKERTOWAGA	STATE NY	9. RESERVED FOR NUCC USE		CITY AMHERST	STATE NY
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951	10. IS PATIENT'S CONDITION RELATED TO: a. OTHER INSURED'S POLICY OR GROUP NUMBER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR PICA NUMBER 14228	TELEPHONE (Include Area Code) (716) 536 0951
b. RESERVED FOR NUCC USE		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. INSURED'S DATE OF BIRTH MM DD YY 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		e. INSURANCE PLAN NAME OR PROGRAM NAME GEICO	f. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					
13. SIGNED SIGNATURE ON FILE			14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 GUAL 431		
15. OTHER DATE MM DD YY 454			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY 111215 FROM <input type="checkbox"/> TO <input type="checkbox"/>		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <input type="checkbox"/> TO <input type="checkbox"/>		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) A. M50.22 B. M51.26 C. M51.27 D. M54.12 E. I52.3 XXXA F. M99.01 G. M99.03 H. M99.02 I. M99.05 J. M54.2 K. M54.5 L. M54.6					
22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER					
24. a. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service E/M b. c. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. d. MODIFIER DIAGNOSIS FINGER S. CHARGES G. CHGS O. CHGS H. CHGS I. CHGS L. ID J. RENDERING PROVIDER ID #					
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2. 05262016	05262016	11	98941	1	ABCD
3. 05262016	05262016	11	97010	1	ABCD
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25. FEDERAL TAX ID NUMBER SSN BN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> (For Non-Career See Below) <input type="checkbox"/> NO					
28. TOTAL CHARGE \$ 63.10 29. AMOUNT PAID 30. Paid for NUCC Use 					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am responsible for them.) PETER GUZINSKI DC					
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849					
33. BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849					
34. SIGNED 06022016 DATE 1235256546 b. 1235256546 b.					

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
June 2, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday May 26, 2016 Provider: Peter Guzinski DC RE-EXAM

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle* driver. *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she has moderate headaches which come infrequently, she can do most of her usual work, but no more, she has a fair degree of difficulty concentrating and her normal sleep has been moderately disturbed (1-2 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Cervical Disability Index:* 34%. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activites of daily living. *Alleviates symptoms:* nothing.

Encounter dated 05/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/02/2016

Numbness: none. *Weakness:* none. *Oswestry score:* 24%. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. Due to the pain, she is unable to sit greater than 60 minutes and she is only able to sleep comfortably for 6 hours. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, shooting, tingling, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 24%. *The Keele STaRt Back Screening Tool:* Low risk. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Activity of Daily Living Form Bathing/Showering: mild impairment; Bending forward/backward: moderate impairment; Driving: moderate impairment; Drying Hair: mild impairment; Household chores: moderate impairment; Laundry: moderate impairment; Lifting less than 10 lbs: mild impairment; Lifting more than 10 lbs: moderate impairment; Kneeling: moderate impairment; Making Meals: mild impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: severe impairment; Restful night's sleep: moderate impairment; Seated to standing position: mild impairment; Sexual activity: moderate impairment; Standing: mild impairment; Squatting: moderate impairment; Tying shoes: mild impairment; Using lavatory: mild impairment; Walking: mild impairment.

Objective

Physical exam: Ht: 5' 3" Wt: 150lbs. BMI: 26.6 Never smoker Temp: 99.0 BP (left): 103/70 Pulse (left/resting): 83.

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* foward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck; right shoulder depression: Negative for right lower neck pain; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:*

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DOB:08/29/1980 Today's date: 06/02/2016

bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* all lower extremity sensory exams (L1-S1) were WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Reflexes:* bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Ely's Heel to Buttock: Negative bilateral; Minor's sign: Negative; Nachlas: Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Hibbs test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-evaluation on March 19, 2016 her VAS score improved from a 5 to 3 out of 10 and she is able to sleep 1 to 2 hours longer with less pain. In addition, her active left cervical rotation improved from 50 to 70 degrees and her left deltoid was stronger and graded 5/5. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADLs. **Diagnosis:** M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** improving, VAS score improved from a 5 to 3 out of 10 and her pain is no longer frequent but now occasional.

Lumbar assessment: Mrs. Harwell has made favorable improvement with chiropractic treatment since her initial evaluation on November 12, 2015. Her VAS score improved from 7 to 4 out of 10 and her pain is no longer constant but now frequent. In addition, since her last re-evaluation on March 19, 2016 she is now able to sleep 2 hours longer with less pain and her left L5 dermatome is now WNL. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to reach, sit and lift with less pain. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy

Encounter dated 05/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/02/2016

and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
June 2, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday May 23, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck pain remains the same. Patient waiting to get her TMJ MRI results. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, tingling, shooting, numb; level: 4/10. **Pain is constant.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also continues to experience headaches. The headaches are now every other day for the past week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she denies any nausea. In addition, light aggravates her headaches. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Thoracic: Patient stated that her middle back pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, shooting; level: 5/10. **Pain is constant.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back has been sore. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, soreness, shooting, tingling, numb; level: 4/10. **Pain is constant.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with no pain

Encounter dated 05/23/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/02/2016

with pain; left rotation: 50/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate to Severe; cervical paraspinal musculature Left Moderate to Severe; scalene Left Moderate to Severe; sternocleidomastoid Left Moderate to Severe; pectoralis minor Left Moderate to Severe; cervical paraspinal musculature Right Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Sensation:** left L5 decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Thoracic assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident.

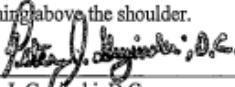
Lumbar assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet

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DOB:08/29/1980 Today's date: 06/02/2016

arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 1 week; Re-examination for 1 week. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (anterior); T9 (anterior); L4 (manual traction); L5 (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal myofascial release with china gel; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA																
1 MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TRICARE <input type="checkbox"/> (DOD/DoD)	CHAMPVA <input type="checkbox"/> (Member/ID)	GROUP HEALTH PLAN <input type="checkbox"/> (GHP)	FEPA EXCLUDING <input type="checkbox"/> (EX)	OTHER <input type="checkbox"/> (ADM)	1a INSURED'S LD. NUMBER 013873940-0101-059									
1b INSURED'S LD. NUMBER (For Program in Item 1)																
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) BARNELL, DANIRLE							3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980	SIX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4 INSURED'S NAME (Last Name, First Name, Middle Initial) - same -							
5 PATIENT'S ADDRESS (No., Street) 56 BERZEAVEN DR							6 PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other									
CITY AMHERST	STATE NY	8 RESERVED FOR NUCC USE X					CITY	STATE								
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951						ZIP CODE	TELEPHONE (Include Area Code) ()								
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10 IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER							a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. INSURED'S DATE OF BIRTH MM DD YY M 01 00								
b. RESERVED FOR NUCC USE							b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	PLACE (BINS) NY	c. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	d. INSURANCE PLAN NAME OR PROGRAM NAME								
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d CLAIM CODES (Designated by NUCC)									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							11. INSURED'S POLICY GROUP OR FECA NUMBER									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below							12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below									
SIGNED - ON 01-06-2016							SIGNED - ON 01-06-2016									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 2015							15. OTHER DATE QUAL MM DD YY 10 31 2015					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY FROM 10 31 2015 TO 10 31 2015				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a HOVIGE, JENNIFER, M.D.							17b NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 10 31 2015 TO 10 31 2015				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD 9c A I944.309 B L C L D L E L F L G L H L I L J L K L L L				
22. RESUBMISSION CODE							23. PRIOR AUTHORIZATION NUMBER					24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY 05 31 15 To 05 31 16				
B PLACE OF SERVICE EWS DEPew							C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 97140					D MODIFIER A				
E DIAGNOSIS CODE I944.309							F. CHARGES G. DAYS H. PROCT I. ID J. RENDERING PROVIDER ID #					K. CHARGES L. DAYS M. PROCT N. ID O. RENDERING PROVIDER ID #				
25. FEDERAL TAX ID NUMBER 47-0989449							26. PATIENT'S ACCOUNT NO BARNELL, D					27. ACCEPT ASSIGNMENT? For gov. claim, see back <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
28. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							29. TOTAL CHARGE \$ 110.00					30. AMOUNT PAID \$ 0.00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMFT							32. BILLING PROVIDER INFO & PH # 716 725-0264									
SIGNED 06.02.2016							DATE 9144462011					33. AMOUNT PAID \$ 110.00				

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PAYMENT ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requires that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical records and medical information and whether the person has employer group health insurance, liability no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participant cases, the physician agrees to accept the charge determined by the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's spouse should be provided in those items captioned in "Insured" i.e., items 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payments including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional services by my employee under my direct supervision, except as otherwise expressly authorized by Medicare or TRICARE; 6) for each service rendered incident to my professional services, the physician (legal name and NPI license #, or BSN) of the primary individual whose care service is reported in the designated section. For services to be considered "incident to" a physician's professional services: 1) they must be rendered under the physician's direct supervision by health care employees, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physician must be included on the physician's bills.

For TRICARE claims, I further certify that I [or any employee] who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 9338). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 203(a), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.24(a) and 424.50(a) (6), and 44 USC 3101, 41 CFR 101-1 et seq and 10 USC 1079 and 1085; 5 USC 8101 et seq, and 30 USC 901 et seq; 36 USC 813; E.O. 13987.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37340, Wed, Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-5, ESA-8, ESA-12, ESA-13, ESA-39, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collector agencies, and consumer reporting agencies in connection with recompence claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosure may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, or makers relating to entitlement claims administration, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits and civil and criminal litigation related to the operation of TRICARE.

DISCLAIMERS: Voluntary however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount rendered would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," causes the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to document fully the extent of services provided to individuals under the State Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State Agency or Dept. of Health and Human Services which request.

I further agree to accept as payment in full the amounts payable by the Medicaid program for those claims on a risk basis for payment under that program, with the exception of insurance or other third party coverage, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

06 09 16

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2, Depew, NY 14043

P: 716-725-0264 F: 716-725-0265

- Hours By Appointment Only -

- Private Pay - No-Fault - Worker's Compensation - Some Insurance Plans Accepted -

May 21, 2016

To Whom It May Concern:

Please note, *effective immediately* our practice will begin using our IRS assigned EIN:

47 - 0989449

Additionally, *ALL* previous addresses in your system for Colleen J. Marx, LMT (tax ID: 099606323) should be deleted.

The *only* address for use should be:

Great Lakes Therapeutic Massage

375 Dick Road

Suite #2

Depew, NY 14043

Thank you for your assistance with this change.

06 09 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14205
 Office: (716) 725-0324 Fax: (716) 725-0355

Client Name: Danielle Howell Date: 5-31-16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 (8) 10 (restricting/continuous pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obligues ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client of 10 yrs. Scapular border over the weekend. LBL continues what appears to be a rotated pelvis causing leg length discrepancy.

Action's Applied: (Check All that Apply) Old PT to talk to client
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion today.
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Can't Meds Ice / Heat

Therapist:

Mel Max

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14205
 Office: (716) 725-0324 Fax: (716) 725-0355

Client Name: Danielle Howell Date: 6/2/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 (8) 10 (restricting/continuous pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obligues ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client continues to Scapular border

Causing difficulty to ADL's & sleeping.

TRT noted in Shoulder & neck regions.

Action's Applied: (Check All that Apply) Client

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Can't Meds Ice / Heat

Therapist:

Mel Max

Form W-9
 (Rev. December 2014)
 Department of the Treasury
 Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 3

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

Colleen J. Marx

2 Business name (disregarded entity name, if different from above).

Great Lakes Therapeutic Massage & Bodywork Practitioners

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:

- Individual/sole proprietor or C Corporation S Corporation Partnership Trust/estate

single-member LLC

- Limited liability company. Enter the tax classification (D=C corporation, S=S corporation, P=partnership) ►

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

- Other (see instructions) ►

5 Address (number, street, and apt. or suite no.)

375 Dick Rd. Suite #2

Requester's name and address (optional)

6 City, state, and ZIP code

Dickson, MI 48043

7 List account number(s) here (if applicable)

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exempt from FATCA reporting code (if any) _____

(Applies to exempt individuals only in the U.S.)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I Instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number		
	-	
	-	

or

Employer identification number			
4	7	-	09894499

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fac.

Purpose of Form

An individual or entity (Form W-9 requestor) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1090-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)

Date ►

May 30, 2016

• Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)

• Form 1099-C (canceled debt)

• Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See What is FATCA reporting? on page 2 for further information.

06-09 16

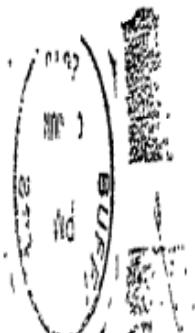
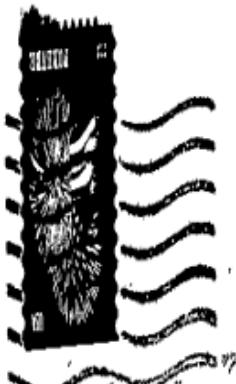
060916

2240985526 3066

66403

Clydeburg, VA

P.O. Box 960
6310-NY-00139



Great Lakes Therapeutic Massage
375 Dick Road, Suite #2
Colleen Mart, LMT
Buffalo, NY 14243

06 10 16

MILLARD FILLMORE SUBURBAN
1540 MAPLE ROAD
WLMSSVILLE, NY 142213647MILLARD FILLMORE SUBURBAN
PO BOX 8000 DEPT 042
BUFFALO, NY 142670002
2168597200

3890065-7

41000780250

0131

HARWELL, DANIELLE

CHEEKTOWAGA

1131 CLEVELAND DR.

NY 14225

98291980.E 050116

01

02 103115 11 103115 35 032316

*GEICO
GEICO
PO BOX 9507
FREDERICKSBURG, VA 224039526

45 8.00 50 7.00

ITEM #	ITEM DESCRIPTION	ITEM PRICE/LINE ITEM/ITEM CODE	DISCOUNT AMT	SELLING UNIT	DISCOUNT %	ITEM QUANTITY	ITEM QUANTITY %
0420	PHYSICAL THERP	97140GP	050416	1	110 04		
0420	PHYSICAL THERP	97010GP	050416	1	25 26		
0420	PHYSICAL THERP	97110GP	050416	1	117 25		
0420	PHYSICAL THERP	97110GP	051816	1	117 25		
0420	PHYSICAL THERP	97010GP	051816	1	25 26		
0420	PHYSICAL THERP	97140GP	051816	1	110 04		
0420	PHYSICAL THERP	97140GP	052516	1	110 04		
0420	PHYSICAL THERP	97010GP	052516	1	25 26		
0420	PHYSICAL THERP	97110GP	052516	1	117 25		

PLEASE PROCESS IN ACCORDANCE WITH
WORKERS COMPENSATION
NO FAULT FEE SCHEDULEMEDICAL RECORDS TO
FOLLOW

0001 PAGE 1 OF 1

CREATION DATE

060616 10:14:58

757 65

1053441907
215.64 161533232
15HARWELL, DANIELLE
HARWELL, DANIELLE18 0138739400101059
18 DBD16761Q00

600008

M5412 M7552

APARTMENT NUMBER	UNIT NUMBER	TYPE	STATUS
103	103	103	103

1447262209

OSTEMPOWSKI

MICHAEL

LAST

FIRST

MID

LNU

AGE

LNU

CHILD

LNU

LAST

LNU

FIRST

LNU

RMWPT

4B3 282N00000X

061016

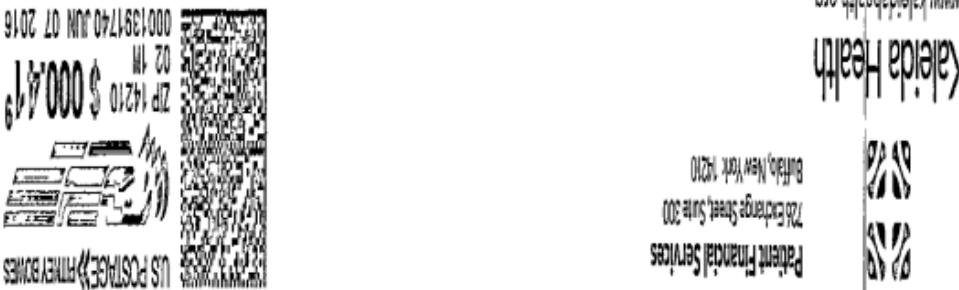
06 10 16

22403



Kaleida Health
www.kaleideahospital.org

Patent Financial Services
76 Exchange Street, Suite 300
Buffalo, New York 14210
ZIP 14210 \$ 000419



UB-4K NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT IT IS A VIOLATION OF FEDERAL LAW TO FURNISH ANY INFORMATION AS REQUESTED IN THIS FORM WHICH IS NOT TRUE AND ACCURATE. CIVIL MONETARY PENALTIES ARE ASSESSED UP TO \$10,000 FOR EACH FALSE STATEMENT OR MISSTATEMENT MADE IN THIS FORM.

Submission of this claim constitutes certification that the billing information as shown on this face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill.

- 1 If third party benefits are indicated, the appropriate assignments by the insurer, beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
 2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
 - 3 Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
 - 4 For Religious Non-medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
 - 5 Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1395I, 42 CFR 424.36, 10 UGC 1071 through 1088, 32 CFR 199) and any other applicable contractual regulations, is on file.
 - 6 The provider of care, submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
 7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and has/could/wants information about his/her claim related to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare instead of insurance, information including employment, age, and whether the person has employer group health insurance which is responsible to pay for the services to which the Medicare claim applies.

8. For Mearud purposes, The subscriber understands that because payment and satisfaction of this claim will be from Federal and State funds any false statements, documents, or representations it is making to us, are subject to prosecution under applicable Federal or State Law.

- e. For TBIGC:5E Purposes:

- (c) This information on the use of this item is true, accurate and complete to the best of my knowledge and belief and services we ~ medically necessary and appropriate for the health of the patient.

KALEIDA
HEALTH

- Buffalo General Hospital
- DeGraff Memorial Hospital
- Millard Fillmore Gates Circle Hospital
- Millard Fillmore Suburban Hospital
- Women & Children's Hospital of Buffalo
- Others:



PT- 3890065
AGE- 035Y SEX- F
ATT- REFERRING DOC
PCP- PANZARELLA JAMES J
FD- THP R ADM DT- 03/23/16
MILLARD FILLMORE SUBURBAN

NF

FACE SHEET 1 of 1

MEDICAL RECORD NO 1000780250	PATIENT NUMBER 3890065	PATIENT NAME (LAST, FIRST, MIDDLE) HARWELL DANIELLE		BIRTH DATE 08/29/80	LOCATION RMWPT	ROOM NO BED 035Y					
STREET ADDRESS, CITY, STATE, ZIP CODE 56 BEREHAVEN DR LEFT			COUNTY 14	SOCIAL SECURITY NO. NOT DISPLAYED	BIRTH DATE 08/29/80	AGE 035Y					
SEX MAR STAT F M	RACE W	RELIGION CRI	ADMIT TYPE PHYS THERA	ADMIT PRIORITY ELECTIVE	ADMIT SOURCE NONHLT FAC	HPI/P Y	MODE OF ARRIVAL	ADMIT DATE 03/23/16	ADMIT TIME 09:10		
HEALTH CARE AGENT			LASBLEP 001	ENGLISH				VIP			
PRIOR STAY LOCATION	PRIOR STAY DATES		HOME PHONE 716-536-0951	ALTERNATE PHONE 716-536-0951	HOSPICE N	HL CONSENT Y	ORGAN DONOR N	VISIT TYPE R			
ATTENDING PHYSICIAN REFERRING DOCTOR	REFERRED PHYSICIAN OSTEMPOWSKI MICHAEL J				ADMIT BY (LOGIN ID) dmrn172		RECEIVED BILL OF RIGHTS? YES				
PRIMARY CARE PROVIDER PANZARELLA JAMES J	STREET ADDRESS, CITY, STATE, ZIP CODE TONAWANDA				OFFICE PHONE 716-833-2200	OFFICE FAX 716-332-0797					
EMERGENCY CONTACT 1 SHAWN HARWELL	REL SPOUSE	HOME PHONE --	WORK PHONE --	CELL PHONE 716-604-7208	PAGER NUMBER --						
EMERGENCY CONTACT 2 DIANE TOTARO	REL PARENT	HOME PHONE --	WORK PHONE --	CELL PHONE 716-507-4308	PAGER NUMBER --						
ADMITTING DIAGNOSIS (CODE & VERBAGE) IM5412 RADICULOPATHY CERVICAL REGION			chief complaint CURTIS CERVICAL/SHOULDER								
LAST NAME, FIRST, MI HARWELL, DANIELLE,			STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTY 56 BEREHAVEN DR LEFT SIDE		W AMHERST, NY 142280000			GUARANTOR			
SOCIAL SECURITY NO. NOT DISPLAYED	TELEPHONE NUMBER 716-536-0951		RELATIONSHIP OF GUARANTOR SELF		EMPLOYER		EMPLOYER TELEPHONE NUMBER --				
COMMENTS										SMOKING CESSATION INFORMATION PROVIDED TO PATIENT/CAREGIVER: YES	
INSURANCE CARRIER NO FAULT	PLAN NAME GEICO		CERTIFICATE/POLICY NO 0138739400101059			SECOND POLICY NUMBER		EFFECTIVE DATE 10/31/2015			
INSURED NAME DANIELLE HARWELL	DATE OF BIRTH 08/29/1980		REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER					
INSURANCE CARRIER IHA GOVT PROGRAMS	PLAN NAME MEDISOURCE		CERTIFICATE/POLICY NO DBD16761Q00			SECOND POLICY NUMBER		EFFECTIVE DATE //			
INSURED NAME DANIELLE HARWELL	DATE OF BIRTH 08/29/1980		REL TO PT 1	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER					
INSURANCE CARRIER	PLAN NAME SELF PAY		CERTIFICATE/POLICY NO			SECOND POLICY NUMBER		EFFECTIVE DATE			
INSURED NAME	DATE OF BIRTH		REL TO PT 1	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER					
INSURANCE CARRIER	PLAN NAME		CERTIFICATE/POLICY NO			SECOND POLICY NUMBER		EFFECTIVE DATE			
INSURED NAME	DATE OF BIRTH		REL TO PT	ACC (Y/N)	DATE OF ACCIDENT	AUTHORIZATION NUMBER					
ISOLATION INDICATOR 1	ISOLATION INDICATOR 2	ISOLATION INDICATOR 3	ISOLATION INDICATOR 4		ISOLATION INDICATOR 5		ISOLATION INDICATOR 6				
PRINCIPAL DIAGNOSIS											
SECONDARY DIAGNOSIS											
PROCEDURES											
ATTENDING PHYSICIAN				DATE							



ATTENDING PHYSICIAN

DATE

INS. NO. 1 INS. NO. 2 INS. NO. 3

Kaleida Health

BUFF THERAPY SERVICES
705 Main Street, Williamsville, NY 14211
Phone (716) 650-7269 • Fax (716) 650-7298

DEGRAFF THERAPY SERVICES
415 Tonawanda Street, North Tonawanda, NY 14210
Phone (716) 655-2051 • Fax (716) 655-2190

HARWELL, DANIELLE

MR- 1000780250

PT- 3890065

DOB-08/29/80

AGE-35Y

SEX-F

ATT- REFERRING DOC

PCP-PANARELLA JAMES

FC-

THP

R

ADM DT- 03/23/16

MILLARD FILLMORE SUBURBAN

Patient ID Area

DAILY PROGRESS NOTE

*Billing Guidelines For Medicare (CCI edits hi-lited) 1 unit = 8-23 2 units = 24-38 3 units = 39-53 4 units = 54-68 5 units = 69-82 minutes
Cancel if unit less than 8 minutes. For other payers use CPT 15 rule for timed services (T) where each 15 min = 1 unit

Date	Visit #	Start	Stop	Total Time	Treatment Provided	MIN	UNITS
5/4/16	5	9:45	10:45	60			

SUBJECTIVE: Palpitations (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse

Pt reports taking antibiotics for strep throat and her shoulder has been locking when she hugs people.

OBJECTIVE:

Ther ex as outlined → c/o discomfort & scapular rays.

Performed grade I onaz 2 inferior and posterior GH motor → pt tolerated well and reported d pain during ROM.

ASSESSMENT:

Original Goals achieved 1 2 3 4
 Continue to pursue previous goals

New problem(s)/pt →

Recommends for future treatment →

PRESENT TREATMENT/PLAN: On Exercise/Treatment Card

Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code _____

Goal G-code _____

D/C G-code _____

Date	Visit #	Start	Stop	Total Time	Treatment Provided	MIN	UNITS
5/4/16	5	9:45	10:45	60			

SUBJECTIVE: Palpitations (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse

"Getting better"

OBJECTIVE:

Ther ex as outlined → well tolerated (+) &
Bend low w/ no
lat/post GH glide (R) ↑ ✓ from 100° to 150°

ASSESSMENT:

Original Goals achieved 1 2 3 4

 Continue to pursue previous goals

New problem(s)/pt →

Recommends for future treatment →

PRESENT TREATMENT/PLAN: On Exercise/Treatment Card

Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code _____

Goal G-code _____

D/C G-code _____

Date	Visit #	Start	Stop	Total Time	Treatment Provided	MIN	UNITS
5/4/16	5	9:00	9:55	55			

SUBJECTIVE: Palpitations (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse

"I'M sick again and need to call my doctor today."

OBJECTIVE:

Ther ex as outlined - well tolerated.

Pt. reported pain in ant/lat shoulder pre-treatment → post treatment pain ↓ completely.

ASSESSMENT:

Original Goals achieved 1 2 3 4

 Continue to pursue previous goals

New problem(s)/pt →

Recommends for future treatment →

PRESENT TREATMENT/PLAN: On Exercise/Treatment Card

Education On: home exercise - see copy proper posture/ADL use of home modalities family instruction

Current G-code _____

Goal G-code _____

D/C G-code _____

Date	Visit #	Start	Stop	Total Time	Treatment Provided	MIN	UNITS
5/4/16	5	9:00	9:55	55			

06 23 16



GEICO
P O BOX 9507
FREDERICKSBURG, VA
22403-9526

Express Envelope

06 23 16

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/9/12

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare)		MEDICAID <input type="checkbox"/> (Medicaid)		TRICARE <input type="checkbox"/> (DOD/DoD)		CHAMPVA <input type="checkbox"/> (Member/Dep.)		GROUP HEALTH PLAN <input type="checkbox"/> (NA)		FECA BENEFITS <input type="checkbox"/> (DoD)		OTHER <input type="checkbox"/> (DoD)		1a. INSURED'S I.D. NUMBER 013873940011059		(For Program in Item 1)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08291980				SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE											
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT													
CITY CHEEKERTOWAGA		STATE NY		CITY AMHERST		STATE NY		ZIP CODE 14228		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951		TELEPHONE (Include Area Code) (716) 536 0951															
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER												9. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 08291980													
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)													
c. RESERVED FOR NUCC USE												c. PLACE (State) <input type="checkbox"/> NY				c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO													
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. If yes, complete items 3, 9a, and 9b													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																	
SIGNED SIGNATURE ON FILE												SIGNATURE ON FILE																	
DATE												SIGNED																	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115												15. OTHER DATE MM DD YY 454 111215				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM <input type="checkbox"/> TO <input type="checkbox"/>													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE QVAL 431												17a. MM DD YY 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM <input type="checkbox"/> TO <input type="checkbox"/>													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				21. CHARGES													
																22. RESUBMISSION CODE ORIGINAL REF. NO.													
																23. PRIOR AUTHORIZATION NUMBER													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE EWS		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS		D. DIAGNOSIS CODE NUMBER		E. DIAGNOSIS PONTER		F. \$ CHARGES		G. DAYS OF STAY IN HOSP.		H. SPEND PER DAY		I. ID CLM.		J. RENDERING PROVIDER ID #	
1	06092016	06092016	11	98941						ABCD	32	28	1					NPI	1710014188										
2	06092016	06092016	11	97010						ABCD	10	53	1					NPI	1710014188										
3	06132016	06132016	11	98941						ABCD	32	28	1					NPI	1710014188										
4	06132016	06132016	11	97010						ABCD	10	53	1					NPI	1710014188										
5	06162016	06162016	11	98941						ABCD	32	28	1					NPI	1710014188										
6	06162016	06162016	11	97010						ABCD	10	53	1					NPI	1710014188										
7	06162016	06162016	11	97010						ABCD	32	28	1					NPI	1710014188										
25. FEDERAL TAX I.D. NUMBER 364500165	SSN EN □ □ *	26. PATIENT'S ACCOUNT NO. 3438Z1Z22		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 128.43		29. AMOUNT PAID \$ 128.43		30. Rcvd for NUCC Use																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If copy the statements on the reverse and attach this bill and one receipt to each item.) PETER GOZINSKI DC												32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849				33. BILLING PROVIDER INFO & P.M.# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849													
SIGNED 06272016 DATE 1235256546^b												PLEASE PRINT OR TYPE				APPROVED OMB-0938-1197 FORM 1500 (02-12)													



Item# 43568
Patent Pending





345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22408

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
June 27, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday June 9, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck

Encounter dated 06/09/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/27/2016

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

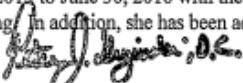
Encounter dated 06/09/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/27/2016

mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (Instrument adjustment Arthrostim); T3 left (Instrument adjustment Arthrostim); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver).

Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Monday June 13, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has been more intense all weekend. She denies any new injuries. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** worse. since last visit. **Pain:** achy, dull, tingling, shooting, numb; level: 6/10. **Pain is:** frequent. **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night**

**Encounter dated 06/13/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/27/2016**

sweats or pain: No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Thoracic: Patient presented today with increased middle back pain as well. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** worse. *since* last visit. **Pain:** achy, dull, shooting; level: 6/10. **Pain is occasional.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. *since* last visit. **Pain:** achy, dull, shooting, tingling, numb; level: 3/10. **Pain is frequent.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Objective

Cervical: **Range of motion:** flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Shepplemans: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower

Encounter dated 06/13/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/27/2016

back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s): L4, L5, Left SI.*
Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: worse, VAS score increased from a 3 to 6 out of 10. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* worse.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program; advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program; advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program; advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and

Encounter dated 06/13/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/27/2016

intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Thursday June 16, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has not been quite as bad, but still present. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain

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neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabre: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** Slight improvement since their last treatment. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** improving.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild

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bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Grzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits
VAS: Visual Analog Scale



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

DOD/OPCA

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

HCA 200X

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BENEFIT		OTHER		1a. INSURED'S ID. NUMBER		(For Program in Item 1)					
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE		MM DD YY		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												6. PATIENT'S RELATIONSHIP TO INSURED		Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR					
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18. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefit to either myself or to the party who originally assigned my claim.												19. i. SIGNATURE ON FILE		DATE: 02 09 16		SIGNED					
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DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Leslie Medsker, MD, Director

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Elizabeth D. Smith, CPNP, ANP
Andrea Ganciak, FNP-C
Christopher Zielinski, FNP-C

Sydney B Grabau, PA

Re-Evaluation
Date: 06/30/2016

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 35 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Patient is here following up for migraines

History of Present Illness

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic reevaluation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a wonderful 35-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at the urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale. The headaches were worse than her baseline. She reported associated sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes, but there are disk extrusions seen at C4-C5 and C5-C6. She did have an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 showed a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8. The remainder of the CBC was within normal limits. CMP, TSH, Vitamin D and Vitamin B12 were within normal limits.

Danielle has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and physical therapy. After initial evaluation, she was started on magnesium oxide, Naprosyn and Rizatriptan. She tried trigger point injections for cervical spasm. She was encouraged to try vestibular therapy in addition to the physical therapy as well.

Danielle returns today with worsening of her symptoms. She continues to have pain in her cervical region and radiating down her left arm. At times, she will experience weakness in her left arm. The patient has continued with physical therapy, but the primary focus of therapy has been on her left shoulder and arm. She states the therapy sessions are quite painful for her. She has continued with regular massage therapy, which has been helpful. In addition to the neck pain, the patient has experienced ongoing dizziness and unsteadiness. She has continued with magnesium oxide daily. She has continued with trigger point injections, which provide temporary relief.

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INFUSION CENTERS
Christina Massi, MBA, Director
Bethesda Nursing, RN, Manager

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) pm headache, up to BID
- Taking nizatidine 10 mg tablet 1 tab(s) pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Not-Taking/PRN Vitamin D2 50,000 int'l units capsule 1 cap(s) 2 times a week
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking: Patient is a. non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illlicit Drugs:

Using illicit drugs: Denies

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro

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 Alice Trzeciak

INFUSION CENTERS

Christina Marr, MBA, Director
 Barbara Mulderig, RN, Manager

Patient: Marwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

Page 3 of 4

- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headaches, dizziness, weakness, numbness, unsteadiness, sleep problems, fatigue, ringing in the ears, joint pain, stiffness, neck pain, muscle aches, asthma, chest pain, palpitations, heartburn, itching, rash and swollen lips No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy

Vital Signs

BP sitting 116/68, HR 72, RR 16, HT 63, WT 150, BMI 26.57, BSA 1.74.

Examination

GENERAL EXAMINATION:

General Appearance: Well-nourished, well-developed, in no apparent distress, participated with the exam. Well groomed. Neck: Trapezius are quite spasmed and tender bilaterally, more so on the left side. Range of motion is limited.. Cardiovascular: peripheral pulses within normal limits. Extremities: Full range of motion of extremities x4. No edema.

NEUROLOGICAL:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Patient is quite unsteady with both Romberg and tandem stance testing. She is unable to maintain her balance.. Sensory: Sensation to touch and cold was intact in all 4 extremities bilaterally.

CRANIAL NERVES:

Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

- Concussion, without loss of consciousness, sequela - S06.0X0S (Primary)
- Myofascial pain - M79.1
- Vestibular dysfunction - H83.2X9
- Cervical radicular pain - M54.12
- Posttraumatic headache - G44.309

Danielle is a 35-year-old female currently under our care for the treatment of postconcussive symptoms, which resulted from motor vehicle accident. The patient continues to struggle with prominent spasm in her cervical region, with radiating symptoms down her left arm. She also reports feeling quite dizzy and unsteady at times. At this point, I encouraged her to initiate physical therapy for the cervical region, as well as vestibular therapy for the dizziness. We will continue with regular trigger point injections. I encouraged her to continue with magnesium oxide daily as well. We discussed trying occipital nerve blocks in the future if her symptoms persist. We also discussed trying Lamictal if therapy is ineffective. We will see the patient back next week for her next round of trigger point injections.

Dr. McVige is the supervising physician on site.

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Patient: Harwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

Page 4 of 4

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Concussion, without loss of consciousness, sequela

Start Lamictal tablet, 25 mg, 1 tab(s), orally, 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID, 30 day(s), 120, Refills 5

2. Myofascial pain

Continue magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day
PHYSICAL THERAPY Cervicalgia1160785

3. Vestibular dysfunction

VESTIBULAR THERAPY1160784

4. Posttraumatic headache

Continue Naprosyn tablet, 500 mg, 1 tab(s), orally, pm headache, up to BID

Continue rizatriptan tablet, 10 mg, 1 tab(s), orally, pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 06/30/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 06/30/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 06/30/2016.

Follow Up

next week triggers

syndrome follow up

S

Electronically signed by Sydney Grabau , PA on 06/30/2016 at 01:29 PM EDT

Sign off status: Completed

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPVA GROUP HEALTH PLAN FECA <small>(Medicare) (Medicaid) (DOD/DoD) (Member/DoD) (FECA) (DOD)</small>												OTHER			1a. INSURED'S ID NUMBER <small>(For Program in Item 1)</small> 013873940-0101-059													
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) BARWELL, DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4 INSURED'S NAME (Last Name, First Name, Middle Initial) - same -										
5 PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR												6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)													
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X			CITY		STATE																			
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE		TELEPHONE (Include Area Code) ()																			
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			11. INSURED'S POLICY GROUP OR FECA NUMBER													
												b AUTO ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> PLACE (State) N.Y.			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>													
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d INSURANCE PLAN NAME OR PROGRAM NAME												10d CLAIM CODES (Designated by NUCC)			c INSURANCE PLAN NAME OR PROGRAM NAME													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNED - ON FILE -												DATE 01-06-2016			SIGNED - ON FILE -													
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 31 2015			15. OTHER DATE QUAL MM DD YY MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA			17a 17b NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LABS YES <input type="checkbox"/> NO			S CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-I to services fee below (24f))												22. RESUBMISSION CODE ORIGINAL REF. NO.																
A M79.1	B	C	D	E	F	G	H	I	J	K	L																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACES OF SERVICE EMR			C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			D. MODIFIER			E. DIAGNOSIS POINTERS			F. S CHARGES	G. DATES OR UNITS	H. RATES PER UNIT	I. ID QUAL	J. RENDERING PROVIDER ID #
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6 07 01 16	07 01 16	11		97140										55 00	3		NPI	1144462011										
25. FEDERAL TAX ID NUMBER 47-0989449			26. PATIENT'S ACCOUNT NO. HARWELL, D			27. ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			28. TOTAL CHARGE \$ 330 00			29. AMOUNT PAID \$ 0 00			30. BALD FOR NUCC USE 330 00													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARX, LMT SIGNED DATE 07.01.2016												32. SERVICE FACILITY LOCATION INFORMATION GRATZ LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043			33. BILLING PROVIDER INFO & PH # 616 725-0264			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043										
NUCC Instruction Manual available at: www.nucc.org												PLEASE PRINT OR TYPE			APPROVED OMB 0938-1197 FORM 1500 (02-12)													

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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בנימוקים של מושבם נתקל בפער

PHYSICAL AND INTRACRANIAL ABNORMALITIES—A neurologist requires that patient's medical and social history as well as any information necessary to precisely the clinical signs observed. He further may require a brief physical examination and complete. In the case of a head injury, the physician may explore any area of the head to rule out life threatening injuries and may require an x-ray of the skull or orbits to explore gross brain tissue damage, fracture, basal skull, or a tumor compressing either intracranial or extracranial structures. The physician may also require a lumbar puncture to rule out meningitis or encephalitis. In the case of a stroke, the physician requires a detailed history as well as a physical examination and may require a CT scan or MRI to rule out hemorrhage or infarction. In the case of a traumatic brain injury, the physician requires a detailed history as well as a physical examination and may require a CT scan or MRI to rule out hemorrhage or infarction.

PLATE LIVESTOCK RECORDS

The panel of experts will review and assess each baseline SCA and its payment model. See Table 1 for a summary of the PEGCA expectations regarding baseline SCA coordination and diagnosis coding, and see

ESTATE PLANNING FOR YOUR RETIREMENT PORTFOLIO: A GUIDE TO THE FUTURE

In September 2012, the government issued its first full budget. I briefly discuss the elements of this budget – tax, revenue, and spending, by 2) the framework of application to us, consumers, and 3) the general measures that will benefit the US consumer. As they would be, the principles and best information reported in other government documents on the impact of the new law and its effects on us, the consumer, are also included. In addition, I provide a brief summary, comprising an overview of the law, its goals and measures and my own personal analysis of the potential impact on us, the consumer. The author is a medical and pharmaceutical law attorney and has been involved in the pharmaceutical industry for over 20 years. She is a member of the American Bar Association and the American Medical Writers Association. She has taught law, medical law, and pharmaceutical law at the University of Florida Levin College of Law, the University of Miami School of Law, and the University of Miami Miller School of Medicine. She has also lectured on pharmaceutical law at the University of Miami Miller School of Medicine, the University of Miami School of Law, and the University of Miami Miller School of Medicine. She has also lectured on pharmaceutical law at the University of Miami Miller School of Medicine, the University of Miami School of Law, and the University of Miami Miller School of Medicine.

For THICARE claims, I further certify that I or my dependents who received services am not active duty members of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government, a U.S. citizen or military polar to U.S.C. § 101. My claim is that the services performed were for a Bona Fide User of THICARE.

No Part B Medicare benefits may be paid unless the form is submitted as required by law, regulations and instructions (72 CFR 621.3(c)).

ACTIVE: *Any new work or service, or addition to an existing one, which is done by anyone except the original contractor, and which is not included in the original contract.*

NOTICE THAT THIS MEANS THE COLLECTION AND USE OF MEDICARE, THROCK, PSCM, AND BLACK LIVING EMPIRICAL (PRIVACY ACT) DATA CHECKS.

We are authorized by DARS, TRICARE, and DODIG to sell for re-enlistment related to the administration of the Uniform TRICARE, FEGL, and Black Lung programs. Anytime a service member is assigned to us, we will provide them with a copy of the DODIG Directive 100-001, DODIG Directive 100-002, and DODIG Directive 100-003.

This file contains VBA code to calculate claims under a life insurance product as used to determine a new database in "Health Valley". It is also used to calculate the sum of the premiums and benefits if all relevant

The mini net meter will be given to the customer of other services, i.e., water, electricity, gas, etc. In case of non-payment of bills, the concerned authority can take action against the customer.

FOR URGENT USE ONLY: Do Not Use the Health Monitoring System No. 00-05001, after "Gloves - Latex Gloves Standard," published in the Federal Register, Vol. 85 No. 177, August 27, 2010.

922 T2M2RS QLTYFLY PRIMTFLE PURPOSEFUL. To evaluate capability for medical care, evaluation by a health insurance agent to issue payment, apply for stabilization or stabilize health insurance plan. This is a one-time application.

PROBLEMS Under Title I of the Small Business Job Protection Act of 1996, tax relief entitlements may be given to the People of Puerto Rico by the Department of Treasury. One of the areas of further grant-making is the Recovery of Online and Local Income Tax.

INTERESTS: Sen. John Barrasso, R-Wyo., pushed for legislation to require companies that sell medical devices to report their sales to the government. The bill would also require manufacturers to provide information about the devices they sell to the government, including how many devices were sold, the price of each device, and the types of medical facilities that purchased them.

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For more information about the University's policies on holding the University liable for damages resulting from your use of the University's facilities, contact the Office of the General Counsel at 303-492-2424 or 303-492-2424.

You should be aware that FCA, requires the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by any or computer means.

INTER-CLASS PATERNITY (PROBLEMS OF IDENTIFICATION)
In full: the extent of services provided by individual units under the
various headings.

Payment by the State Agency or Dept. of Health and Human Services may require payment claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

Government customer credit history charge

NOTICE: This is to advise you that I am a participant in the Uniformed Firefighters Pension Fund and that my contributions will be deducted from my pay by my employer under my present contract.



DENT
NEUROLOGIC INSTITUTE

Dent Neurologic Group LLP

3980 Sheridan Dr, Suite B
Amherst, NY, 142261727
Tel: 716-250-2000 Fax: 716-250-2040

Sydney B Grabau, PA (NPI:1013323740)

Provider Code:

State License No: 017733

Physician Assistant

Patient: Harwell, Danielle**Order Date:** 06/06/2016 04:20 PM**DOB:** 08/29/1980 **Sex:** Female **Phone:** 716-536-0951**Today:** 06/07/2016 09:28 AM**Address:** 1131 Cleveland Dr, Cheektowaga, NY 14225**Primary Insurance Name:****Insurance Address:****Subscriber Number:****Insured Name:** **Address:****DIAGNOSTIC IMAGING:**

Code	Diagnostic Name	Assessment(s)	Notes	Instructions
	MASSAGE Therapy	M79.1, Myofascial pain		

Electronically Signed By: **Sydney B Grabau, PA**

Signature of Patient/Guardian

Patient: Harwell, Danielle DOB: 08/29/1980

Harwell, Danielle
1131 Cleveland Drive
Cheektowaga, NY 14225

H-Phone: (716) -536-0951 DOB :08/29/1980
W-Phone:
C-Phone: Sex :F
Race :Declined to Spec Chart:040516TA
Account:102251

Co#: 86 Policy#: 0138739400101059
NF Geico
PO Box 9507
Fredericksburg, Va 22403

PRIMARY INSURANCE

Insured Name: Danielle Harwell

Group Number:

Plan Name

Expired Date: 00/00/00

Co#: 20 Policy#: DBDI6761Q00
Iha Medisource/Essential
P O Box 9066
Buffalo, NY 14231-9066

SECONDARY INSURANCE

Insured Name: Danielle Harwell

Group Number: 13207

Plan Name

Expired Date: 00/00/00

THERAPY ORDER

Status : Open
Doctor : Cheryl L. Owczarzak, PA-C
Address : 3980A SHERIDAN DRIVE
Address2 : AMHERST, NY 14226-1727
Address3 :
Phone : (716)-218-1000
Therapist:
Address1 :
Address2 :
Phone : Fax:

Ordered Date: 06/07/16

Start Date : 06/07/16

End Date : 07/11/16

Duration : 0

Therapy MASSAGE Frequency AS NEEDED

Diagnosis: I67.89 Other cerebrovascular disease

INSTRUCTIONS

Massage Therapy: Continue Treatment - Cervical, Continue Treatment - Lumbar

Ordering Physician's Signature:

07 05 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

313 Dick Rd Dept, NY 14048

Office: (716) 725-0214

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 6/7/16

Client Status (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports no significant visit 1/2 week ago.
+6 remain restricted + painful. 1 tone w/eff.

C-T-L musculature this session.

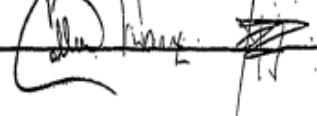
Actions Applied (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners

313 Dick Rd Dept, NY 14048

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 6/14/16

Client Status (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client continues to feel mid to upper back restrictions. No elbow pain in prone position.

Clients rib cage appeared to be shifted as one side

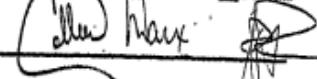
Actions Applied (Check All that Apply) was higher/more rounded

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction Set D/R
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat

Therapist:



07 05 16

Great Lakes Therapeutic Massages & Bodywork Practitioners

375 Clark Rd Dept. NY 14063
Office (716) 725-0324 Fax (716) 725-0363

Client Name: Daniel M. Hanwell Date: 6/17/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunctions: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client continues to complain of cervical

then remains restricted D/S NLR extensor

both arms. Muscle stretching applied to C-T

Action's Applied: (Check All that Apply) Heat/Cold Therapy.

Heat Packs Cold Packs Bombo/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: John Hay Signature

Great Lakes Therapeutic Massages & Bodywork Practitioners

375 Clark Rd Dept. NY 14063
Office (716) 725-0324 Fax (716) 725-0363

Client Name: Daniel M. Hanwell Date: 6/20/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunctions: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client going in a lot of pain today.

No changes in sensitivity this session.

Aches/pains present in C-T muscle/tissue area.

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Bombo/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: John Hay Signature

07 05 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0655

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0355

Client Name: Danielle Howell Date: 6/28/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/confining pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client of a ↑ Cervical/thoracic/lumbar off

↑ activity over the weekend. No D/L shr shr pain.

Hyperirritability remains through all C-T-L musculature

Action's Applied: (Check All that Apply) esp in W/LS/Rhombo

- Heat Packs Cold Packs Combra/Biofreeze
 Light Pressure Massage Mod Pressure Massage areas.
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Melissa MayClient Name: Danielle Howell Date: 7/1/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/confining pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunctions: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client report being very sore + restricted

today. Saw MD @ DENT; Doing P.T. continue w/

M.T. & chiro. No physical therapy for this reason.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Combra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Melissa May

07 05 16

07 05 16

07/05/16

FREDERICKSBURG VA 22403-9527

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Great Lakes Therapeutic Massage
375 Dixie Road, Suite #2
De Pere, WI 54143
Attn: C. Myers

07 11 16

MILLARD FILLMORE SUBURBAN MILLARD FILLMORE SUBURBAN 3890065-10
1540 MAPLE ROAD PO BOX 8000 DEPT 042 1000780250 0133
WLMSSVILLE, NY 142213647 BUFFALO, NY 142670002 5100 VAR NO
7168597200 161533232 060116 [062916]

H H 1131 CLEVELAND DR.
HARWELL, DANIELLE CHEEKTOWAGA NY 14225
08291980 F 060116 01
02 103115 11 103115 35 032316

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PO BOX 9507

FREDERICKSBURG, VA 22403-9526

DRG V TO	DRG DESCRIPTION	DRG CODE	DRG DRG DRT	DRG DRG UNITS	DRG DRG CHARGE	DRG DRG ALLOWED DRG DRG	DRG DRG
0420	PHYSICAL THERP	97140GP	060116	1	110.04		
0420	PHYSICAL THERP	97010GP	060116	1	25.26		
0420	PHYSICAL THERP	97110GP	060116	1	117.25		
0420	PHYSICAL THERP	97110GP	060816	1	117.25		
0420	PHYSICAL THERP	97010GP	060816	1	25.26		
0420	PHYSICAL THERP	97140GP	060816	1	110.04		
0420	PHYSICAL THERP	97140GP	062916	1	110.04		
0420	PHYSICAL THERP	97010GP	062916	1	25.26		
0420	PHYSICAL THERP	97110GP	062916	1	117.25		

PLEASE PROCESS IN ACCORDANCE WITH
V. F. & S. COMMISSION
MAIL REGULATIONS

MEDICAL RECORDS TO FOLLOW

0001 PAGE 1 OF 1 CREATION DATE 070516 REVISED 757 651

GEICO 98819 Y Y 215.64 1053441907
THE GOVT PROGRAMS 95202 Y Y 161533232 115

HARWELL, DANIELLE 18 0138739400101059
HARWELL, DANIELLE 18 DBD16761Q00 60000S

(D) **EMI** And **EMI** A **EMI** B **EMI** C **EMI** D **EMI** E **EMI** F **EMI** G **EMI** H **EMI** I **EMI** J **EMI** K **EMI** L **EMI** M **EMI** N **EMI** O **EMI** P **EMI** Q **EMI** R **EMI** S **EMI** T **EMI** U **EMI** V **EMI** W **EMI** X **EMI** Y **EMI** Z **EMI**

For more information about the study, please contact Dr. Michael J. Hwang at (319) 356-4000 or email at mhwang@uiowa.edu.

WMS-12-2 NCEP-DOE-1

M5912 M7552

Figure 1. A schematic diagram of the experimental setup. The sample was placed in a glass tube and positioned in the center of the magnetic field. The magnetic field was generated by a superconducting magnet.

Table 1. Summary of the main characteristics of the four groups of patients.

• 100% of the time, the system will correctly identify the correct answer.

07/11/16

07/11/16



Patient Financial Services
726 Exchange Street, Suite 300
Buffalo, New York 14210

Kaleida Health

www.kaleidahealth.org



EYM-SMB 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG, VA 22403

100

VICAS XCCX

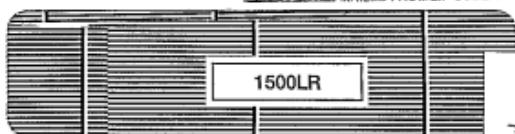
1 MEDICARE	MEDICAID	TDCARE	CHAMPVA	GROUP HEALTH PLAN (N/A)	FECA BUILDING (N/A)	OTHER (N/A)	1a INSURED'S ID NUMBER 0138739400101059	(For Programs in Item 1)	
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DADeD)	<input type="checkbox"/> (Member D2)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		
5 PATIENT'S ADDRESS (No. Street) 1131 CLEVELAND DR			6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No. Street) 1131 CLEVELAND DR		
CITY CHEEKTONWAGA		STATE NY	8 RESERVED FOR NUCC USE		CITY CHEEKTONWAGA		STATE NY		
ZIP CODE 14225	TELEPHONE (Include Area Code) ()				ZIP CODE 14225	TELEPHONE (Include Area Code) ()			
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15				
a OTHER INSURED'S POLICY OR GROUP NUMBER			a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F				
b RESERVED FOR NUCC USE			b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		b OTHER CLAIM ID (Designated by NUCC)				
c RESERVED FOR NUCC USE			c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME				
d INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)		d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
SIGNED SIGNATURE ON FILE			DATE 02 09 16			SIGNATURE ON FILE			
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL			15 OTHER DATE QUAL 439 MM DD YY 10 31 15		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI			17a LG U62607		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24)) ICD Ind 0									
A S060X0S	B M791	C H832X9	D M5412	22. RESUBMISSION CODE ORIGINAL REF NO					
E G44309	F L	G L	H L	23. PRIOR AUTHORIZATION NUMBER					
I L	J K	K L	L L	F	G DESCRIPTION OR UNITS	H AMOUNT PAID PER UNIT	I ID # OR QUAL	J RENDERING PROVIDER ID #	
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY				B PLACE OF SERVICE EMR		C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER		D DIAGNOSIS CODER NUMBER	
06 30 16	06 30 16	11	99214			ABCD	74 79 1	NPI	161582336
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	
25. FEDERAL TAX ID NUMBER	SSN	BN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For Govt. Clients, See Below) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 74 79 s 0 00	29. AMOUNT PAID 0 00	30. Rev'd for NUCC Use 0 00		
161582336	<input type="checkbox"/>	<input checked="" type="checkbox"/>	1401050						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and we made a photocopy.)			32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727		33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002				
JENNIFER W MCIVIGE, MD			07 05 16		e 1497850911 b				
SIGNED	DATE				e 1497850911 b				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

07 12 16

DENT NEUROLOGIC INSTITUTE
BILLING OFFICE
3980 SHERIDAN DRIVE SUITE 501
BUFFALO, NY 14226



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**INSURANCE CLAIM
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NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, hobby no-tau, worker's compensation or other insurance which is responsible to pay for the services or which the Medicare claim is made. See 42 CFR 411.2(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., Items 4, 6, 7, 9 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government, as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral Law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my expert supervision except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal) name and MPI, license #, or SSN of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direct supervision by her/his employee, 8) they must be an integral, although incidental, part of a covered physician's service; 9) they must be of benefit commonly furnished in physician's offices; and 10) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government, either civilian or military (as per 10 USC 3386). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless the form is received as required by existing law and regulations (42 CFR 424.22).

NOTICE: Any one who manufactures or facilitates essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in sections 206(a), 1832, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.2(a) and 425.5(a)(6) and 44 USC 3101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 39 USC 801 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies for the effective administration of Federal programs that require other third parties pay or pay priority to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, Med "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept. 12, 1990 or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990 Sce ESA-5, ESA-6, ESA-12, ESA-13, ESA-30 or as updated and republished.

FOR TRICARE CLAIMS (PRINCIPLE PURPOSE(S)): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

FOR DOD LIFE/DEATH: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE-CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recuperation claims, and to Congressional Offices in response to inquiries made at the request of the citizen to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care or matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, insurance, pay review, premium integrity, third party liability coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1138B of the Social Security Act and 31 USC 3801-38-2 provides penalties for withholding this information.

You should be aware that P.L. 100-360, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

STATE MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claim statements, documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0938-187. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-08-05, Baltimore, Maryland 21244-1850. This document is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO.	0482
DESTINATION ADDRESS	18562945154
SUBADDRESS	
DESTINATION ID	Geico PIP Claim
ST. TIME	07/05 06:46
TX/RX TIME	01'14
PGS.	5
RESULT	OK



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Christopher Zdziarski, FNP-C

Sydney B Grabau, PA

Re-Evaluation
Date: 06/30/2016

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 35 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Patient is here following up for migraines

History of Present Illness

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic reevaluation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a wonderful 35-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at the urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale. The headaches were worse than her baseline. She reported associated sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face.

The patient was evaluated by Dr Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes, but there are disk extrusions seen at C4-C5 and C5-C6. She did have an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 showed a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8. The remainder of the CBC was within normal limits. CMP, TSH, Vitamin D and Vitamin B12 were within normal limits.

Danielle has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and physical therapy. After initial evaluation, she was started on magnesium oxide, Naprosyn and Rizatriptan. She tried trigger point injections for cervical spasm. She was encouraged to try vestibular therapy in addition to the physical therapy as well.

Danielle returns today with worsening of her symptoms. She continues to have pain in her cervical region and radiating down her left arm. At times, she will experience weakness in her left arm. The patient has continued with physical therapy, but the primary focus of therapy has been on her left shoulder and arm. She states the therapy sessions are quite painful for her. She has continued with regular massage therapy, which has been helpful. In addition to the neck pain, the patient has experienced ongoing dizziness and unsteadiness. She has continued with magnesium oxide daily. She has continued with trigger point injections, which provide temporary relief.

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Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking nzatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Not-Taking/PRN Vitamin D2 50,000 int'l units capsule 1 cap(s) 2 times a week
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use

Smoking Patient is a: non smoker

Alcohol use

Alcohol Consumption: Patient does not drink alcohol

Ilicit Drugs

Using illicit drugs: Denies,

Resides with:

Spouse: Husband, Children Yes, x3

Working

Employed: Stay at home mom

Marital Status

Married: Yes.

Driving

Does Patient Drive: Yes.

Exercise

Daily Yes, Walks

Caffeine

Soda Pop Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro

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 Alice Trzeciak

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- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headaches, dizziness, weakness, numbness, unsteadiness, sleep problems, fatigue, ringing in the ears, joint pain, stiffness, neck pain, muscle aches, asthma, chest pain, palpitations, heartburn, itching, rash and swollen lips No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 116/68, HR 72, RR 16, Ht 63, Wt 150, BMI 26.57, BSA 1.74.

Examination

GENERAL EXAMINATION

General Appearance: Well-nourished, well-developed, in no apparent distress, participated with the exam. Well groomed Neck Trapezius are quite spasmed and tender bilaterally, more so on the left side. Range of motion is limited. Cardiovascular peripheral pulses within normal limits. Extremities: Full range of motion of extremities x4 No edema

NEUROLOGICAL:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Patient is quite unsteady with both Romberg and tandem stance testing. She is unable to maintain her balance.. Sensory: Sensation to touch and cold was intact in all 4 extremities bilaterally

CRANIAL NERVES:

Cranial Nerves III, IV, VI, Extracocular movements intact PERRLA Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

1. Concussion, without loss of consciousness, sequela - S06.0X0S (Primary)
2. Myofascial pain - M7.1
3. Vestibular dysfunction - H83.2X9
4. Cervical radicular pain - M54.12
5. Posttraumatic headache - G44.309

Danielle is a 35-year-old female currently under our care for the treatment of postconcussive symptoms, which resulted from motor vehicle accident. The patient continues to struggle with prominent spasm in her cervical region, with radiating symptoms down her left arm. She also reports feeling quite dizzy and unsteady at times. At this point, I encouraged her to initiate physical therapy for the cervical region, as well as vestibular therapy for the dizziness. We will continue with regular trigger point injections. I encouraged her to continue with magnesium oxide daily as well. We discussed trying occipital nerve blocks in the future if her symptoms persist. We also discussed trying Lamictal if therapy is ineffective. We will see the patient back next week for her next round of trigger point injections. Dr. McVige is the supervising physician on site.

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 Alice Trzaski

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 Barbara Meldring, RN, Manager

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Concussion, without loss of consciousness, sequela

Start Lamictal tablet, 25 mg, 1 tab(s), orally, 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID, 30 day(s), 120, Refills 5

2. Myofascial pain

Continue magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day
PHYSICAL THERAPY Cervicalgia1160785

3. Vestibular dysfunction

VESTIBULAR THERAPY1160784

4. Posttraumatic headache

Continue Naprosyn tablet, 500 mg, 1 tab(s), orally, prn headache, up to BID

Continue rizatRIPTAN tablet, 10 mg, 1 tab(s), orally, prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3

Preventive Medicine

COUNSELING Healthy Living: Patient counseled on the importance of healthy lifestyle. 06/30/2016.

Diet Patient counseled on importance of lowering sugar intake, sodium and fats 06/30/2016

Exercise Patient counseled on importance of moderate physical activity daily. 06/30/2016.

Follow Up

next week triggers

Sydney Grabau PA-C

J

Electronically signed by Sydney Grabau , PA on 06/30/2016 at 01:29 PM EDT

Sign off status: Completed

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JULY 5, 2016

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

DIAGNOSTICS & SERVICES	
<i>MRA/CT</i>	Neurophysiology
<i>Angiograms</i>	<i>Pneumography</i>
<i>Breath</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>EPIC/T</i>	<i>PNG</i>
<i>Infrared</i>	

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NY PIP CLAIMS
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CARRIER →

X0094A

FICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	SHOMU HEALTH PLAN	REGA HILK LUNS	OTHER	16. INSURED'S ID. NUMBER	(For Program in Item 1)
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> SHOMU	<input type="checkbox"/> REGA	<input type="checkbox"/> OTHER	0138739400101059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARWELL, DANIELLE			DB 29 1980			M <input checked="" type="checkbox"/>	HARWELL, DANIELLE	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)	
1131 CLEVELAND DR			Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				1131 CLEVELAND DR	
CITY CHEEKTONWAGA	STATE NY	8. RESERVED FOR NUCC USE			CITY CHEEKTONWAGA		STATE NY	
ZIP CODE 14225	TELEPHONE (Include Area Code) ()				ZIP CODE 14225		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FEDAL NUMBER DOI 10/31/15		
			a. EMPLOYMENT (Current or Previous)			a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input checked="" type="checkbox"/>		
			b. AUTO ACCIDENT?			b. OTHER CLAIM ID (Designated by NUCC)		
			c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. RESERVED FOR NUCC USE			d. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			e. INSURANCE PLAN NAME OR PROGRAM NAME		
f. INSURANCE PLAN NAME OR PROGRAM NAME			10. CLAIM CODES (Designated by NUCC)			g. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepted assignment below.								
SIGNATURE ON FILE								
SIGNED	DATE	02 09 16						
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL			15. OTHER DATE QUAL 439 MM DD YY 10 31 15			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN: PETER J GUSINSKI			18. 10 U62607 1710014188			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								
20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Check A-L to service line below) ICD-9-CM A. M791 B. L C. L D. L E. L F. L G. L H. L I. L J. L K. L L. L								
22. BILL/COMMISSION CODE ORIGINAL RFF. NO.								
23. PRIOR AUTHORIZATION NUMBER								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY R. PLACE OF SERVICE C. CPT/HCPCS O. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. AMOUNT PAID H. ID CODE J. RENDERING PROVIDER ID #								
1	07 05 16	07 05 16	11	20553		A	95 74 1	NPI 161582336
2								NPI 1649596495
3								NPI
4								NPI
5								NPI
6								NPI
25. FEDERAL TAX ID. NUMBER 161582336			26. PATIENT'S ACCOUNT NO 1403446			27. ACCEPT ASSIGNMENT X YES NO		
						28. TOTAL CHARGE \$ 95 74 s		
						29. AMOUNT PAID 0 00		
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to it if it is filled in and are made a part thereof.) JENNIFER W MCVIGE, MD			31. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727			32. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002		
SIGNED 07 08 16			DATE e 1497850911 h			33. Read for NUCC Use e 1497850911 h		



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Christopher Zalawski, FNP-C

Sydney B Grabau, PA

Procedure Note

Date: 07/05/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Patient is here today for trigger point injections

History of Present Illness

General:

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking Naprosyn 500 mg tablet 1 tab(s) pm headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Discontinued Vitamin D2 50,000 int'l units capsule 1 cap(s) 2 times a week
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

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Orchard Park Office | Sterling Medical Park • 280 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0113
Batavia Office | 13 Natura City Center • Batavia, NY 14509 | Fax: (716) 250-2015

ADMINISTRATIVE SUPPORT

Shawn Fager, Clinic Manager
Kathleen Bowry
Annette McFayden
Alice Trzaski

INFUSION CENTERS

Christina Mass, MA, RNC
Barbara Maledig, RN, MSAcpra

- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History
Tobacco Use:

Smoking: Patient is a: non smoker .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Ilicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 120/66, HR 76, RR 16, Ht 63", Wt 150, BMI 26.57, BSA 1.74.

Examination
NEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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ADMINISTRATIVE SUPPORT
 Sherry Horner, Clinic Manager
 Kristina Finner
 Amanda McPeek
 Alice Trzcienski

INJECTION CENTERS
 Christine Moore, MPA, Director
 Roxana Muldeng, RN, Manager

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 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

Patient: Harwell, Danielle | DOB: 08/29/1980 | Procedure Note

Page 3 of 3

points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness. An additional 0.5cc was injected at the C1-2 facet bilaterally.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 07/05/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 07/05/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 07/05/2016.

Follow Up

4 Weeks

Electronically signed by Sydney Grabau , PA on 07/05/2016 at 04:34 PM EDT

Sign off status: Completed

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Suzanne Finger, Clinic Manager
Katrina Bowes
Amanda McFayden
Alice Trzeciak

INFUSION CENTERS

Christine Mass, MBA, Director
Barbara Malinow, RN, Manager

Health Service Examination Request

Date Request Generated 12/4/2018
Claim Number 0138739400101059
Date of Loss 10/31/2015
Interested Party Danielle Harwell
Interested Party Address 1131 Cleveland Dr
Buffalo, NY 14225-1257
Interested Party Phone Number 716-536-0951
Attorney Law Office Of William Matar
Law Office Of William Matar
Attorney Address 6720 Main St
Williamsville, NY 14221-5986
Attorney Phone Number 716-444-4444

Interested Party Injuries	Body Part	Body Sub Type
Sprain/Strain		

Specialty Neurology

Instructions

Vendor / Physician Empire Stat

Comments Please Schedule Dr. Kanoff who performed the initial evaluation on 08/28/18.

FPM Adjuster Wade Stroble

FPM Adjuster Address

FPM Adjuster Phone Number 516-496-6213



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

EXCEP CAN

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentations or any false, incomplete or misleading information may be guilty of a criminal or punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and enables that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(b). If item 9 is completed, the patient's signature authorizes release of the information on the health plan or agency shown in Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the local carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the local carrier or TRICARE fiscal intermediary if the is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health services provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 1a, 4, 5, 7, 9, and 11.

BLACK LUNG AND PEGA CLARIS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and PEGA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, PEGA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and MPR, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's ambulatory services: 1) they must be rendered under the physician's direct supervision by either employee; 2) they must be an integral, although incidental part of a covered physician service; 3) they must be of kinds commonly furnished in physician's offices; and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who manufactures or distributes essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PEGA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CHIS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, PEGA, and Black Lung programs. Authority to collect information is in section 203(j)(4), 1982, 1987 and 1974 of the Social Security Act as amended, 42 CFR 411.24(d) and 424.5(a)(6) and 44 USC 3101 et seq and 10 USC 1079 and 1086; 5 USC 5101 et seq. and 39 USC 801 et seq. 38 USC 813. E.O. 1337

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties payers to pay primary to Federal programs, and as otherwise necessary to administer those programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0891, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177 page C7548, Wed Sept 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor Privacy Act of 1974. Republication of Notice of Systems of Records, Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-3, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to make payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHIPS/VA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompensable claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlements, claims adjudication, fraud, program abuse, utilization review, quality assurance, policy review, program integrity, third-party liability coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under PEGA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1106B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matching.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collected. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Comments, Office, Mail Stop 04-08-05, Baltimore, Maryland 21244-1850. This address is for comments, and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



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Marie Rizzo, RPA-C
Elizabeth D. Smith, CNP, AMP
Andrea Gassaci, FNP-C
Christopher Zulawski, FNP-C

Sydney B Grabau, PA

Procedure Note

Date: 07/05/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Patient is here today for trigger point injections

History of Present Illness

General:

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
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- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 intl units capsule 1 cap(s) once a day
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- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Discontinued Vitamin D2 50,000 intl units capsule 1 cap(s) 2 times a week
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

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Christine Massa, MBA, Director
Barbara Muldeng, RN, Manager

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- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking: Patient is a: non smoker .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Ilicit Drugs:

Using illicit drugs: Denies

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married. Yes.

Driving:

Does Patient Drive: Yes

Exercise:

Daily Yes, Walks

Caffeine:

Soda Pop. Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 120/86, HR 76, RR 16, Ht 63", Wt 150, BMI 26.57, BSA 1.74

Examination

NEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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ADMINISTRATIVE SUPPORT

Stacey Feger, Clerk Manager
 Kimma Beaver
 Amanda McFayden
 Alice Trzeciak

INFUSION CENTERS

Christine Mass, MBA, Director
 Barbara Mulderig, RN, Manager

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points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness. An additional 0.5cc was injected at the C1-2 facet bilaterally.

Preventive Medicine

COUNSELING: Healthy Living Patient counseled on the importance of healthy lifestyle 07/05/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 07/05/2016.

Exercise: Patient counseled on importance of moderate physical activity daily 07/05/2016

Follow Up

4 Weeks

Sydney Grabau PA-C

J

Electronically signed by Sydney Grabau , PA on 07/05/2016 at 04:34 PM EDT

Sign off status: Completed

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ADMINISTRATIVE SUPPORT

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Kathleen Bowler
Amanda McFayden
Alice Trzeciak

INFUSION CENTERS

Christine Moran, MBA, Director
Barbara Mulderig, RN, Manager

***** FAX TX REPORT *****

TRANSMISSION OK

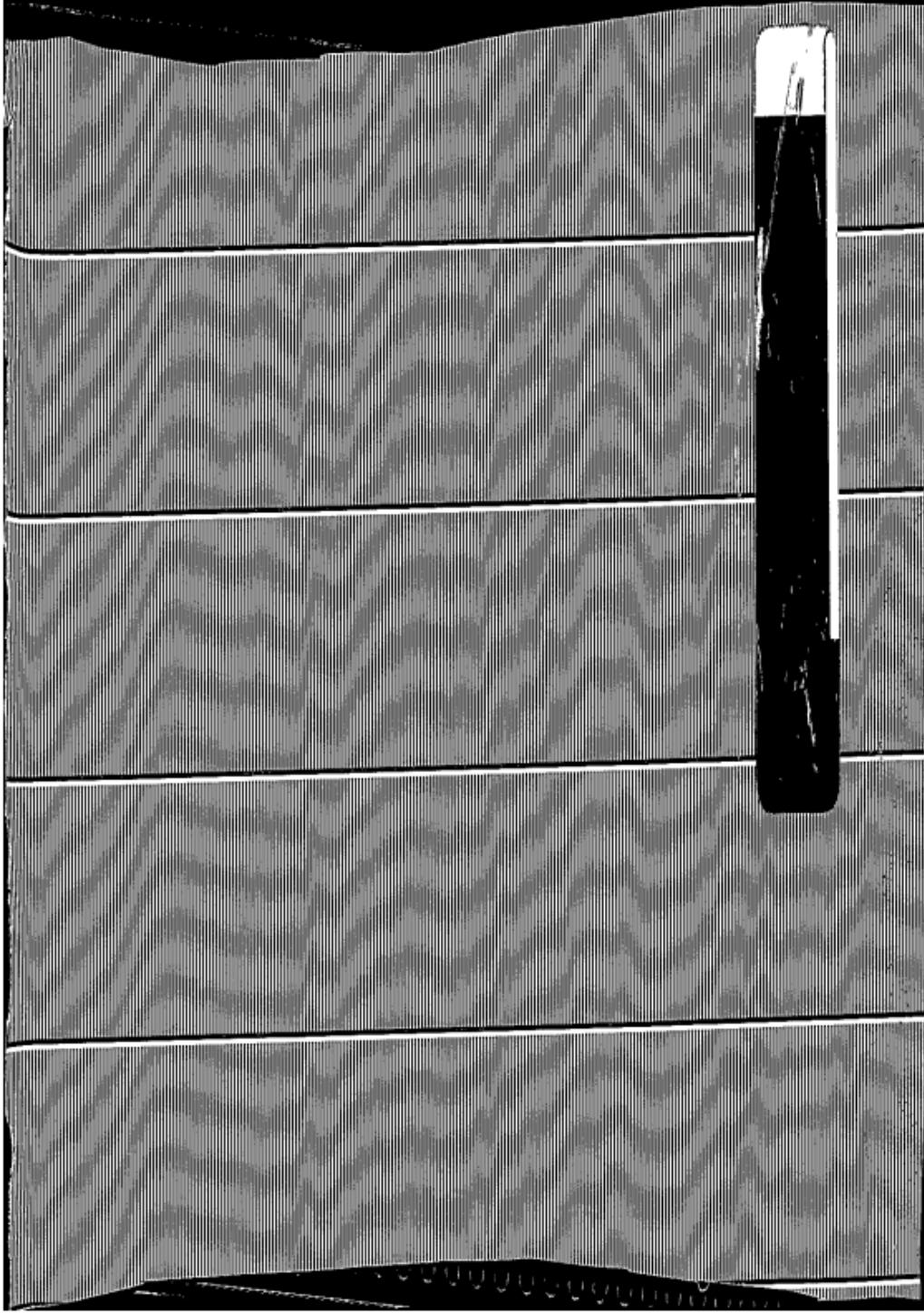
JOB NO.	0710
DESTINATION ADDRESS	18562945154
SUBADDRESS	
DESTINATION ID	Geico PIP Claims
ST. TIME	07/12 08:45
TX/RX TIME	01' 04
PGS.	4
RESULT	OK



HEALTH INSURANCE CLAIM FORM

ABRIDGED BY MATERIAL UNISONO FROM COMMITTEE ON LEGISLATION

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403



07 18 16



FIRST CLASS MAIL

PLEASE DO NOT BEND

••••

**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

NUCC

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

013873940-0101-059

NUCA

1. MEDICARE (Medicare)		MEDICAID (Medicaid)		TRICARE (TRICARE)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FED-X EXCLUDING (NOM) <input type="checkbox"/>	OTHER <input type="checkbox"/>	1a. INSURED'S ID NUMBER 013873940-0101-059 (For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY CHEEKETOWAGA		STATE NY		8. RESERVED FOR NUCC USE				CITY AMHERST		STATE NY							
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980 MM DD YY <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. AUTO ACCIDENT? <input checked="" type="checkbox"/> WEB <input type="checkbox"/> NO <input type="checkbox"/> NY		b. OTHER CLAIM ID (Designated by NUCC)			
b. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
c. RESERVED FOR NUCC USE												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d			
d. INSURANCE PLAN NAME OR PROGRAM NAME												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED SIGNATURE ON FILE												DATE		SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 CUAL 431												15. OTHER DATE MM DD YY 051 454 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY -- -- -- --			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY -- -- -- --					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))												ICD IND 0		22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. M50.22		B. M51.26		C. M51.27		D. M54.12		E. M99.03		F. M99.02		23. PRIOR AUTHORIZATION NUMBER					
E. I523.3XXA		F. M99.01		G. M99.03		H. M99.02		I. M99.05		J. M54.5		K. M54.6					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. FLUDEOF SERVICE EMR		C. CPT/NCPCS		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. CHARGES		G. DAYS ON UNITS		H. AMOUNT PER UNIT	I. ID CODE	J. RENDERING PROVIDER ID #	
1 06302016 06302016 11				96941				ABCD		32 28 1				NPI	1710014188		
2 06302016 06302016 11				97010				ABCD		10 53 1				NPI	1710014188		
3																	
4																	
5																	
6																	
25. FEDERAL TAX I.D. NUMBER 364500165		SSN EIN 343821224		26. PATIENT'S ACCOUNT NO. 343821224		27. ACCEPT ASSIGNMENTS BY INSURANCE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 42.81		29. AMOUNT PAID \$ 0		30. Reserved for NUCC Use 					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and any medical treatment provided.) PETER GOZINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849						33. BILLING PROVIDER INFO & PH# (716) 681-3333									

SIGNED **07122016** DATE**1235256546****1235256546**

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
July 12, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday June 30, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that she remains the same. She stated that she had an ortho IME yesterday. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also has headaches since the accidents. The headaches are back to every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences less dizziness since last visit. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck

Encounter dated 06/30/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: slightly worse. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

Encounter dated 06/30/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 1 week; Re-examination for 1 week. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (anterior); T7 (anterior); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Gulaniski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

07 18 16



07 18 16



Geico
P.O. Box 9507
Fredericksburg, VA 22403

345 Dick Rd.
Depew, NY 14043



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

PICA

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

013873940-001-059

PICA

1 MEDICARE (Medicare)	2 MEDICAID (Medicaid)	3 TRICARE (DOD/DoD)	4 CHAMPVA (Member/DM)	5 GROUP HEALTH PLAN (RGA) <input type="checkbox"/>	6 FECA (RGA) <input type="checkbox"/>	7 OTHER <input type="checkbox"/>	1a. INSURED'S ID NUMBER 013873940011059	1b. FOR PROGRAM IN LINES 1 PICA		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			3 PATIENT'S BIRTH DATE MM DD YY 08291980			4 SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			6. PATIENT'S RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT				
CITY CHEEKETOWAGA	STATE NY	8. RESERVED FOR NUCC USE			CITY AMHERST	STATE NY				
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 08291980				
			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC) b. OTHER CLAIM ID (Designated by NUCC)				
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										
SIGNED SIGNATURE ON FILE				DATE						
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115				15. OTHER DATE MM DD YY 0454 111215			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____							18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD IND: O										
A M50.22	B M51.26	C M51.27	D M54.12				22. RESUBMISSION CODE ORIGINAL REF NO			
E I22.3XXXA	F M99.01	G M99.03	H M99.02				23. PRIOR AUTHORIZATION NUMBER			
I M99.05	J M54.2	K M54.5	L M54.6							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACED OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. CPT/HCPCS F. MODIFIER G. DIAGNOSIS H. POINTER I. S CHARGES J. ID K. RENDRING L. PROVIDER ID #										
1 06212016	06212016	11	98941	ABCD	32 28	1	NPI	1710014188		
2 06212016	06212016	11	97010	ABCD	10 53	1	NPI	1710014188		
3 06232016	06232016	11	98941	ABCD	32 28	1	NPI	1710014188		
4 06232016	06232016	11	97010	ABCD	10 53	1	NPI	1710014188		
5 06272016	06272016	11	98941	ABCD	32 28	1	NPI	1710014188		
6 06272016	06272016	11	97010	ABCD	10 53	1	NPI	1710014188		
25. FEDERAL TAX ID NUMBER 364500165	SSN/EIN 343871223	26. PATIENT'S ACCOUNT NO 343871223			27. ACCEPT ASSIGNMENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 128.43			29. AMOUNT PAID \$ 1	30. Rcvd for NUCC Use 1
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in my behalf) PETER GOZINSKI DC									32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849	
33. BILLING PROVIDER INFO & PH# (716) 681-3333									CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849	
34. APPROVED OMB-0838-1197 FORM 1500 (02-12)									35. APPROVED OMB-0838-1197 FORM 1500 (02-12)	

07 18 16



Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
July 12, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday June 21, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activites of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting, tingling, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck

Encounter dated 06/21/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

Encounter dated 06/21/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday June 23, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that "I feel about the same". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, tingling, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient

Encounter dated 06/23/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

stated that she also had headaches since the accidents. The headaches are back daily again. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness occasionally but she is definitely sensitive to light. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit:* *Pain:* achy, dull, shooting, tingling, numb. *Range:* 4->5/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower

Encounter dated 06/23/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s): L4, L5, Left SI.*
Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: slightly worse. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and

Encounter dated 06/23/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Monday June 27, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that "I feel a little bit better". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* slightly improved. *since last visit:* Pain: achy, dull, tingling, shooting, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are back daily again. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness occasionally but she is definitely sensitive to light. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been more intense. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* slightly worse. *since last visit:* Pain: achy, dull, shooting, tingling, numb. Range: 5->6/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain

**Encounter dated 06/27/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016**

neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* Slight improvement since their last treatment. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: slightly worse. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild

Encounter dated 06/27/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/12/2016

bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (diversified prone); T7 (diversified prone); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction); L5 left (manual traction); Left SI left (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to June 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzarski, D.C.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

07-21-16

MILLARD FILLMORE SUBURBAN MILLARD FILLMORE SUBURBAN
 1540 MAPLE ROAD PO BOX 8000 DEPT 042
 WILMSVILLE, NY 142213647 BUFFALO, NY 142670002
 7168597200

39 PATIENT NAME	39 PATIENT ADDRESS	39 PAYOR CODE	3890065-10				
HARWELL, DANIELLE	CHEEKTOWAGA	3 MED PAY	0131				
19 BIRTHDATE	11 SEX	12 DATE ADMISSION	13 HRS 14 TYPE 15 ENC	16 GMR	17 STATUS	18 CONDITION CODES	19 ADMIT 20 STATE
08291980	F	060116	1	01			

20 OCCURRENCE CODE	21 COVERAGE CODE	22 DATE	23 OCCURRENCE CODE	24 COVERAGE CODE	25 DATE	26 OCCURRENCE SPAN FROM	27 OCCURRENCE SPAN THROUGH	28 COVERAGE SPAN FROM	29 COVERAGE SPAN THROUGH
02 103115	11	103115	35	032316					

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a 45 8.00	b 50 10.00	c
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GRICO
 GEICO
 PO BOX 9507
 FREDERICKSBURG, VA 224039526

40 PRO CD	41 DESCRIPTION	42 HCPCS / RATE / HCPS CODE	43 SDW DATE	44 DERY UNITS	45 TOTAL CHARGES	46 NON-COVERED CHARGES
0420 PHYSICAL THERP		97140GP	060116	1	110.04	
0420 PHYSICAL THERP		97010GP	060116	1	25.26	
0420 PHYSICAL THERP		97110GP	060116	1	117.25	
0420 PHYSICAL THERP		97110GP	060816	1	117.25	
0420 PHYSICAL THERP		97010GP	060816	1	25.26	
0420 PHYSICAL THERP		97140GP	060816	1	110.04	
0420 PHYSICAL THERP		97140GP	062916	1	110.04	
0420 PHYSICAL THERP		97010GP	062916	1	25.26	
0420 PHYSICAL THERP		97110GP	062916	1	117.25	

PLEASE PROCESS IN ACCORDANCE WITH
 WORKERS COMPENSATION
 NO FAULT FEE SCHEDULE

**Please pay estimated amount
 due in box 55**

0001 PAGE 1 OF 1 CREATION DATE 070516 TOTALS 757.65

50 PAYOR NAME	51 HEALTH PLAN ID	52 PNL	53 PNL	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 PAYOR ID
GRICO	98919	Y	Y		215.64	161533232
IHA GOVT PROGRAMS	95308	Y	Y		OTHER 15	PWD

58 INSURED'S NAME	59 PNL 60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP ID
HARWELL, DANIELLE	18 0138739400101059		
HARWELL, DANIELLE	18 DBD16761Q00		60000S

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
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66 M5412 M7552	67	68		
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68 ADMIT 69 PATIENT REASON DATE	70 OTHER PROCEDURE DATE	71 OTHER PROCEDURE DATE	72 COI	73

74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI
		1447262209	LAST OSTEPOWSKI
76 OTHER	NPI	DEML	FIRST MICHAEL
LAST			
79 OTHER	NPI	DEML	
LAST			

RMWPT	80 COI	81 83 282N0000X
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US-04 CMS-1500 NCP-0884 APPROVED CMMR 0838-0987 CCW original NUBC Version 2/23/2004 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

USER NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT IT IS AN AGREEMENT TO RELEASE ALL INFORMATION CONTAINED IN THIS FORM, OR DERIVED THEREFROM, AS A RECORD OF ESSENTIAL INFORMATION AS REQUESTED BY THE STATE OF CALIFORNIA PURSUANT TO THE CALIFORNIA PUBLIC RECORD ACT AND ASSESS RELATED FEES FOR THE FILING, PROCESSING, AND MAINTENANCE OF THIS RECORD. THE SUBMITTER AGREES TO HOLD EBCOM LENDER, INC., ITS OFFICERS, EMPLOYEES, AGENTS, AND ATTORNEYS HARMLESS FROM ANY AND ALL LIABILITY ARISING OUT OF THE SUBMISSION OF THIS RECORD.

Submission of this claim constitutes certification that the billing information as shown on the rate hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

- 1 If third party beneficiaries are indicated, the appropriate assignments by the insured, beneficiary and signature of the patient or parent or a legal guardian, covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
 2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
 - 3 Physician's certifications and re-certifications, if required by contract, or Federal regulations are on file.
 - 4 For Religious Non-Medical facilities verifications and if necessary re-certifications of the patient's need for services are on file.
 - 5 Signature of patient or his representative on certifications authorizing to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935i, 42 CFR 421.35, 10 CFR 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file
 6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
 7. For Medicare Purposes: If the patient has verified that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare, medical and non-medical institution including employment status and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
 8. For Medicaid purposes: The submitter understands that because payment and satisfaction of the claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
 9. For TRICARE Purposes:
 - (f) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient.



- Buffalo General Hospital
- DeGraff Memorial Hospital
- Millard Fillmore Gates Circle Hospital
- Millard Fillmore Suburban Hospital
- Women & Children's Hospital of Buffalo
- Others:

Patient ID Area

HARWELL DANIELLE

PT- 3890065

DOB- 08/29/80

AGE- 035Y

SEX- F

ATTI- REFERRING DOC

PCP- PANZARELLA JAMES J

FC- THP R ADM DT- 03/23/16
MILLARD FILLMORE SUBURBAN

NF

FACE SHEET 1 of 1

MEDICAL RECORD NO.	PATIENT NUMBER	PATIENT NAME (LAST, FIRST, MIDDLE)			BVC AREA	LOCATION	ROOM NO BLDG
1000780250	3890065	HARWELL DANIELLE			THP	TMWPT	
STREET ADDRESS, CITY, STATE, ZIP CODE 56 BEREHAVEN DR LEFT			COUNTY	SOCIAL SECURITY NO	BIRTHDATE		AGE
			14	NOT DISPLAYED	08/28/80		035Y
SEX	MARITAL STATUS	RACE	RELIGION	ADMIT TYPE	ADMIT PRIORITY	ADMIT SOURCE	HPI/H
F	M	W	CRI	PHYS THERA	ELECTIVE	NONHILT FAC	Y
HEALTH CARE AGENT				LASEREP	VIP		
				001	ENGLISH		
PRIOR STAY LOCATION		PRIOR STAY DATES		HOME PHONE	ALTERNATE PHONE	HOSPICE	ORGAN DONOR
				716-536-0951	716-536-0951	N Y	N R
ATTENDING PHYSICIAN REFERRING DOC			REFERRED PHYSICIAN OSTEMPOWSKI MICHAEL J			ADMIT BY (LOGIN ID) dmrm172	RECEIVED BILL OF RIGHTS? YES
PRIMARY CARE PROVIDER PANZARELLA JAMES J			STREET ADDRESS, CITY, STATE, ZIP CODE TONAWANDA			OFFICE PHONE	OFFICE FAX
						716-833-2200	716-332-0797
EMERGENCY CONTACT 1 SHAWN HARWELL			REL			HOME PHONE	WORK PHONE
			SPOUSE			--	716-604-7208
EMERGENCY CONTACT 2 DIANE TOTARO			REL			HOME PHONE	WORK PHONE
			PARENT			--	716-507-4308
ADMITTING DIAGNOSIS (CODE & VERBAGE) MS5412 RADICULOPATHY CERVICAL REGION				CHIEF COMPLAINT CURTIS CERVICAL/SHOULDER			
LAST NAME, FIRST, MI HARWELL, DANIELLE,			STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTY 56 BEREHAVEN DR LEFT SIDE			W AMHERST, NY 142280000	
SOCIAL SECURITY NO NOT DISPLAYED	TELEPHONE NUMBER 716-536-0951		RELATIONSHIP OF GUARANTOR SELF		EMPLOYER		GUARANTOR EMPLOYER TELEPHONE NUMBER --
COMMENTS				SMOKING CESSION INFORMATION PROVIDED TO PATIENT/CARRIER: YES			
INSURANCE CARRIER NO FAULT	PLAN NAME GEICO		CERTIFICATE/POLICY NO 0138739400101059		SECOND POLICY NUMBER		EFFECTIVE DATE 10/31/2015
INSURED NAME DANIELLE HARWELL	DATE OF BIRTH 08/29/1980		REL TO PT	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER DB16761Q	
INSURANCE CARRIER IHA' GOVT PROGRAMS	PLAN NAME MEDISOURCE		CERTIFICATE/POLICY NO DBD16761Q00		SECOND POLICY NUMBER		EFFECTIVE DATE //
INSURED NAME DANIELLE HARWELL	DATE OF BIRTH 08/29/1980		REL TO PT	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER DB16761Q	
INSURANCE CARRIER	PLAN NAME SELF PAY		CERTIFICATE/POLICY NO		SECOND POLICY NUMBER		EFFECTIVE DATE 10/31/2015
INSURED NAME	DATE OF BIRTH		REL TO PT	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER DB16761Q	
INSURANCE CARRIER	PLAN NAME		CERTIFICATE/POLICY NO		SECOND POLICY NUMBER		EFFECTIVE DATE 10/31/2015
INSURED NAME	DATE OF BIRTH		REL TO PT	ACC (Y/N) Y	DATE OF ACCIDENT 10/31/2015	AUTHORIZATION NUMBER DB16761Q	
ISOLATION INDICATOR 1	ISOLATION INDICATOR 2	ISOLATION INDICATOR 3	ISOLATION INDICATOR 4		ISOLATION INDICATOR 5	ISOLATION INDICATOR 6	
PRINCIPAL DIAGNOSIS							
SECONDARY DIAGNOSIS							
PROCEDURES							
ATTENDING PHYSICIAN				DATE			

BL ILO THERAPY SERVICES
 205 Isaacs Road, Wiltonville, NY 14221
 Phone (716) 500-7200 • Fax (716) 500-7299
DEGRAFF THERAPY SERVICES
 415 Terminal Shell, Methuen, MA 01843
 Phone (716) 395-3031 • Fax (716) 395-2190

Kaleida Health

DAILY PROGRESS NOTE

*Billing Guidelines For Medicare (CCI edits hit-listed) 1 unit = 8-23 2 units = 24-38 3 units = 39-53 4 units = 54-68 5 units = 69-82 minutes
 Cannot bill any less than 8 minutes. For other payors use CPT 15 rule for timed services (T) Where each 15 min=1 unit

Date	Visit #	Start	Stop	Total Time	Treatment Provided
6/1/16	8	10:00	10:50	50	CPT-Description NH UNITS
SUBJECTIVE: Complaints (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse <i>"I pulled something... now my shoulder feels (S)"</i>					
OBJECTIVE: <i>The ex as outlined → well tolerated</i>					
PROM: abd 110°, flex 170°, IR @ 45° add -30° → post inf/post joint mobilizations PROM: abd 110°, flex 180°, IR @ 45° add -45°					
ASSESSMENT: <input type="checkbox"/> Original Goals achieved <input checked="" type="checkbox"/> Continue to pursue previous goals <input type="checkbox"/> New problem(s)/pt → <input type="checkbox"/> Recommitment to rehab treatment → <i>"It hurts today right between the shoulder blades."</i>					
PRESENT TREATMENT/PLAN: <input type="checkbox"/> On Exercise/Treatment Card <input type="checkbox"/> Education On: <input type="checkbox"/> home exercise - see copy <input type="checkbox"/> proper posture/ADL <input type="checkbox"/> use of home modalities <input type="checkbox"/> family instruction Current G-code: Goal G-code: DIC G-Code:					
Date	Visit #	Start	Stop	Total Time	Treatment Provided
6/8/16	9	9:30	10:30	60	CPT-Description NH UNITS
SUBJECTIVE: Complaints (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse <i>"It hurts today right between the shoulder blades."</i>					
OBJECTIVE: <i>The ex as outlined - well tolerated.</i> <input checked="" type="checkbox"/> hot pack to thoracic spine during fit inf/post glides → pt report ↓ Sx.					
ASSESSMENT: <input type="checkbox"/> Original Goals achieved <input checked="" type="checkbox"/> Continue to pursue previous goals <input type="checkbox"/> New problem(s)/pt → <input type="checkbox"/> Recommitment to rehab treatment → <i>"It hurts today right between the shoulder blades."</i>					
PRESENT TREATMENT/PLAN: <input type="checkbox"/> On Exercise/Treatment Card <input type="checkbox"/> Education On: <input type="checkbox"/> home exercise - see copy <input type="checkbox"/> proper posture/ADL <input type="checkbox"/> use of home modalities <input type="checkbox"/> family instruction Current G-code: Goal G-code: DIC G-Code:					
Date	Visit #	Start	Stop	Total Time	Treatment Provided
6/29/16	10	10:20	10:30	10	CPT-Description NH UNITS
SUBJECTIVE: Complaints (Circle) none 0 1 2 3 4 5 6 7 8 9 10 worse <i>"S+H sore between the shoulder blades"</i>					
OBJECTIVE: <i>The ex as outlined → well tolerated</i> <i>Sit-up PMR taught & (I) postural/tex in sup rec pos.</i>					
ASSESSMENT: <input type="checkbox"/> Original Goals achieved <input checked="" type="checkbox"/> Continue to pursue previous goals <input type="checkbox"/> New problem(s)/pt → <input type="checkbox"/> Recommitment to rehab treatment → <i>"S+H sore between the shoulder blades"</i>					
PRESENT TREATMENT/PLAN: <input type="checkbox"/> On Exercise/Treatment Card <input type="checkbox"/> Education On: <input type="checkbox"/> home exercise - see copy <input type="checkbox"/> proper posture/ADL <input type="checkbox"/> use of home modalities <input type="checkbox"/> family instruction Current G-code: Goal G-code: DIC G-Code:					



HARWELL, DANIELLE

MR. 1000780250

PT. 3890065

DOB-08/29/80

AGE-35Y

SEX-F

ATT-REFERRING DOC

PCP-PANZARELLA JAMES

FC- THP

R

ADM DT-03/23/16

Patient ID Area MILLARD FILLMORE SUBURBAN

Treatment Provided

CPT-Description	NH	UNITS
<input type="checkbox"/> CHIROPRACTIC / COLD	97010	UNITS
<input type="checkbox"/> TRACTION	97012	UNITS
<input type="checkbox"/> ESTIM (unilateral)	97014	UNITS
<input type="checkbox"/> BAL/COOR/POST	97112	
<input type="checkbox"/> ESTIM (bilateral)	97032	
<input type="checkbox"/> FUNCT ACTIVITY/T	97030	
<input type="checkbox"/> GAIT TRAIN	97116	
<input type="checkbox"/> MANU/MOBILIZAT	97040	15
<input type="checkbox"/> MASSAGE	97124	
<input type="checkbox"/> STRET PT 780	97110	15
<input type="checkbox"/> OTHER EXERCISE	97110	15
<input type="checkbox"/> ULTRASOUND	97035	
<input type="checkbox"/> PT EVAL/PT RENEVAL	97051/02	<0.00
<input type="checkbox"/> AQUATIC THER	97113	
<input type="checkbox"/> TENS set-up only	84550	united

Total timed minutes*
(for Medicare unit calc. only)

PROVIDER SIGNATURE

CPT-Description	NH	UNITS
<input type="checkbox"/> CHIROPRACTIC / COLD	97010	UNITS
<input type="checkbox"/> TRACTION	97012	UNITS
<input type="checkbox"/> ESTIM (unilateral)	97014	UNITS
<input type="checkbox"/> BAL/COOR/POST	97112	
<input type="checkbox"/> ESTIM (bilateral)	97032	
<input type="checkbox"/> FUNCT ACTIVITY/T	97030	
<input type="checkbox"/> GAIT TRAIN	97116	
<input type="checkbox"/> MANU/MOBILIZAT	97040	15
<input type="checkbox"/> MASSAGE	97124	
<input type="checkbox"/> STRET PT 780	97110	15
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<input type="checkbox"/> ULTRASOUND	97035	
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<input type="checkbox"/> AQUATIC THER	97113	
<input type="checkbox"/> TENS set-up only	84550	united

Total timed minutes*
(for Medicare unit calc. only)

PROVIDER SIGNATURE

CPT-Description	NH	UNITS
<input type="checkbox"/> CHIROPRACTIC / COLD	97010	UNITS
<input type="checkbox"/> TRACTION	97012	UNITS
<input type="checkbox"/> ESTIM (unilateral)	97014	UNITS
<input type="checkbox"/> BAL/COOR/POST	97112	
<input type="checkbox"/> ESTIM (bilateral)	97032	
<input type="checkbox"/> FUNCT ACTIVITY/T	97030	
<input type="checkbox"/> GAIT TRAIN	97116	
<input type="checkbox"/> MANU/MOBILIZAT	97040	15
<input type="checkbox"/> MASSAGE	97124	
<input type="checkbox"/> STRET PT 780	97110	15
<input type="checkbox"/> OTHER EXERCISE	97110	15
<input type="checkbox"/> ULTRASOUND	97035	
<input type="checkbox"/> PT EVAL/PT RENEVAL	97051/02	<0.00
<input type="checkbox"/> AQUATIC THER	97113	
<input type="checkbox"/> TENS set-up only	84550	united

Total timed minutes*
(for Medicare unit calc. only)

PROVIDER SIGNATURE

CLINIC

07 21 16

Express Envelope



22403-9526
FREDERICKSBURG, VA.
P O BOX 9507
GEICO



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

CARRIER

013873940-0101-059

PIRA

1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TRICARE <input type="checkbox"/> (DoD/DoA)	CHAMPVA <input type="checkbox"/> Member (DoD)	GROUP HEALTH PLAN <input type="checkbox"/> (DoD)	FEDERAL EMPLOYMENT TRUST FUND <input type="checkbox"/> (FETF)	OTHER <input checked="" type="checkbox"/> (NDM)	1a. INSURED'S ID NUMBER 013873940010159- (For Programs in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Hawell, Danielle		3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Hawell, Danielle	
5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive	
CITY Cheektowaga	STATE NY	8. RESERVED FOR NUCC USE		CITY Cheektowaga	STATE NY		
ZIP CODE 14225	TELEPHONE (Include Area Code) ()			ZIP CODE 14225	TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Hawell, Danielle		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FEDERAL NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER DBD16761Q00		a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURE'S DATE OF BIRTH MM DD YY 08 29 1980 M		b. OTHER CLAIM ID (Designated by NUCC) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. PLACE (State)		c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		d. OTHER INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE

DATE _____

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL: _____	15. OTHER DATE QUAL: _____ MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM: _____ MM DD YY TO: _____ MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR Jennifer McVige MD	17a. _____ 17b. NPI: 1649596495	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM: _____ MM DD YY TO: _____ MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LABS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24f))		ICD IND: <input type="checkbox"/> 0	22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____
A. R42	B. _____	C. _____	D. _____
E. _____	F. _____	G. _____	H. _____
I. _____	J. _____	K. _____	L. _____

24. A. DATE(S) OF SERVICE From: MM DD YY To: MM DD YY	B. PLACE OF SERVICE ENG: _____	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CP/TH/POS: _____	D. MODIFIER MODIFIER: _____	E. DIAGNOSIS PICKLIST CODE: _____	F. G. DATES OR UNITS CHARGES: _____	H. PAY PER UNIT AMOUNT PAID: _____	I. ID QUAL: _____	J. RENDERING PROVIDER ID #: _____
1. 07 14 16	2. 07 14 16	3. 11	4. 97001	5. A	6. 90.00	7. 1	8. NPI	9. 225100000X
10. 07 14 16	11. 07 14 16	12. 11	13. 97001	14. A	15. 90.00	16. 1	17. NPI	18. 1205129921
19. 07 14 16	20. 07 14 16	21. 11	22. 97001	23. A	24. 90.00	25. 1	26. NPI	27. -----
28. 07 14 16	29. 07 14 16	30. 11	31. 97001	32. A	33. 90.00	34. 1	35. NPI	36. -----
37. 07 14 16	38. 07 14 16	39. 11	40. 97001	41. A	42. 90.00	43. 1	44. NPI	45. -----
46. 07 14 16	47. 07 14 16	48. 11	49. 97001	50. A	51. 90.00	52. 1	53. NPI	54. -----
55. 07 14 16	56. 07 14 16	57. 11	58. 97001	59. A	60. 90.00	61. 1	62. NPI	63. -----

25. FEDERAL TAX ID NUMBER 201163729	SSN/BN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 103558	27. ACCEPT ASSIGNMENT TO GOVT. OFFICE, FEDERAL PROGRAM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE 5. 90.00	29. AMOUNT PAID 5. 0.00	30. RECD FOR NUCC USE 5. 0.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.) McPherson, Jacob PT, DPT		32. SERVICE FACILITY LOCATION INFORMATION 804/15/16		33. BILLING PROVIDER INFO & PH# 716 8038220 Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432		
SIGNED		804/15/16		34. 1710021001 b		

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT & PRIVATE HEALTH PROGR/MS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a crime. I, the patient, file under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICAID AND TRICARE PAYMENTS: A patient's signature requests that payment be made and/or releases release of any information necessary to process the claim and certifies that the information provided in Boxes 1 through 12 is true, accurate and complete. In the case of a Medicaid claim, the patient's signature authorizes any entity to release to Medicaid medical and related information and bills for the person has employer group health insurance, briefly, self-employed workers compensation or other insurance which is responsible to pay for the services for which the Medicaid claim is made. See 42 CFR 411.2(a). If item 1 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In like manner as assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE for intermediary as the full charge and the patient is responsible only for the deductible, copayments and non-covered services. Copayments and deductible are based upon the charge determined by the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniform Services. Information on the patient's agreement shall be provided in those items captioned as "Initial"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide essential information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare rules, Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-fraud statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were principally necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, SBN#) of the primary individual rendering such service is reported in the designated section for notation to be considered "incident to" a physician's professional services; 7) they must be rendered under the physician's direct supervision by either employee; 8) they must be an integral, although incidental part of a covered physician service; 9) they must be of kinds commonly furnished in physician's office; and 10) services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I or any employee who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disease.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.2(a) and 424.5(a) (8), and 44 USC 3101-1; 41 CFR 101.10(a) and 10 USC 1079 and 1086; 5 USC 8101 et seq. and 30 USC 801 et seq. 38 USC 813, E.O. 13659.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to give priority to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used at a hospital or doctor. Additional disclosures are made through routine uses for information collection in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. IRB-70-0501, titled, "Center Medicare Claims Record," published in the Federal Register Vol. 55 No. 177, page 37518, Wed, Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See PIA-5, ESH-6, ESH-12, ESH-13, ESH-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE CHAG/PWIC; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; in the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosure may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, benefit, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability coordination of benefits and civil and criminal litigation. All disclosure is pursuant to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1103B of the Social Security Act and 31 UBC 3801-0812 provide penalties for not disclosing this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

LEDGER/AD PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the level of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount, paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-payment or similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0935-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the needed data, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-04-25-05, Baltimore, Maryland 21204-1630. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

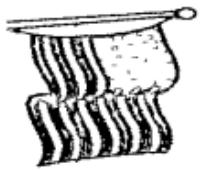
07 25 16

• 04 17 16 00 00 00

07 25 16

Susan Bennett, PT, PC
Bennett Rehabilitation Institute
2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403



224003826 ENEE



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

四百九

1. MEDICARE	MEDICAID	TPCARE	CHAMPVA	GROUP HEALTH PLAN	FICA SICKLING	OTHER	1a INSURED'S ID NUMBER 01387394001059	(For Program in Item 1)				
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TPCare)	<input type="checkbox"/> (CHAMPVA)	<input type="checkbox"/> (Group Health Plan)	<input type="checkbox"/> (FICA SICKLING)	<input type="checkbox"/> (Other)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE					
HARWELL DANIELLE			08291980									
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)						
1131 CLEVELAND DRIVE			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			56 BEREHAVEN DR., LEFT						
CITY CHEEKWAGA	STATE NY	8. RESERVED FOR NUCC USE			CITY AMHERST			STATE NY				
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												
a. OTHER INSURED'S POLICY OR GROUP NUMBER												
b. RESERVED FOR NUCC USE												
c. RESERVED FOR NUCC USE												
d. INSURANCE PLAN NAME OR PROGRAM NAME												
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below												
SIGNED SIGNATURE ON FILE				DATE								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115				15. OTHER DATE MM DD YY 0454 111215								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY _____								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to A-L to service line below (B4))												
A <u>M50.22</u>	B <u>M51.26</u>	C <u>M51.27</u>	D <u>M54.12</u>	E <u>I22.3XXA</u>	F <u>M99.01</u>	G <u>M99.03</u>	H <u>M99.02</u>	I <u>M99.05</u>				
J <u>M54.2</u>	K <u>M54.5</u>	L <u>M54.6</u>										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. RUC/OF SERVICE C. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D/CPT-ICD-9 CODES E. MODIFIER F. G. H. I. J. DIAGNOSIS PORTER F. CHARGES G. DRS OR UNITS H. PER UNIT I. ID QUAL J. RENDERING PROVIDER #												
07112016	07112016	11	98941			ABCD	32 28 1	NPI	1710014188			
07112016	07112016	11	97010			ABCD	10 53 1	NPI	1710014188			
07152016	07152016	11	98941			ABCD	32 28 1	NPI	1710014188			
07152016	07152016	11	97010			ABCD	10 53 1	NPI	1710014188			
07212016	07212016	11	98941			ABCD	32 28 1	NPI	1710014188			
07212016	07212016	11	97010			ABCD	10 53 1	NPI	1710014188			
25. FEDERAL TAX ID NUMBER SSN EN 26. PATIENT'S ACCOUNT NO.									27. ACCEPT ASSIGNMENT I certify that the statements on the reverse apply to this bill and no one else is entitled to receive payment from this bill.	28. TOTAL CHARGE \$ 128.43	29. AMOUNT PAID \$ _____	30. Rev'd for NUCC Use
3454500165 <input checked="" type="checkbox"/> X 343881225									<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and no one else is entitled to receive payment from this bill.)									32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH# (716) 681-3333
PETER GOWINSKI DC									CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849
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Encounter dated 07/21/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits
VAS: Visual Analog Scale

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07 29 16

Federal Building, VA 34403
PO Box 9507
Gloucester

Depew, NY 14043

345 Dick Rd.

(1110) 777-1111



Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
July 26, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday July 11, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain has been slightly better. Patient saw Dr; Pollina earlier today. Patient also saw Dr. McVige who recommended PT with Susan Bennett for PT with her balance issues. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, tingling, shooting, numb. **Pain is frequent.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also has headaches since the accidents. The headaches are back to every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences less dizziness since last visit. **Recent medical treatment for this condition:** Massage therapy; Neurosurgeon evaluation; Neurological evaluation. **Changes in past medical history:** None.

Thoracic: Patient stated that her middle back pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, shooting; level: 5/10. **Pain is occasional.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been more intense. She states that the pain radiates into both posterior thighs and at times into both posterior legs with tingling / numbness into her toes. Patient saw Dr. Pollina who referred her to Dr. Siddique for injections. Dr. Pollina stated that she will give it to October for further improvement and if she does not improve he is recommending surgery. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** getting worse. **since last visit.** **Pain:** achy, dull, shooting, tingling, numb. **Pain is frequent.** **Pain radiates to:** bilateral posterior thighs and legs. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** Massage therapy; Neurosurgeon evaluation. **Changes in past medical history:** None.

Encounter dated 07/11/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

Objective

Cervical: Range of motion: flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. Posture: forward head carriage; rounded shoulders. Strength: all upper extremity musculature (C5-T1) were WNL and graded 5/5. Hypertonicity & Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. X-ray findings: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C5, C6. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Moderate. Trigger points: bilateral rhomboids. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. Heel to toe walking: WNL. Gait pattern: normal. Strength: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. Tenderness & Hypertonicity lumbar paraspinal bilateral moderate to severe; TFL / ITB left moderate.

Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: worse. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:**

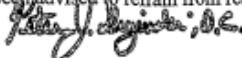
Encounter dated 07/11/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks with a treatment change to decompression due to increased lower back and lower extremity pain; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (anterior); T7 (anterior); T8 (diversified prone); T9 (diversified prone); L4 left (manual traction and anterior maneuver); L5 left (manual traction and anterior maneuver); Left SI left (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy.

Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / CAmel stretches 2 sets of 10 daily hold 5 sec. *Home care:* ice: lumbar 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Friday July 15, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Encounter dated 07/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

Cervical: Patient returned today stating that her neck pain remains the same. Patient had an appointment with Susan Bennett for PT yesterday. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also has headaches since the accidents. The headaches are back to every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences less dizziness since last visit. *Recent medical treatment for this condition:* Massage therapy; Physical therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain continues which makes it difficult to walk. "I can't get comfortable". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 6/10. *Pain is frequent.* *Pain radiates to:* bilateral posterior thighs and legs. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy; Neurosurgeon evaluation. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Encounter dated 07/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

Lumbar/Sacral/Pelvis: Range of motion: flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. Heel to toe walking: WNL. Gait pattern: normal. Strength: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. Tenderness & Hypertonicity: lumbar paraspinal bilateral moderate to severe; TFL / ITB left moderate. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

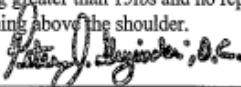
Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. **Treatment schedule:** 2x/week for 4 weeks with a treatment change to decompression due to increased lower back and lower extremity pain; Re-examination for 4 weeks. **Subluxations found on assessment and adjusted:** C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (anterior); T7 (anterior); T8 (diversified prone); T9 (diversified prone); L4 left (flexion/distraction); L5 left (flexion/distraction); Left SI left (prone mobilization). **Physical Modalities:** bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar

Encounter dated 07/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / CAmel stretches 2 sets of 10 daily hold 5 sec. *Home care:* ice: lumbar 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday July 21, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also has headaches since the accidents. The headaches are back to every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences less dizziness since last visit. *Recent medical treatment for this condition:* Massage therapy; Physical therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activites of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been worse since last visit. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* worse. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb; level: 8/10. *Pain is frequent.* *Pain radiates to:*

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bilateral posterior thighs and legs. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy; Neurosurgeon evaluation. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity:* lumbar paraspinal bilateral severe; TFL / ITB left moderate to severe. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc

Encounter dated 07/21/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/26/2016

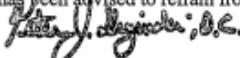
extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: worse, VAS score increased from a 6 to an 8 out of 10. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks without decompression at this time because her lower back is so sore she would not be able to tolerate it; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (anterior); T7 (anterior); T8 (diversified prone); T9 (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); Left SI left (prone mobilization). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: lumbar 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA										PICA					
1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FPCA BILLING (NDA)	OTHER (NDA)	1a. INSURED'S ID. NUMBER			(For Program in Item 1)					
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> Member/Off	<input type="checkbox"/> (NDA)	<input type="checkbox"/> (NDA)	<input type="checkbox"/> (NDA)	013873940-0101-059								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							3. PATIENT'S BIRTH DATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
EARWELL, DANIELLE							MM	DD	YY	SEX	- NAME -				
5. PATIENT'S ADDRESS (No., Street)							6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)					
56 BERKEHAVEN DR							<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other						
CITY		STATE		8. RESERVED FOR NUCC USE			CITY			STATE					
AMHERST		NY		X											
ZIP CODE		TELEPHONE (Include Area Code)					ZIP CODE			TELEPHONE (Include Area Code)					
14228		(716) 536-0951								()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10. IS PATIENT'S CONDITION RELATED TO:								
							a. EMPLOYMENT? (Current or Previous)	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR PEDA NUMBER					
							b. AUTO ACCIDENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PLACE (State)			MM DD YY		
							c. OTHER ACCIDENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	M <input type="checkbox"/> F <input checked="" type="checkbox"/>					
d. INSURANCE PLAN NAME OR PROGRAM NAME							12. IS THERE ANOTHER HEALTH BENEFIT PLAN?								
							<input type="checkbox"/> YES	<input type="checkbox"/> NO	If yes, complete lines 9, 10a, and 10c.						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.															
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															
SIGNED _____ ON FILE _____ DATE 01-06-2016 SKIMED _____ ON FILE _____															
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)		15. OTHER DATE (QUAL)		MM	DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION								
1-0 31 2015		QUAL					FROM	MM	DD	YY	TO	MM	DD	YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
SYDNEY GRABAU, PA		17b. NPI _____		FROM	MM	DD	YY	TO	MM	DD	YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															
20. OUTSIDE LAB? \$ CHARGES															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))															
ICD Ind.															
A. L179.1	B. _____	C. _____	D. _____	E. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	GPT/HCP(S)	E. MODIFIER	F. R.	G. DRS OR UNITS	H. AMT PER UNIT	I. ID. #	J. RENDERING PROVIDER ID #				
1	07 05 16	07 05 16	11	97140							NPI				
2	07 12 16	07 12 16	11	97140							NPI				
3	07 16 16	07 16 16	11	97140							NPI				
4											NPI				
5											NPI				
6											NPI				
25. FEDERAL TAX ID NUMBER	SSN/IN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT (FOR GOVT. CASH & ETC)			28. TOTAL CHARGE	29. AMOUNT PAID	30. Rwd for NUCC Use						
47-0989449	<input type="checkbox"/>	HARWELL, D		<input type="checkbox"/> YES	<input type="checkbox"/> NO		\$ 165.00	\$ 0.00	165.00						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)															
32. SERVICE FACILITY LOCATION INFORMATION															
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043															
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043															
COLLEEN MARK, LMFT 07.16.2016 SIGNED DATE 8/14/16 97011															
B 8/14/16 97011 b															

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE REPRINTED INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

POLICIES: Any person who knowingly makes a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act pursuant to our law and may be subject to civil penalties.

REFERS TO HOMEWORK TIME SPANS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's insurance company that pays for Medicare and supplemental rates of pay may determine, in accordance with the terms of the policy, to process the claim and certain costs of the services as follows:
1. Through a Medicare claim, the patient's insurance authorizes any entity to release to Medicare medical and nonmedical information and relating to the patient's health condition, laboratory test results, hospital stay, and other treatment which is responsible for any or all of the patient's expenses.
2. In Medicare assignment or TRICARE participation, the patient's insurance accepts the charge determinations of the Medicare carrier or TRICARE beneficiary in full.
3. The patient's insurance may make payment for health care services rendered by a provider listed on the enrollment list with this insurance.
4. Insurance resulting in a deductible or coinsurance amount should be processed in those areas where applicable. In the case of items 1, 2, 3, 6, 7, 8, and 11.

THE SOUTHERN CALIFORNIA CLASS

The following terms are used throughout this document as defined in all *See Black Line* and *ERGIC* instructions including *new-old procedure* and *diagnose coding systems*.

SCHEMATIC DRAWING NO. 100-1227000-001 DATE 11-10-03 BY ECA AND BLDG. 1003

In submitting this claim for payment from Mutual Health, I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished myself with all applicable laws, regulations, rules, codes, or requirements, which may apply to the medical contractor; 3) I have provided or will provide sufficient information required to allow the corporation to issue insurance or reinsurance coverage to my employer; 4) my claim is being submitted by me or my employee to my employer, my agent, or billing company, along with all applicable bills, claims, authorizations, and payment instruments or paper work that is not furnished in the Federal Form 1040, Schedule C, Physician Self-Reliance Tax Law (Form 1040 Schedule C); 5) the services, on this form, were medically necessary and personally required; 6) my services were furnished entirely to my professional service by my employee under my direct supervision, except as otherwise expressly provided by Medicare or TRICARE; 7) no such service rendered is related to my professional service, the identity (legal name and NPI), license # (or SSN) of the primary intended recipient, and/or cause is listed in the designated "other services" to be rendered to "me" (self), "my" wife, "my" spouse, professional service; 8) they must be rendered under the physician's direct supervision by the employee; 2) they must be an integral, though incident, part of a covered physician service; 3) they must be of kind commonly furnished in private office practice; 4) the "other services" must be rendered "in person" as defined.

For TAD/CARE claims, I further certify that (a) my employee who received services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the "Under" Status Command, either civilian or military (refer to 5 USC 553); For Back/Lung claims, I further certify that the services performed were for a Profit-Limited Company.

iii. Part B Medicare payments may be paid in installments if required by existing law or regulations (42 CFR 434.32).

MONIQUE. Am I correct in my assumption or has the court information to receive payment from Federal funds requested by the former may upon conviction be subject to fine and imprisonment under reasonably Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF LBD-1005, TRIC-056, ZEGO-1, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by GI-5, TRICARE and OHCP to ask you for information needed in the administration of the Medicare, TRICARE, PBOA, and Black Lung programs. Authority to collect information is under 30 USC, 106, 107-2 and 1874 of the Veterans' Benefits Act as amended, 42 CFR 411.24(a) and 37 CFR 5(a)(6), and 44 USC 3101, 41 CFR 101-10 seq and 10 UGC 1079 and 1083. 5 USC 5501 seq, and 41 USC 601 et seq, 29 USC 181 E.O. 13937.

The information we obtain to complete claims and to determine your aid to determine your eligibility. It is also used to decide if the service is supplied to you under the law.

The information on many of the topics in this chapter is derived from the Federal Register and other publications of the Federal Interagency. In this chapter, the following terms are used to refer to the programs and activities of the Federal government:

POR MEDICARE CL 44132: See also notes modifying systems No. 00-70-0010, 4 Vol. *Cover Medicare Claims Report*, published in the Federal Register, Vol. 55 No. 177 page 3758, Wed. Nov. 12 1990 or as in listed and reprinted book.

FOR OFFICE OF CLIMATE CHANGE DEPARTMENT OF LABOR, PROSECUTIVE ACT OF 1974, 'REGULATION OF POWER SYSTEMS OF NUCLEAR,' FEDERAL REGISTER VOL. 55 NO. 40, WED FEB. 28, 1990. SEE EBA-5, EBA-6, EBA-12, EBA-13, EBA-30, OR AS AMENDED AND RESTATED.

FOR TRICARE CLASS: PRINCIPAL PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the service member's dependents are authorized beneficiaries.

ROUTINE USES. Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation, or to contractors and consultants with statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the International Review Board, private collection agencies, and consumer reporting agencies; in connection with procurement claims, and to Congressional Offices, in response to inquiries made at the request of the person or entity named, received pursuant to appropriate disclosure laws; to state, local, foreign government agencies, private business entities, and individuals, providers of care, or entities relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, prior review, program integrity, third-party liability, providers of medical and related services located within the boundaries of TRICARE.

DISCLOSURE REQUESTS: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no pre-existing disclosure waivers under these programs, for releasing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information requested by JPSA could bar processing of a claim.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

Medicaid Payments (Provider Certification)

I hereby agree to loan such records as are necessary to disclose fully the cost of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State agency or Dept. of Health and Human Services as may be requested.

I further agree to accept as payment in full the amount paid by the Medicare program for these claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPERVISOR): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

Argentina to the Pan American Health Organization: As of 1975, no person can be employed in a public or private establishment unless it displays a valid Quill control number. The valid Quill control number is required for all employees of Federal and Provincial governments, and for all employees of State-owned enterprises, including the Post Office, telephone, electric power, gas, water, and sewerage systems.

08 01 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14243
 Office: (716) 725-0634 Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 7/1/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliges ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client/Referral Note(s) in center of

Thoracic pain/Chest P. w/o hyperactivity

This session.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Cheri May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243
 Office: (716) 725-0634 Fax: (716) 725-0265

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliges ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

08 01 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 7/15/16

Client Status: (Circle) Better Progressing Worse Same/No Change
Best Worst

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Bend Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Root (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client of continued Cervical / Shoulder

Pain: ↓ ROM in Shoulder/unable to flex past

↓ load @ 90°. Muscle stretching applied

Action's Applied: (Check All that Apply) to Cervical muscles.

- Heat Packs Cold Packs Bomber/Blowouts
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Can't Meds Ice / Heat

Therapist:

Danielle Harrell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 7/12/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Bend Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client continues to complain of radicular symptoms to L5/S1

LES: L5/S1 muscle are hypertrophic & tender. No D

in cervical mm. tone this session.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Bomber/Blowouts
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Can't Meds Ice / Heat

Therapist:

Danielle Harrell

08 01 16

08 01 16

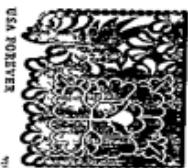
Great Lakes Therapeutic Massage

& Bodywork Practitioners
375 Dick Road, Suite #2

Depew, NY 14043
Attn: C. Marx

Dep't, N.Y. 190-9
Attn: C. Marx

ב' ז'



GEICO INS CO of NY

P.O.BOX 9507

FREDRICKSBURG, VA 22403

224 LOGISTICS

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CI AIM COMMITTEE (NUCC) 08/02

XNUCC

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FEDERAL BUILDING OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> Member/Dep <input type="checkbox"/> Group <input type="checkbox"/> Federal Building <input checked="" type="checkbox"/> Other												1a. INSURED'S ID NUMBER (For Program in Item 1) 0138739400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE SEX 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
4. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												5. PATIENT'S RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
6. CITY CHEEKERTOWAGA				7. CITY CHEEKERTOWAGA				8. STATE NY							
ZIP CODE 14225				ZIP CODE 14225				TELEPHONE (Include Area Code) ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____			
d. INSURANCE PLAN NAME OR PROGRAM NAME												11. INSURED'S POLICY GROUP OR FCA NUMBER DOI 10/31/15			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I acknowledge the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												12. INSURED'S DATE OF BIRTH MM DD YY 08 29 1960 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
13. SIGNATURE OF AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												13. OTHER CLAIM ID (Designated by NUCC) I II III			
14. SIGNATURE ON FILE												14. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.			
15. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) DUE: 439												16. DATE MM DD YY TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI												17a. 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES IG 062607 FROM MM DD YY TO MM DD YY 17b. NPI 1710014188			
19. ADDITIONAL CI AIM INFORMATION (Designated by NUCC)												19. INSURED'S LAB TEST CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20. PHYSICIAN/LAB TEST CHARGES												21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Please A-L to service line below (24a) A M791 B M5442 C _____ D _____ E _____ F _____ G _____ H _____ I _____ J _____ K _____ L _____			
22. REINSTATEMENT CODE												22. ICD IND. 0 ORIGINAL RET. NO.			
23. PRIOR AUTHORIZATION NUMBER												23. PNR			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 08 02 16 08 02 16												B. PHARMACEUTICALS, SERVICES, OR SUPPLIER (Prohibit Unusual Concentrations) CPT/ICPC MOD/DRG 20553			
C. DIAGNOSIS CODE ICD-9-CM A												D. CHARGES \$ CHARGE 95 74 1 NPI			
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Megan Kuschke, PA-C	Audrae Ozaelli, PA-C
Lorraine Lotis, FNP-C	Christopher Zielinski, PA-C

Sydney B Grabau, PA

Procedure Note Date: 08/02/2016

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 35 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- Migraine, Trigger Points

History of Present Illness

General:

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Danielle states the trigger point injections have been quite helpful for her neck pain. She has also continued with regular massage therapy, chiropractic and physical therapy. The patient has new concerns of worsening low back pain in recent weeks. She has been following with Dr. Pollina and may be considering an epidural injection within the next month.

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A

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Karinne House
Amanda McFayden
Alice Truskala

INFUSION CENTERS

Christina Marrs, MBA, Dir.cler
Barbara Mulderrig, RN, Manager

- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking: Patient is a non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex

- codeine

- penicillin

- Biaxin

- Cipro

- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 104/72, HR 78, RR 16, Ht 63", Wt 150, BMI 26.57, BSA 1.74.

ExaminationNEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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 Alice Trzeciak

INFUSION CENTERS

Clementina Minas, MBA, Director
 Barbara Muderig, RN, Manager

points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)
2. Left-sided low back pain with left-sided sciatica, unspecified chronicity - M54.42

The patient was advised to try physical therapy for the lumbar spine. We elected to continue with regular trigger point injections, but in 6 week intervals at this point.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Left-sided low back pain with left-sided sciatica, unspecified chronicity

PHYSICAL THERAPY Lower Back1194079

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 7 cc was injected with a 25-gauge needle without complication into 7 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness

An additional 0.5 mL was injected at the C1-2 facet bilaterally..

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 08/02/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 08/02/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 08/02/2016.

Follow Up

6 weeks

spine flr PA-C

J

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INFUSION CENTERS

Christine Massa, MBA, Director
Barbara Maldonig, RN, Manager

Patient: Harwell, Danielle | DOB: 08/29/1980 | Procedure Note

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Electronically signed by Sydney Grabau , PA on 08/02/2016 at 11:56 AM EDT
Sign off status: Completed

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Christine Marie, MBA, Director
Barbara Mulderig, RN, Manager



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

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PICA												PCA	
1 MEDICARE <input type="checkbox"/> Medicare	2 MEDICAID <input type="checkbox"/> Medicaid	3 TRICARE <input type="checkbox"/> DOD/DoD	4 CHAMPVA <input type="checkbox"/> Member/DoD	5 GROUP HEALTH PLAN <input type="checkbox"/> DoD	6 FECA ELIGIBILITY <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	7 OTHER <input type="checkbox"/> Other	8 INSURED'S ID NUMBER 013873940-0101-059		(For Program In Item 1)				
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY			4. INSURED'S NAME (Last Name, First Name, Middle Initial) EARWELL, DANIELLE	5. PATIENT'S ADDRESS (No., Street) 56 BERBHAVEN DR		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)		
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE		CITY		STATE					
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X		ZIP CODE		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>PLACE (State) N.Y.</small>												a. INSURED'S DATE OF BIRTH MM DD YY	
c. RESERVED FOR NUCC USE												b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME												c. INSURANCE PLAN NAME OR PROGRAM NAME	
10e. CLAIM CODES (Designated by NUCC)												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												If yes, complete items 9, 10a, and 10d.	
SIGNED <u>ON FILE</u> DATE 01-06-2016												SIGNED <u>ON FILE</u>	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)		15. OTHER DATE QUAL		MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
1.0 31 2-3-5		QUAL											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA		17a		18. HOSPITALIZATION/DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
		17b (NP)											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (24e))												22. RESUBMISSION CODE ORIGINAL REF. NO.	
A <u>M79.1</u>	B <u> </u>	C <u> </u>	D <u> </u>	23. PRIOR AUTHORIZATION NUMBER									
E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>										
I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER	F. DIAGNOSIS CODE POINTERS	G. DATES OR UNITS	H. REPORT PER UNIT	I. ID QUAL	J. RENDERING PROVIDER ID #		
1 07-18-16	07-18-16	16	11	97140							NPI 2144462031		
2 07-22-16	07-22-16	16	11	97140							NPI 2144462031		
3 07-26-16	07-26-16	16	11	97140							NPI 2144462031		
4 07-28-16	07-28-16	16	11	97140							NPI 2144462031		
5 											NPI		
6 											NPI		
25. FEDERAL TAX ID NUMBER 47-0989449		SSN/BIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO EARWELL, D		27. ADJUST ASSIGNMENT FOR DEBILIZING <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE 6 220	29. AMOUNT PAID 8 0 100	30. Read for NUCC Use 220	31. BILLING PROVIDER INFO & PH# (716) 725-0264			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043	
COLLEEN MARX, LMT SIGNED DATE 07.29.2016 # 1144462011												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043 # 1144462011	

Great Lakes Therapeutic Massage & Bodywork Practitioners

373 Dick Rd Depew, NY 14203

Office: (716) 725-0324

Fax: (716) 725-0325

Client Name: Danielle Harrell Date: 7/18/16

Client Status: (Click) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) IT Band
 Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports no discomfort/sacroiliac/pelvis.
 I have a slower ambulatory gait. No hypertension
 in cervical spine this session.

Action/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist:

Allen Tracy 

Great Lakes Therapeutic Massage & Bodywork Practitioners

373 Dick Rd Depew, NY 14203

Office: (716) 725-0324

Fax: (716) 725-0325

Client Name: Danielle Harrell Date: 7/18/16

Client Status: (Click) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

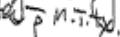
- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) IT Band
 Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client/c/o M LBP = DLE paraesthesia. Unable to bend; driving is extremely difficult & slower gait noted.

↓ swollen / hot / tender. Massage followed by ice / tape.

Action/s Applied: (Check All that Apply) Client felt better P.M.T. 

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist:

Allen Tracy 

08 04 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0834

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 7/20/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling Stabbing/Shooting

Observed Areas of Problem/Dysfunction: (Check All that Apply) Shoulder Arm Hand

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes IT Band
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: (Light (1), Moderate (2), Severe (3))
 Left shoulder to 1/2 (severe) left leg
 Antalgic gait. Pain shoots up & down in L-LF especiallyGhoul? No Acute/Chronic:Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice/Heat

Therapist: ellen harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0834

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 7/20/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling Stabbing/Shooting

Observed Areas of Problem/Dysfunction: (Check All that Apply) Back Arm Hand

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes IT Band
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has significant radiating into L-LF. Left knee, thumb & middle finger in supine position.Restrictions: L-LF, right knee, thumb & middle finger throughout lumbosacral.Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice/Heat

Therapist: ellen harwell

98.04.16

08 04 16

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marr



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

5/5 Dick Road, Suite #7

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09-02

PICA										PICA					
1. MEDICARE <input type="checkbox"/> (Medicare)	2. MEDICAID <input type="checkbox"/> (Medicaid)	3. TRICARE <input type="checkbox"/> (DOD/DoD)	4. CHAMPVA <input type="checkbox"/> (Member ID#)	5. GROUP HEALTH PLAN <input type="checkbox"/> (GHP)	6. FECA <input type="checkbox"/> (FPI)	7. OTHER <input type="checkbox"/> (O)	8. INSURED'S I.D. NUMBER 0138739400101059			(For Program in Item 1)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							3. PATIENT'S BIRTH DATE MM DD YY 08 29 80			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X					
HARRELL, DANIELLE										4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARRELL, DANIELLE					
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE							6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE					
CITY CHEERTOWAGA			STATE NY		8. RESERVED FOR NUCC USE			CITY CHEERTOWAGA			STATE NY				
ZIP CODE 14225			TELEPHONE (Include Area Code) ()					ZIP CODE 14225			TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10. IS PATIENT'S CONDITION RELATED TO,			11. INSURED'S POLICY GROUP OR FECA NUMBER					
							a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. INSURED'S DATE OF BIRTH MM DD YY 08 29 80					
							b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY			c. OTHER CLAIM ID (Designated by NUCC) Y4 0138739400101059					
							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO INSURANCE NY PIP					
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODE# (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															
SIGNED Signature On File							DATE 7/19/2016								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 31 15							15. OTHER DATE QUAL 439		MM DD YY 10 31 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN J PETER GUZINSKI							17b. NPI 1710014188		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							20. OUTSIDE LAB?			\$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. O							22. REBMISSION CODE			ORIGINAL REF. NO.					
A. <u>M48.06</u>	B. <u>M54.16</u>	C. <u>M54.2</u>	D. <u> </u>												
E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>												
I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>												
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY							B. NURS OF SERVICE EMR	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)	E. MODIFIER	F. DIAGNOSIS PONTER	G. DATES ON UNITS	H. AMOUNT PAID PER UNI	I. ID. QUAN.	J. RENDERING PROVIDER ID. #
07 11 16	07 11 16	11	99213		ABC	51	54	1	OB 201503						
									NPI						
									NPI						
									NPI						
									NPI						
									NPI						
26. FEDERAL TAX I.D. NUMBER BSN BN							27. PATIENT'S ACCOUNT NO. 102251			28. ACCENT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	29. TOTAL CHARGE \$ 51.54	30. AMOUNT PAID \$ 0.00	31. Rev'd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) John Pollina							32. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery 3980A Sheridan Drive Amherst, NY 14226			33. BILLING PROVIDER INFO & PH# () UB Neurosurgery, Inc PO Box 8000 Dept 883 Buffalo, NY 14267					
34. DATE 7/19/2016							35. DATE 201503			36. DATE 1306896220					

Carrier Manifest

GEICO
PO BOX 9507
FREDERICKSBURG, VA 224039998

Total Claims: 62
Claims per Organization:

DAVID J. WEISSBERG, MD,PC : 1

Empowerdr : 49

excelsior orthopaedics, llp : 12

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Carriers Grouped Together

Carrier Address	Pages	Carrier Address	Pages
4197 Geico P O BOX 9507 Fredericksburg, VA 22403-9526	671	14814 GEICO PO BOX 9507 FREDERICKSBURG, VA 224039998	414
14633 GEICO INSURANCE NY PIP PO BOX 9507 FREDERICKSBURG, VA 224039526	54		(O)

Carrier Manifest

Geico
P O BOX 9507
Fredericksburg, VA 22403-9526

Total Claims: 148

Claims per Organization:

Brain and Spine Center : 13
BUFFALO NEUROSURGERY GROUP : 6
BUFFALO ORTHOPAEDIC GROUP, LLP : 3
CareMount Medical, P.C. : 24
CLINICAL PRACTICE MANAGEMENT PLAN : 72
EMPDRS Flatbush : 1
FLH Medical, PC : 1
Hamilton Orthopaedics and Sports Medicine : 1
HUDSON VALLEY DIAGNOSTIC IMAGING : 2
MONMOUTH MEDICAL IMAGING P.A. : 1
ORANGE RADIOLOGY AND MRI OF MONROE : 1
ORANGE RADIOLOGY AND MRI OF NEWBURGH : 1
Radiology Services of New York, PC : 1
Radiology Solutions Associates, PLLC : 1
RAMAPO DIAGNOSTIC IMAGING : 1
ST. JOSEPH IMAGING ASSOCIATES : 1
Tier Orthopedic Associates P.C. : 6
University Orthopaedic Services, Inc. : 7
Vericle : 5

08 08 16



UNITED STATES
POSTAL SERVICE®

FROM:

		Click-N-Ship®
WEIGHT 0.040 \$7.95 US POSTAGE RegalBox B		
08/04/2016 11 lb 8 oz Mailed from 07981 06290000000314		
PRIORITY MAIL 2-DAY™		
IHCFA.COM 110 S JEFFERSON RD STE 201 WHIPPANY NJ 07981-1038		Expected Delivery Date: 08/08/16 0004
Carrier - Leave If No Response		B086
SHIP TO GEICO PO BOX 9507 FREDERICKSBURG VA 22403-9526		
USPS TRACKING #		
9405 5036 9930 0369 7124 21		
Electronic Rate Approved #038555749		

PRIORITY
★ MAIL ★

Danielle Harwell DD 07/11/2016

Page #2

experiencing in both her low back and her low extremities. Overall her cervical complaints are much improved and tolerable. I recommend that she continue with her current treatment in regards to her cervical and lumbar complaints. Since her lumbar complaints are more persistent at this time, I recommend a trial of epidural steroid injections to add to the current treatment plan. I will refer her to Dr. Jafar Siddiqai for this. We will see her back in the office in about eight weeks to continue following her progress. Should her symptoms remain intolerable and persistent following her conservative management attempts, we will consider any surgical intervention. We will discuss this further at the next office visit.

The patient and proposed treatment plan was discussed with Dr. Pollina.

Thank you very much for allowing me to participate in the ongoing care of this patient.

Diagnosis: Spinal stenosis, lumbar region, Radiculopathy, lumbar region, Cervicalgia

Sincerely,



Electronically signed by Thomas Falletta, ANP-BC on 07/22/2016 at 1:45 pm
Thomas Falletta, ANP-BC in conjunction with Dr. Pollina
Nurse Practitioner
UB Neurosurgery



Electronically signed by John Pollina, MD
John Pollina, Jr., M.D.
Clinical Vice Chairman
Director of Spine Surgery
Assistant Professor of Neurosurgery
TF/JP/dlp
cc James Panzarella DO

Organization Manifest

Sun Knowledge, INC.(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03019795701010311		VASQUEZ, MARIELA	07/26/2016	07/26/2016

Organization Manifest

WEST HUDSON IMAGING ASSOCIATES PLLC. (2)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
4446096069	1	CUNNINGHAM, BRANDI	07/27/2016	07/27/2016
4446096069	2	CUNNINGHAM, RAYMOND	07/27/2016	07/27/2016

Organization Manifest

DAVID J.WEISSBERG, MD,PC(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01706307601011787		ARMATA, JANINE	08/01/2016	08/01/2016

Carrier Manifest



GEICO INSURANCE NY PIP
PO BOX 9507
FREDERICKSBURG, VA 224039526

Total Claims: 13
Claims per Organization:

Sun Knowledge, INC. : 1
UB Neurosurgery, Inc : 10
WEST HUDSON IMAGING ASSOCIATES PLLC. : 2

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Organization Manifest

UB Neurosurgery, Inc(10)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01730813901010541		BROOKS, CATHERINE	06/30/2016	06/30/2016
03957638901010132		KANE, KARA	07/06/2016	07/06/2016
03874813501010722		KAUFMANN, AMANDA	07/06/2016	07/06/2016
03739363401010331		HOOKER, ROBERT	07/11/2016	07/11/2016
01549860001010181		MERCHANT, MICHAEL	07/12/2016	07/12/2016
01742594001010531		SALADA-CONROY, JEANNE	07/08/2016	07/08/2016
04128004301010351		ZAWIERUSZYNKI, DAWN	07/12/2016	07/12/2016
01387394001010591		HARWELL, DANIELLE	07/11/2016	07/11/2016
03957638901010132		KANE, KARA	07/11/2016	07/11/2016
05024362901010121		BARLOW, RACHEL	07/07/2016	07/07/2016

Organization Manifest

excelsior orthopaedics, llp(12)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
02354765101010322		WALKER, MARK	07/11/2016	07/11/2016
04081689801010453		ATKINSON, NIAMA	07/12/2016	07/12/2016
02049589501010902		SMITH, ALVAR	07/11/2016	07/11/2016
02049589501010903		SMITH, ALVAR	07/13/2016	07/13/2016
02354765101010323		WALKER, MARK	07/14/2016	07/14/2016
04081689801010452		ATKINSON, NIAMA	07/14/2016	07/14/2016
02354765101010322		WALKER, MARK	07/18/2016	07/18/2016
02524014401010172		BOLTON, MIKA	07/13/2016	07/13/2016
02049589501010902		SMITH, ALVAR	07/18/2016	07/18/2016
04081689801010452		ATKINSON, NIAMA	07/19/2016	07/19/2016
04368453001010542		HERNANDEZ, DAVID	07/20/2016	07/20/2016
01641438801010432		HITZGES, DENISE	07/21/2016	07/21/2016



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GRICO
PO BOX 9507

Fredericksburg VA 22403

CARRIER

PICA

1. MEDICARE MEDICAID TRICARE CHAMPAVA GROUP HEALTH PLAN FECA OTHER (Medicare) (Medicaid) (TRICARE) (Member ID#) (HMO) (FECA) (Other)												1a. INSURED'S ID. NUMBER (For Program in Item 1) 013873940010158 <input checked="" type="checkbox"/> <input type="checkbox"/>		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle						3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle		
5. PATIENT'S ADDRESS (No. Street) 1131 Cleveland Drive						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No. Street) 1131 Cleveland Drive		
CITY Cheektowaga			STATE NY			CITY Cheektowaga			STATE NY					
ZIP CODE 14225			TELEPHONE (Include Area Code) ()			ZIP CODE 14225			TELEPHONE (Include Area Code) ()					
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER		
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>								
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)								
d. INSURANCE PLAN NAME OR PROGRAM NAME						c. INSURANCE PLAN NAME OR PROGRAM NAME								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d		
SIGNED JENNIFER McVIGE SIGNATURE ON FILE DATE 07/27/16												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below		
SIGNED JENNIFER McVIGE SIGNATURE ON FILE DATE 07/27/16												14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		
15. OTHER DATE MM DD YY QUAL												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR JENNIFER McVIGE MD												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services less below (24e) A. R42 B. L C. L D. L E. L F. L G. L H. L I. L J. L K. L L. L												22. RESUBMISSION CODE ORIGINAL REF. NO.		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service EMB 27. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER												23. PRIOR AUTHORIZATION NUMBER 013873940010159		
B. D. DIAGNOSIS CODE ICD IND 0 1												F. G. H. I. J. CHARGES DAYS OR UNITS H. AMOUNT PER DAY I. ID QUAL J. RENDERING PROVIDER ID # 225100000X		
1	07	27	16	07	27	16	11	97110		A	46.00	1	NPI 1205129921	
2	07	27	16	07	27	16	11	97140		A	46.00	1	NPI 1205129921	
3	07	27	16	07	27	16	11	97010		A	26.00	1	NPI 1205129921	
4														
5														
6														
25. FEDERAL TAX ID NUMBER	SSN	BN	26. PATIENT'S ACCOUNT NO	27. ACCEPT. ASSIGNMENT? I certify that the statements on the reverse apply to this bill and are made a part hereof. <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE	29. AMOUNT PAID	30. Rcv'd for NUCC Use					
201163729	<input type="checkbox"/>	<input checked="" type="checkbox"/>	103558				\$ 116.00	\$ 0.00						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I certify that the statements on the reverse apply to this bill and are made a part hereof.) McPherson, Jacob PT, DPT												32. SERVICE FACILITY LOCATION INFORMATION Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432		
SIGNED 07/29/16												33. BILLING PROVIDER INFO & PH# (716) 8038220		
												* 1710021001 b		

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly uses a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a crime if not punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

TRICARE, PEC, AND BLACK LUNG: A patient's signature on this form is a statement that payment will be made and authorizes release of any information necessary to process the claim and certifies that the information provided in block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare and all other health insurance plan(s) and employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services, a copy of the Medicare claim is made. See 42 CFR 411.27(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Med Care and TRICARE participation cases, the plan can agree to accept the charge determination of the Medicare carrier or TRICARE local interim carrier for the full charge and the patient is responsible only for the deductible, copayments and non-covered services. Copayments and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local interim carrier. In TRICARE fiscal intermediary cases, the charge submitted, TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned as "Insured," i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND PECRA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and PECRA Instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, PECRA, PEC AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and reasonably furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI), location, or % (25%) of the primary individual rendering such service, is indicated in the claim submission. For services to be considered "incident to" a physician/professional services, 1) they may not be rendered under the physician's name or supervision by another employee; 2) they must be an integral, although incidental part of a covered physician service; 3) they must be directly and personally furnished in my office; and 4) the name of the physician rendering the service is indicated on the physician's bill.

For TRICARE claims, I further certify that 1) (any employee) who rendered service, are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government, other than in military (refer to 5 USC 5538). For Black Lung claims, I further certify that the individual patient is not a Black Lung related disorder.

No Part B Medicare benefits may be paid unless the form is received as required by statute law and regulations (42 CFR 434.27).

NOTICE: Any person who knowingly furnishes false or inaccurate information to receive payment from Federal funds required by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PECRA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We act authorized by CMS, TRICARE and OMB to ask you for information needed in the administration of the Medicare, TRICARE, PECRA and Black Lung programs. Authority to collect information is taken from OMB 2010-01, 100-07 and 100-08 of the Social Security Act as amended, 42 CFR 411.84(b) and 194.60 (b), and 41 USC 3101(a)(1) through 3101(d) and 10 USC 1079 and 1080; 5 U.S.C. 5501 et seq. and 40 USC 501 et seq.; 38 USC 1012; F.O. 1070.

The information we obtain is complete, clear, and concise—provided I used to identify you and to determine your eligibility. It is also used to verify that the services and payment you received are covered by the program and to insure that proper payment is made.

The information we obtain is given to other providers of services, centers, laboratories, medical review boards, health plans, and other organizations or individuals, or to the executive administration of Federal programs that require other third parties to pay money to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the patient, you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 03-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37549, Wed. Sep. 12, 1990, or as updated and republished.

FOR OMB CLM/RB: Department of Labor, Privacy Act of 1974, "Publication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-6, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/claims received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation and other their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agents, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to requests made at the request of Congress to determine the status of a particular claim. Appropriate disclosures may be made to other Federal, State, local, foreign government agencies, private business entities, and individual members of the public in a timely manner, if there is a need to protect the public interest, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE OF MEDICAL INFORMATION: Failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under the programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under TRICARE could result in claim denials.

If, at any time, you tell us you know that another party is responsible for paying for your treatment, Section 1128B of the Social Security Act and 31 USC 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-202, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matching.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

Please be advised that such forms or documents are to depict fully the usual of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payment claim or payment made to an individual or to a State Agency. Dpt. of Health and Human Services may request.

Under section 1903(e) of the Medicaid program, the amount paid by the Medicaid program for these claims submitted for payment under this program, with the exception of authorized deductible, coinsurance, co-payment or similar cost sharing charges.

DISCLAIMER OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: The use of forged, altered, falsified, or forged and altered documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the "Regulations of the Rehabilitation Act of 1973," a program is required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this form is 2500-0100. The estimated average burden for this collection is approximately 1 hour per response, including the time to review instructions, search existing data sources, gather and validate data, and complete and return the information collection. If you have any comments concerning the accuracy of the time estimate, its burden, or if you experience difficulty in responding to this form, please contact: OMB, 7301 Peachtree Boulevard, Attn: LHA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21201-2505. This survey is for comment only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

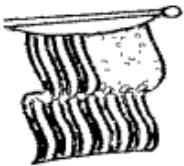
PS 08 16

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Susan Bennett, PT, PC
Bennett Rehabilitation Institute
2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

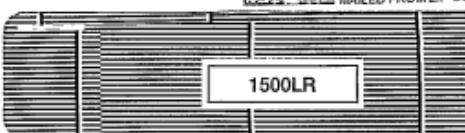
ZONICA

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

PICA X000

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA EXCLUDING <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (For Program in Item 1)													
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE													
3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980 SEX M F X													
4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE													
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR													
6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>													
7 INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR													
CITY CHEEKTONAGA		STATE NY		CITY CHEEKTONAGA		STATE NY							
ZIP CODE 14225		TELEPHONE (Include Area Code) ()		ZIP CODE 14225		TELEPHONE (Include Area Code) ()							
8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
9 OTHER INSURED'S POLICY OR GROUP NUMBER													
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____													
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
d. INSURANCE PLAN NAME OR PROGRAM NAME													
10d CLAIM CODES (Designated by NUCC)													
11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNATURE ON FILE DATE 02 09 16 SIGNED _____													
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
SIGNATURE ON FILE SIGNED _____													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAN: 15. OTHER DATE MM DD YY QUAN: 439 10 31 15													
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. DR. PETER J GUEZINSKI 17b. U62607 17c. 1710014188													
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES _____													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (See) ICD IND: 0 A. M791 B. M5442 C. D. E. F. G. H. I. J. K. L.													
22. REBIMBSSION CODE ORIGINAL REF NO _____													
23. PRIOR AUTHORIZATION NUMBER _____													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMR C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS FINGER													
F. G. H. I. J. RENDERING PROVIDER ID #													
1	08 02 16	08 02 16	11	20553				A	95	74	1	NPI	161582336
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	
25. FEDERAL TAX ID. NUMBER	SSN EN	26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE	29. AMOUNT PAID	30. Rcvd for NUCC Use					
161582336	<input checked="" type="checkbox"/>	1420705				\$ 95	\$ 74	\$ 0.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.)													
JENNIFER W MCVIGE, MD OB 04 16													
32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727													
33. BILLING PROVIDER INFO & P.F. (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002													
SIGNED DATE a 1497850911 b a 1497850911 b													

08 08 16
DENT NEUROLOGIC INSTITUTE
BILLING OFFICE
3980 SHERIDAN DRIVE SUITE 501
BUFFALO, NY 14226



FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature certifies any only to release to Medicare medical and non-medical information and whether the person has employer group health insurance, lottery, no-duty worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the "educator center or TRICARE local intermediary as the biller chooses and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare center or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e., items 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direct supervision by his/her employee; 8) they must be an integral, although incidental part of a covered physician service; 9) they must be of kind commonly furnished in physician's office; and 10) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who renders services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who manufactures or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWC to ask you information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 208(a), 1062, 1072 and 1074 of the Small Business Act, as amended, 42 CFR 411.2'(a) and 44 CFR 3101.101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 38 USC 801 et seq; 38 USC 813, E.O. 9307.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties pay or to pay pursuant to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice "Medicare System No. 09-70-0501, titled, 'Carrier Medicare Claims Record', published in the Federal Register Vol. 55 No. 177, page 37319, Wed Sept. 12, 1989, as updated and republished.

FOR OWC CLAIMS: Department of Labor, Poysey Act of 1974, "Republication of Notice of Systems of Records, Federal Register Vol. 53 No. 40, Wed Feb. 28, 1980. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with debt collection claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate notifications may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal liaison issues as the operation of TRICARE.

DISCLOSURES: Voluntary, however failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, could delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claim statement or document, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Rm. ARA-RPRA Room 3300, Mail Stop C4-35-05, Baltimore, Maryland 21214-1650. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Lamie Machler, MD, Director

Karly A. Benavent, RPA-C
Rebecca Battocle, PA-C
Sydney B Grabau, PA
Lauren Jendrzejek, RPA-C
Megan Keele, PA-C
Larissa Lous, FNP-C

Jennifer W. McVige, MD
Nicolae Salkali, MD
Ajay Ahd, MD

Colin T. Mahoney, PA-C
Kathryna L. Murphy, FNP
Marie Rizzo, RPA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Ozarska, FNP-C
Christopher Zulawski, FNP-C

Sydney B Grabau, PA

Procedure Note

Date: 08/02/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 35 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Migraine, Trigger Points

History of Present Illness

General:

Danielle is a 35-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Danielle states the trigger point injections have been quite helpful for her neck pain. She has also continued with regular massage therapy, chiropractic and physical therapy. The patient has new concerns of worsening low back pain in recent weeks. She has been following with Dr. Pollina and may be considering an epidural injection within the next month.

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A

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Shawn Feger, Clinic Manager
Kathrina Bower
Amanda McFayden
Alice Trzeciak

INFUSION CENTERS

Christina Massi, MBA, Director
Barbara Maderig, RN, Manager

- D&C
- Endoscopy
- Colonoscopy

Family History

Father, alive, Stroke
 Mother alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Resides with:

Spouse: Husband. Children. Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married. Yes

Driving:

Does Patient Drive: Yes.

Exercise:

Daily Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems. neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy

Vital Signs

BP sitting 104/72, HR 78, RR 16, Ht 63", Wt 150, BMI 26.57, BSA 1.74

Examination

NEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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INFUSION CENTERS
 Christine Mass, MBA, Director
 Barbara Muldeng, RN, Manager

points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)
2. Left-sided low back pain with left-sided sciatica, unspecified chronicity - M54.42

The patient was advised to try physical therapy for the lumbar spine. We elected to continue with regular trigger point injections, but in 6 week intervals at this point

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime

Treatment

1. Left-sided low back pain with left-sided sciatica, unspecified chronicity

PHYSICAL THERAPY Lower Back1194079

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 7 cc was injected with a 26-gauge needle without complication into 7 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness

An additional 0.5 mL was injected at the C1-2 facet bilaterally .

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 08/02/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 08/02/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 08/02/2016.

Follow Up

6 weeks

spine flr m-c

J

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 Amanda McFayden
 Alice Trzeciak

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Electronically signed by Sydney Grabau , PA on 08/02/2016 at 11:56 AM EDT

Sign off status: Completed

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Katrias Brewer
Auranda McFayden
Alice Torecanli

INFUSION CENTERS

Christine Minn, MBA, Director
Barbara Mclderig, RN, Manager

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 1451
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 08/04 07:35
 TX/RX TIME 01' 06
 PGS. 5
 RESULT OK



GEICO INSURANCE - NF
 NY PIP CLAIMS
 POBOX 9507
 FREDERICKSBURG VA 22403

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 04/12

1. PATIENT		2. PATIENT'S ADDRESS (Name, Street)		3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> CREDIT	<input type="checkbox"/> MONTH PLAN	<input type="checkbox"/> HMO	<input type="checkbox"/> OTHER
<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)	<input type="checkbox"/> (Member Only)
HARWELL, DANIELLE		1131 CLEVELAND DR		08-29-1980		HARWELL, DANIELLE	
CITY: CHEEKSTOWNSA, STATE: NY		ZIP CODE: 14225		TELEPHONE (Include Area Code): ()		CITY: CHEEKSTOWNSA, STATE: NY	
a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		b. RESERVED FOR NUCC USE		c. EMPLOYMENT (Daniel or Nonworking)		d. INSURED'S DATE OF BIRTH	
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY	
e. OTHER INSURED'S POLICY GROUP NUMBER		f. AUTO ACCIDENT?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY	
		g. OTHER ACCIDENT?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY	
h. RESERVED FOR NUCC USE		i. OTHER ACCIDENT?		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		j. INSURANCE PLAN NAME OR PROGRAM NAME	
k. INSURANCE PLAN NAME OR PROGRAM NAME		l. CLAIM CODDS (Designated by NUCC)		m. IS THERE ANOTHER HEALTH BENEFIT PLAN?		n. INSURANCE OR AUTHORIZED PERSON SIGNATURE	
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		o. INSURED'S DATE OF BIRTH	
12. PATIENT'S SIGNATURE ON FILE		DATE: 02 09 16				MM DD YY	
13. PATIENT'S SIGNATURE ON FILE		DATE: 02 09 16				MM DD YY	
14. DATE OF CURRENT INJURY, OR PREGNANCY (MM/YY)		15. OTHER DATE (MM/YY)		16. DATE OF PATIENT'S LAST WORKING CURRENT OCCUPATION (MM/YY)		17. DATE OF PATIENT'S LAST WORKING CURRENT OCCUPATION (MM/YY)	
MM DD YY		MM DD YY		MM DD YY		MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		19. OUTPATIENT LAW		20. OUTPATIENT LAW	
DN: PETER J GUZINSKI		FROM: MM DD YY TO: MM DD YY		S CHARGES		S CHARGES	
21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. SUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER		24. HENDRICKSON INSURANCE POL. #	
		ORIGINAL REF. NO.				161502336	
A M791		C M5442		D CHARGES		E. H. MVA	
F	G	H	I	J	K	L	M
25. A. DATES OF SERVICE		B. PLACER/FCPS		C. DIVISIONS POINTED		D. HENDRICKSON INSURANCE POL. #	
MM DD YY MM DD YY		MM DD YY MM DD YY		MM DD YY MM DD YY		1649596495	
1 08 02 16		2 08 02 16		3 11		4	
5 20553		6		7		8	
8 A		9 95 74 1		10		11	
9 NPI		10 NPI		11 NPI		12 NPI	

CARRIER

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION



DENT

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Vernice Bates, MD	Franzia M. George, PharmD	Bennett Myers, MD
Bela Ajai, MD	Surjeet Gupta, MD	Maha Patel, MD
Alfred Bates III, MD	Tomas Holmlund, MD	Mohamed M. Qazmyneh, MD
Hercio Capote, MD	J. Maurice Houriene, MD	Michelle M. Ruska, PharmD
Dennis M. Czarcinski, PhD	Xiali Li, MD	Luisa Rojas, MD
Steve Doffman, MD	Lauro Mochiles, MD	Nicolas Salikas, MD
J. Anthony Dujman, PhD	Jennifer W. McVige, MD	Lixun Zhang, MD, PhD
Marc S. Frost, MD	Kenneth R. Murray, MD	Joseph V. Fritis, PhD, CEO

August 4, 2016

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

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DIAGNOSTICS & SERVICES	
MR/CT	Neurophysiology
Angiogramm	Pneurography
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNG
Defenses	

FIRST CLASS MAIL





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA										PICA									
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FICA REG. #	LONG TERM CARE	OTHER	1a. INSURED'S ID NUMBER			(For Program in Item 1)								
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP HEALTH PLAN	<input type="checkbox"/> FICA REG. #	<input checked="" type="checkbox"/> LONG TERM CARE	<input type="checkbox"/> OTHER	1a. INSURED'S ID NUMBER			(For Program in Item 1)								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
HARRELL, DANTELLA				MM	DD	YY	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
				08	29	1980	M	<input checked="" type="checkbox"/>	<input type="checkbox"/>	- 888B -									
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)											
56 BRIERHAVEN DR.				<input checked="" type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other												
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE				CITY		STATE									
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X				ZIP CODE		TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FICA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT (Current or Previous)				a. INSURED'S DATE OF BIRTH											
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	MM	DD	YY	SIX	<input type="checkbox"/> M	<input type="checkbox"/> F								
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?				b. OTHER CLAIM ID (Designated by NUCC)											
				<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	NY													
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME											
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO														
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?											
								<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	If yes, complete items 9, 9a, and 9d									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																			
SIGNED - ON FILE -				DATE 01-06-2016				SIGNED - ON FILE -											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 14. 01 31 2015 QUAL:				15. OTHER DATE QUAL				MM	DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. SYDNEY GRABAU, PA 17b. NPI								MM	DD	YY	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24f))				ICD IND.				22. RESUBMISSION CODE ORIGINAL REF. NO.											
A. <u>M79.1</u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE ENG				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				D. MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. PAYOR PMT PER UNIT	I. ID, QUAL	J. RENDERING PROVIDER ID.#
1	08 01 16	08 01 16	17	97140								55 00	3	NPI	1144462011				
2	08 04 16	08 04 16	11	97140								55 00	9	NPI	1144462011				
3															NPI				
4															NPI				
5															NPI				
6															NPI				
25. FEDERAL TAX ID NUMBER	SSN ENR	26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT BY OTHER INSURANCE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE	29. AMOUNT PAID	30. Rev'd for NUCC Use							
47-0989449	<input checked="" type="checkbox"/>	HARRELL, D								\$ 110 00	\$ 0 00	\$ 110 00							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#					
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043		725-0264					
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							
COLEEN MARK, LMT 08.06.2016 SIGNED DATE												#1144462011		#1144462011					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person knowingly making false, a statement of facts containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act and punishable under state law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROCESS AND ONLY

Medicare - And TRICARE: If the MEBT-A presents an authorization request that requires **TRICARE** to make and authorize release of **any information necessary to process the claim and/or issue a payment**, the information is provided in block 1 through 12 as applicable and complete. In the case of a Medicare claim, the patient's signature suffices any entity to release to Medicare medical and dental information and whether the provider has group health insurance, **TRICARE**, no-fault, workers' compensation or other insurance which is responsible to pay for the services to which the medical claim is a result. See [TRICARE R11 411 2019](#). Is there a co-payment? Is the patient's signature authorizes release of the "information to the health plan or agency" (block 11). In Medicare assignment or TRICARE participation cases, the physician agrees to sign off charge information of the medical claim and the patient is responsible for any deductible, copayments and non-covered services. **Conversely, the Medicare** is based upon the charge information of the medical claim or TRICARE local rate even if it is less than the charge submitted. **TRICARE** is a health insurance program, not a plan, for military health benefits in medical through dental situations. **Under TRICARE Insurance Statute**, information on the patient's treatment should be provided in those items required in **blocks 1, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 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BLACK TOP GROUT FLOOR CLEANER

In this, also, according to America the continental states by the late Government, as payment of full Sec. Sixty-one, and § 772, it instructs, as regards the revenue and drainage, and the system

STRUCTURE OF PANCAKES ON SWINGER (THERMOS "T-CLAVE, 160" AND BLACK LUMA)

For the **Non-Military** claimants, I further certify that I AM NOT any active (or) former member or non-commissioned member of the Uniformed Services or a civilian employee of the United States Government or a civilian contractor for the United States Government, active or inactive, under E.O. 13141. For the **Civilian** claimants, I further certify that the service performed during the time of the Black Lung disease disability.

No Part B allowances benefit any individual unless she/he is deemed as required by regulations the regulations 1-2 CFR §79.32.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICAL, DEMOGRAPHIC AND PLATELLET COUNT INFORMATION (PRIVACY ACT STATEMENT)

We are grateful to Dr. G. T. TROMBLE and Dr. P. C. WILSON for information received in their reports of the Dose-Response, TICARINE, FBCA, and Glutaraldehyde programs. Additional thanks are expressed to Dr. R. J. HARRIS and Dr. J. A. M. BROWN for their contributions to the development of the TICARINE and FBCA programs.

The information you obtain is complete and accurate, your programs will be able to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by these programs and to receive this program payment.

The information may be given orally or written by telephone, e-mail, or facsimile. All individuals involved must be made fully aware of the potential ramifications of Potential agents. If the client is informed, even if it is not necessary, that he or she may be a target in a criminal or Federal program, it is also often necessary to terminated his or her employment. If you are aware of any threats, try to determine information about the threat. You are urged to report any threat to your supervisor or director. Additional databases are used through regular use for reference purposes in the event of a threat.

FOR MEDICINE PLATES. See the notes preceding system No. 08-70-CR01, titled "Cancer Mortality Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37-119, U.S. Govt. Print. Off., 1982, or at www.access.gpo.gov/2009-editions/cancer-mortality-claims-record.html.

FOR OFFICE USE ONLY: Department of Labor, DOL, Act of 1974, "Reproduction or House of Disclosure of Records." Federal Register Vol. 55 No. 46, Wed. FEB. 28, 1990. See FRA-5, E90-1, F3A-12, E90-10, FCA-90, or the Bureau's Circular Handbook.

FOR THIRTY-FIVE MILLION DOLLARS THE FIRM IS TO BUILD A CIRCULAR AIR TERMINAL, 1,000 FEET IN DIAMETER, HAVING 100 AND 500 PASSENGER SEATS, ESTABLISHMENT OF AIRPORT AND AIRPORT HOTEL.

10.11.2019, 10:57:58. Inquiries from citizens and related documents may be sent to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation, or, in connection with any other law, to the appropriate agency, under T-100(LAW-NAME). Direct to the Dept. of Justice by using section 6, 100. Requests of Disclosure are best directed to the relevant

Power of Service, please call your local telephone company or consumer reporting agencies in concert, or via your state's attorney general or Consumer Protection Office, in order to file a complaint about the original creditor.

the formation of lamellae and the mechanical behavior resulting from the structure of TPU-IPF

Under California law, consumers have the right to receive information regarding the cost of their medical services. Consumers may request this information from their healthcare providers under these provisions for relating to single itemization. However, failure to furnish information regarding the modest service rendered or the amount charged would prevent patients and claimants from understanding their bill. Failure to furnish any other information such as name or claim number, would delay payment of the claim. Failure to provide medical information under FOB would be considered other care.

The material on this page, unless otherwise indicated, is not responsible for paying for your treatment. Section 1808 of the Social Security Act and 31 USC 9801-9812 provide guidelines for distributing this information.

ing and Privacy Protection Act of 1968", permits the government

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

ACKNOWLEDGMENT OF PATIENT/DOCTOR RELATIONSHIP OR SUPPLIER: I certify that the services listed above were medically indicated and necessary in the health of this patient and were personally furnished by

NON-EFILED: This is to certify that the foregoing "Statement is true, accurate and complete. I understand that payment of one-half of the amount of this claim will be from Federal and State funds, and that any false statement, or concealment of a material fact, may be punished under applicable Federal and State law."

According to the Privacy Act's disclosure rule, no notices are required if the information collection displays a valid OMB control number. The valid OMB control number for this information collection is 0620-1197. The term requires to complete this information collection is currently 10 minutes per response, includes the time to read instructions, review data resources, update the data received, and complete and review the information collection. If you have any comments concerning the accuracy of the instructions or suggestions for reducing the time please write to: GAO, 450 7th Street, Washington, DC 20585.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0234

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 8/14/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 10 (restricting/continuous pain)

& All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep

Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure

Cervical (Posterior) Cervical (Anterior)

Upper Thoracic (Anterior) Upper Thoracic (Posterior)

Mid/Thoracic Ribs Scapula (R) Scapula (L)

Abdomen/Obliges ASIS PSIS

Lumbar Sacrum Coccyx Hips Glutes (R) (L)

IT Band Quads Hamstrings Knee (R) Knee (L)

Calve Muscles (R) Calve Muscles (L)

Ankle (R) Ankle (L) Foot (R) Foot (L)

Shoulder (R) Shoulder (L)

Upper Arm (R) Upper Arm (L)

Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has LBP & radicular symptoms into right leg.
 AS is a 2-3/10 but less intensity at times.

Therapist Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/IceFreeze

Light Pressure Massage Moderate Pressure Massage

Deep Tissue Massage Myofascial Release Friction

Manual Traction Stretching Range-of-Motion

Stripping Compression Lymph Drainage

Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.

Follow-up w/ PT Stretches Don't Meds Ice / Heat

Therapist:

Allen Marx

Great Lakes Therapeutic Massage & Bodywork Practitioners

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Calve Muscles (R) Calve Muscles (L)

Ankle (R) Ankle (L) Foot (R) Foot (L)

Shoulder (R) Shoulder (L)

Upper Arm (R) Upper Arm (L)

Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has LBP + C1/L2 P.T. causing exercise intolerance

at severe 7/10 in LBP+C1/L2P. Was in a lot of pain.

Last night Client reports T decreased - T-Pt injection A.

Action's Applied: (Check All that Apply) 2 days ago - T-pain to T-1

Heat Packs Cold Packs Sombra/IceFreeze Ultrasound/elp.

Light Pressure Massage Mod Pressure Massage

Deep Tissue Massage Myofascial Release Friction

Manual Traction Stretching Range-of-Motion

Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.

Follow-up w/ PT Stretches Don't Meds Ice / Heat

Therapist:

Allen Marx

08-11-16

os 11 16

Great Lakes Therapeutic Massage

& Bodywork Practitioners

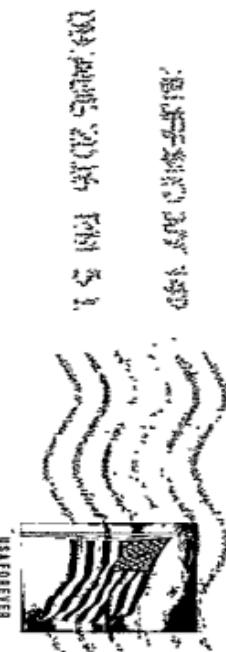
375 Dick Road, Suite #2

Depew, NY 14043

Arth: C. Marx

GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-03207





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

CARBONLESS

<input type="checkbox"/> PICA		PICA															
1. MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TRICARE <input type="checkbox"/> (DOD/DoD)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (DV)	FICA BUKLUNG <input type="checkbox"/> (DV)	OTHER <input type="checkbox"/> (DV)	1a. INSURED'S ID. NUMBER 013873940010159 (For Program in Item 1)										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle			3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980M <input checked="" type="checkbox"/> F <input type="checkbox"/> M			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle											
5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive											
CITY Cheektowaga	STATE NY	8. RESERVED FOR NUCC USE			CITY Cheektowaga			STATE NY									
ZIP CODE 14225	TELEPHONE (Include Area Code) ()				ZIP CODE 14225	TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FICA NUMBER											
b. OTHER INSURED'S POLICY OR GROUP NUMBER DAD16761Q00			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (STAN)			a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)											
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																	
SIGNED <u>Jennifer McVige MD</u>			SIGNATURE ON FILE			DATE <u>08/05/16</u>			SIGNED <u>Jennifer McVige MD</u>					SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL			15. OTHER DATE QUAL			MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr Jennifer McVige MD			17a. <input type="checkbox"/> NPI			17b. <input type="checkbox"/> NPI 1649596495			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services less below (24b) ICD Ind. 0																	
A. <input type="checkbox"/> R42	B. <input type="checkbox"/>	C. <input type="checkbox"/> L	D. <input type="checkbox"/>	E. <input type="checkbox"/> F. L	G. <input type="checkbox"/> L	H. <input type="checkbox"/> L	I. <input type="checkbox"/> L	22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER 013873940010159																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PAYOR EMR			C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			D. MODIFIER			E. DIAGNOSIS CODER NUMBER pointer	F. \$ CHARGES	G. DAYS HOURS UNITS	H. PAYOR NAME PER UNIT	I. L. ID. NUM BER	J. RENDERING PROVIDER ID. #
1. 08 03 16	08 03 16	11				97140				A	45.00	1			ZZ 225100000X		
2. 08 03 16	08 03 16	11				97110				A	45.00	1			ZZ 225100000X NPI 1205129921		
3.															NPI		
4.															NPI		
5.															NPI		
6.															NPI		
25. FEDERAL TAX ID. NUMBER 201163729	SSN EN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO 103558			27. ACCEPT ASSIGNMENT TO THIRD PARTY CARRIER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. TOTAL CHARGE \$ 92.00		29. AMOUNT PAID \$ 0.00		30. Raid for NUCC Use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on my resume apply to this bill and are made a part thereof.) McPherson, Jacob PT, DPT																	
32. SERVICE FACILITY LOCATION INFORMATION 716 8038220 Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432																	
33. BILLING PROVIDER INFO & PH# a. 1710021001 b																	

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who voluntarily files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

HEDICARE AND TRICARE PAYMENTS: A patient's signature requires that payment be made and authorizes release of any information necessary to process the claim and certifies that all information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare a medical record nomination information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information on the health plan or agency shown. In Medicare enrollment or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare center or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, copayments and non-covered services. Contributions and the deductible are based upon the charge determination of the Medicare center or TRICARE local intermediary if the charge submitted, TRICARE is not a health insurance program but makes payment for health benefits provided through cancer affiliations with the Uniformed Services. Information on the patient's status should be provided in those items captioned in "insured", i.e., Items 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The new law requires the completion and acceptance by the Government of payment under the Black Lung and FECA contractors regarding medical procedures and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (HEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) my claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for coverage including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 7) for each service rendered incident to my professional service, the identity (legal name and NPI license #, or SSN) of the primary individual rendering such service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of funds commonly furnished in physician's offices, and 4) the services of non-physician must be indicated on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered service am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a current employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black-Lung related disorder.

No Part B Medicare benefit may be paid unless the form is received as required by existing law and regulations (42 CFR 442.82).

NOTICE: Any one who misrepresents or falsifies, intentional information to known payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by Title XIX, Title XXI, Title XVII, and Title II of the Social Security Act, and 42 CFR 411.24(a) and 405(k)(6) (i), and 44 U.S.C. 3501 et seq. and 10 USC 1601 et seq. and 10 USC 1606, 5 USC 8101 et seq. and 10 USC 801 et seq. and 20 USC 1032, 1033, 1034, 1035, 1036, 1037, and 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, and 1073, and 40 CFR 100.1 et seq. and 10 USC 1601 et seq. and 10 USC 1606, 5 USC 8101 et seq. and 10 USC 801 et seq. and 20 USC 1032, 1033, 1034, 1035, 1036, 1037, and 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, and 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, and 1073, and 40 CFR 100.1 et seq. and 10 USC 1601 et seq. and 10 USC 1606, 5 USC 8101 et seq. and 10 USC 801 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1071, 1072, and 1073, and 40 CFR 100.1 et seq. and 10 USC 1601 et seq. and 10 USC 1606, 5 USC 8101 et seq. and 10 USC 801 et seq. and 20 USC 1032, 1033, 1034, 1035, 1036, 1037, and 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, and 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, and 1073, and 40 CFR 100.1 et seq. and 10 USC 1601 et seq. and 10 USC 1606, 5 USC 8101 et seq. and 10 USC 801 et seq. and 20 USC 1032, 1033, 1034, 1035, 1036, 1037, and 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, and 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, and 1073, and 40 CFR 100.1 et seq. and 10 USC 1601 et seq. and 10 USC 1606, 5 USC 8101 et seq. and 10 USC 801 et seq. and 20 USC 1032, 1033, 1034, 1035, 1036, 1037, and 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 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08 15 16

100% of the time he worked out his

08 15 16

Susan Bennett, PT, PC
Bennett Rehabilitation Institute
2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403



224035526 8005

|||||||||||||||||||||||||||||||||||||



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIGA												PICA												
1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TRICARE <input type="checkbox"/> DOD/DoD	CHAMPVA <input type="checkbox"/> Member/VA	GROUP HEALTH PLAN <input type="checkbox"/> (None)	FEDERAL (FED) <input type="checkbox"/>	OTHER <input type="checkbox"/> (None)	1a. INSURED'S ID. NUMBER 013873940-0101-059	(For Program In Item 1)																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -																	
HARWELL, DANIELLE			08 29 1980																					
5. PATIENT ADDRESS (No., Street)			6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)																	
56 BEVERHAVEN DR.																								
CITY AMHERST		STATE NY	8. RESERVED FOR NUCC USE X				CITY		STATE															
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951						ZIP CODE	TELEPHONE (Include Area Code) ()																
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FEDA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY																	
			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <u>UNK</u>				SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F																	
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. OTHER CLAIM ID (Designated by NUCC)																	
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)				e. INSURANCE PLAN NAME OR PROGRAM NAME																	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												
SIGNED <u>ON FILE</u> DATE 01-06-2016												SIGNED <u>ON FILE</u>												
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 14a. <u>01 06 2016</u> QMUL			15. OTHER DATE QUAL <u>17a. 01 06 2016</u>			MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYNTHEX CRABAU, PA			17a. <u>17b. NPI</u>				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	21. CHARGES											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.												22. RESUBMISSION CODE	ORIGINAL REF. NO.											
A. <u>L1679-1</u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>	23. PRIOR AUTHORIZATION NUMBER												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service Eng.												F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>	M. <u> </u>	N. <u> </u>	O. <u> </u>	P. <u> </u>	25. RENDING PROVIDER ID. #	
1 06 09 16 06 09 16 14	2 08 13 16 08 13 16 11	3 	4 	5 	6 	7 	8 	9 	10 	11 	12 	13 	14 	15 	16 	17 	18 	19 	20 	21 	22 	23 	24 	25
26. FEDERAL TAX ID NUMBER 47-0989449	SSN SSN <input type="checkbox"/> <input type="checkbox"/>	27. PATIENT'S ACCOUNT NO. HARWELL, D	28. ADJUST ASSIGNMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	29. TOTAL CHARGE \$ 110.00	30. AMOUNT PAID \$ 0.00	31. Reasons for NUCC Use NPI																		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof)												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043					33. BILLING PROVIDER INFO & PH# (716) 725-0264							
COLLEEN MARX, INT SIGNED DATE 08.11.2016												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043												
11646672011												11646672011												

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENTAL AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

NOTICE: Any person who fraudulently files a statement of claim containing any false identification or any false, incomplete or misleading information may be guilty of a criminal and/or civil offence under the Court Rules.

REFERS TO ANNUALMENT PROGRAMS ONLY

BLACK Holes / CP/CMS - 24/24

The payment to the vendor has been made by the City via check. The payment is for Svc B-Lang and PEGC's instructions regarding settlement procedure and design. A carbon copy of the

DETAILED LIST OF PHARMACEUTICAL SUPPLIES (THERAPEUTICS, TROCHARS, PECTA, AND ELASTIC LINERS)

In submitting this claim or payment from my own funds, I certify that: 1) The information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program requirements which are available from the Medicare contractor; 3) I have provided to all private sufficient information required to allow the government to make an informed decision regarding my claim; 4) I claim a lesser amount than my full or my deductible, co-payment, co-insurance or deductible Medicare and/or Medicaid amounts, services, and programs authorized for payment including but not limited to the Federal Employees Health and Disability Self-Referral law (amounts not to exceed \$100); 5) The services, on this form, do not medically necessary and previously furnished by me or were furnished incident to my professional services by my employee under my direct supervision, except as otherwise specifically provided by law contained in "TRICARE" for health service rendered and to receive payment promptly. I identify (legal name and SS#) of the provider (physician, hospital, and/or laboratory) in whom I am employed as the designated Carrier for services. I am overpaid in relation to a physician's charges (or amounts) if they fail to be rendered under the physician's direct supervision by his/her employee. 20. It is my intent, although in general case of a cover of place of service so they must be paid by funds exclusively furnished in this procedure.

For TRICARE claims, "Former employee" for new employment, and "red arrows" can not be a spouse, family member of the Uniformed Services or a civilian employee of the Uniformed Services Government or a civilian employee of the United States Government, other civilian or military (not in § 1030.8(b)). For Blue-Card claims, "Former employee" for a B-C-A, B-C-B, or B-C-D.

No Part 600-6000, 6001-6002 may be paid unless this form is received or required by existing law and regulation (42 CFR 420.32).

NOTICE: Any written or spoken communication that you have with us concerning your loan application or any other information to receive, originate, or modify a loan from us may be subject to review and impairment, under applicable Federal laws.

INFORMED CONSENT TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND PLACES LIEN INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OIG to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Blue Lung programs. Authority to collect information is provided by 42 CFR 411.204(a), 1362.102 and 1374.6 of the Board; Social Security Act as amended; 42 CFR 411.208 and 404.5(c) (6); and 44 URC 3101.01(CR 10, 10 sqq and 10 USC 1099 and 1099.5 (USC 8101 et seq. and 36 USC 3951 et seq.), 29 CFR 200 E.O. 9837.

The information you give in this census or to teams under this program is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are paid for by the government or to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs and as otherwise necessary to administer these programs. For example it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the source modifying system No. 09-70-0301, titled, 'Cancer Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept 12, 1980, it is updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, Sac E34-5, E34-6, E34-12, F34-13, E54-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/benefits received are justified by law.

ROUTINE USES: To obtain claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Defense for representation of the Secretary of Defense in civil cases; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recovery of claims; and to Congressional Offices in response to inquiries made at the request of the person to whom the information applies. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individuals, providers of care, or matters relating to entitlement, claims adjudication, issues program areas, utilization review, quality assurance, peer review, program integrity, third-party audits, construction of benefit, and civil and criminal liability related to the operation of TRICARE.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under this program for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information might TEFCA could be delayed or denied.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1129B of the Social Security Act and 31 USC 380-i-3812 provide penalties for withholding this information.

You should file a claim for P.L. 404-509, the "Consumer Protection and Disaster Protection Act of 1988," against the power company for any information it receives of wrongdoing matches.

NONCASH PAYMENT METHODS CERTIFICATION

I hereby agree to keep confidential - as necessary to do - the full extent of services provided to individuals under the State's Title XXI plan and to furnish information or records my agents or clients for rendering such services as the State Attorney or Dept. of Health and Human Services may request.

I further agree to notify the insurance company if I receive a medical program for my claim submitted or payment under this program with the exception of authorized reductions, discounts, co-payments or fees as defined in this plan.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above are medically indicated and necessary to the health of the patient and were previously furnished by me or my employee under my personal direction.

NOTICE: This is costly but the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or representations, or overstatement of a material fact, may be prosecuted under applicable Federal or State laws.

Accruing fee for Information collection is \$11.00, no person is required to respond to a collection of information unless it does not cost a valid DMV citizen member. The valid DMV citizen member shall submit the DMV citizen member's name, address, mailing date information, gather the data materials, and complete and review the information collection. If you have any comment, concern, or question regarding the form, please call us at: 800-750-0000, County Boulevard, ATM FPA Records Office, Mail Stop C-03, Hollywood, Maryland.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-1824

Fax: (716) 725-2825

Client Name: Danielle Harrell Date: 8/11/16

Client Status: (Circle) Better Progressing Worse Same No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client states no CP continues to be severe & radiating.

S/S into R/L's. Neck pain slowly returning as TrP

back pain and swelling off. ENPCE hyper tonic trigger points

Actions Applied: (Check All that Apply) Heat Pack Cold Pack Sombra/Biofreeze Lumbar sacral hip
 Heat Packs Cold Packs Sombra/Biofreeze & glutes.
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction Manual Traction Stretching Range-of-Motion Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

 ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D. Follow-up w/ PT Stretches Con't Meds Ice/HeatTherapist: Danielle Harrell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0824

Fax: (716) 725-0825

Client Name: Danielle Harrell Date: 8/11/16

Client Status: (Circle) Better Progressing Worse Same No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client had P.T. yesterday & is no worse today

Feeling ok today. numbness is less intense. ↓ the comb

A P.T. m.n.t. chiro. Felt better & tx. Continued to c

Actions Applied: (Check All that Apply) Lumber/SI jt/P.

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat

Therapist: Danielle Harrell

08-15-16

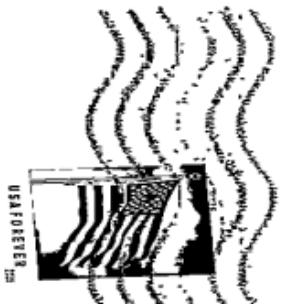
08 15 16

Great Lakes Therapeutic Massage

Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043

GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-252207





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

NUCA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> to INSURED'S ID NUMBER (For Program in Item 1)																
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE 3. PATIENT'S BIRTH DATE MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F 4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE																
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE 6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other 7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT																
CITY CHEEKERTOWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY AMHERST		STATE NY								
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:																
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F 08291980																
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO																
d. INSURANCE PLAN NAME OR PROGRAM NAME 11. INSURED'S POLICY GROUP OR FECA NUMBER																
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																
SIGNED SIGNATURE ON FILE DATE DATE SIGNER SIGNATURE ON FILE																
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 15. OTHER DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY																
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 103115 QUA 431 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY																
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES																
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-I to service line below (24E)) ICD IND. O 22. RESUBMISSION CODE ORIGINAL REF NO																
A M50.22			B M51.26			C M51.27			D M54.12							
E I52.3 XXXA			F M99.01			G M99.03			H M99.02							
I M99.05			J M54.2			K M54.5			L M54.6							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE NM DO YY		C. CPT/HCPCS EMR		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS CODES		F. CHARGES		G. DAYS ON UNIT	H. OVER PAY PER	I. ID QMUL	J. RENDERING PROVIDER ID #	
1. 07292016		07292016		11		99212		25		ABCD		20	29	1	NPI	1710014188
2. 07292016		07292016		11		98941				ABCD		32	28	1	NPI	1710014188
3. 07292016		07292016		11		97010				ABCD		10	53	1	NPI	1710014188
4. 08052016		08052016		11		98941				ABCD		32	28	1	NPI	1710014188
5. 08052016		08052016		11		97010				ABCD		10	53	1	NPI	1710014188
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9. 08052016		08052016		11		97010				ABCD		10	53	1	NPI	1710014188
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24. 08052016		08052016		11		97010				ABCD		10	53	1	NPI	1710014188
25. FEDERAL TAX ID NUMBER 364500165		SSN/EIN □ X		26. PATIENT'S ACCOUNT NO 34382127		27. ACCEPT ASSIGNMENTS <small>(For genl. claims, see back)</small> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 105.91		29. AMOUNT PAID \$ 8		30. Reserved for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS PETER GOZINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333												
SIGNED 08162016 DATE 1235256546																

Encounter dated 08/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/16/2016

extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* worse. *since last visit at PT after the tried to stretch my lower back.* *Pain:* sharp, shooting, tingling, numb. *Range:* 6->7/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 46/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain;

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DOB:08/29/1980 Today's date: 08/16/2016

Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s): L4, L5, Left SI.*
Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

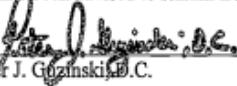
Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 7 weeks; Re-examination for 7 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI right PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform

Encounter dated 08/05/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/16/2016

standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

08 19 16



Item# 43568
Patent Pending



08.19.16

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Geico
P.O. Box 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 04/12

GEICO
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FREDERICKSBURG VA 22403-9526

PIGA

PIGA

1 MEDICARE (Medicare)	2 MEDICAID (Medicaid)	3 TRICARE (DOD/DoD)	4 CHAMPVA (Member ID#)	5 GROUP HEALTH PLAN (HGP) NAME	6 FECA SUSLUNG (SUSL) NAME	7 OTHER	8 INSURED'S ID NUMBER 013873940011059 (For Program in Item 1)		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 PATIENT'S BIRTH DATE MM DD YY		4 SEX M		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
HARWELL DANIELLE		08291980		F		5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			
		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY CHEEKERTOWAGA		STATE NY		CITY AMHERST		STATE NY			
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716 536 0951			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>NY</u>									
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED SIGNATURE ON FILE				DATE					
				SIGNED SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD YY) 103115 15. OTHER DATE (MM DD YY) 454 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) 111215 FROM _____ TO _____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM _____ TO _____									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to services line below (24e)) A. M50.22 B. M51.26 C. M51.27 D. M54.12 E. I23.3XXA F. M99.01 G. M99.03 H. M99.02 I. M99.05 J. M54.2 K. M54.5 L. M54.6									
22. RESUBMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. SERVICE OF C. PROCECDURES, SERVICES, OR SUPPLIES To MM DD YY From MM DD YY B. SERVICE OF C. PROCECDURES, SERVICES, OR SUPPLIES EMR EMR CPT/HCPCS I. MODIFIER E. DIAGNOSIS CODE F. G. DAYS OF H. OVERNIGHT I. ID CODE CODE PER UNIT PER DAY PER UNIT PER DAY 25. RENDRING PROVIDER ID #									
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2	07252016	07252016	11	97010	ABCD	10 53	1	NPI	1710014188
3								NPI	
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5								NPI	
6								NPI	
26. FEDERAL TAX ID NUMBER	SSN EN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENTS? I certify that the statements on the reverse side of this bill and my medical record are correct.	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rcv'd for NUCC Use			
364500165	<input type="checkbox"/> <input checked="" type="checkbox"/>	3438Z1226	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 42.81	\$ 				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this bill and my medical record are correct.) PETER GOZINSKI DC									
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849									
33. BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849									
SIGNED 08162016 DATE 1235256546 b 1235256546 b									

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
August 16, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday July 25, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also has headaches since the accidents. The headaches are back to every other day. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences less dizziness since last visit. *Recent medical treatment for this condition:* Massage therapy; Physical therapy. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* Massage Therapy.

Lumbar/Sacral/Pelvis: Patient stated that "the adjustment last time helped. I was able to sit longer with less pain. However the pain continues to shoot down my left leg". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, shooting, tingling, numb. *Range:* 6->7/10. *Pain is frequent.* *Pain radiates to:* bilateral posterior thighs and legs. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 45/50 with pain neck and upper back; extension: WNL 60/60 with pain

Encounter dated 07/25/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/16/2016

neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: 70/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive lower neck mostly to the left; right lateral compression: Positive lower neck mostly to the left; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with no pain; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with no pain; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal bilateral severe; TFL / ITB left moderate to severe; piriformis muscle(s) left severe. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 70 degrees; Bechterew: Positive left for left lower back pain; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

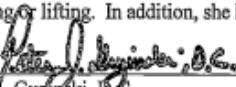
Lumbar assessment: slight improvement since last treatment. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with

Encounter dated 07/25/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/16/2016

central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left (Instrument adjustment Arthrostim); C6 left (Instrument adjustment Arthrostim); T2 left (diversified prone); T3 left (diversified prone); T6 (anterior); T7 (anterior); T8 (diversified prone); T9 (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); Left SI left (prone mobilization). *Physical Modalities:* bilateral cervical cold therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar cold therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy; left piriformis myofascial release. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: lumbar 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Gajewski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
August 16, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday July 29, 2016 Provider: Peter Guzinski DC RE-EXAM

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she can only lift very light weights, she has slight headaches which come frequently, she cannot do her usual work, she has a fair degree of difficulty concentrating and her normal sleep has been moderately disturbed (2-3 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, tingling, shooting, numb; level: 2/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Cervical Disability Index:* 42%. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing.

Encounter dated 07/29/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 08/16/2016

Numbness: none. Weakness: none. Oswestry score: 68%. Recent medical treatment for this condition: None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. Due to the pain, she can only lift very light weights, she is unable to walk greater than 1/4 of a mile, she is unable to sit greater than 30 minutes, she is unable to stand greater than 10 minutes, she is unable to travel on journeys greater than 30 minutes and she is only able to sleep comfortably for 6 hours. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* getting worse. *since last few weeks.* *Pain:* sharp, shooting, tingling, numb; level: 7/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 68%. *The Keele STarT Back Screening Tool:* Medium risk. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Activity of Daily Living Form Bathing/Showering: mild impairment; Bending forward/backward: moderate impairment; Brushing teeth: mild impairment; Driving: moderate impairment; Drying Hair: moderate impairment; Household chores: moderate impairment; Laundry: moderate impairment; Lifting less than 10 lbs: moderate impairment; Lifting more than 10 lbs: severe impairment; Kneeling: moderate impairment; Making Meals: moderate impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: moderate impairment; Reaching above the shoulders: mild impairment; Restful night's sleep: mild impairment; Seated to standing position: moderate impairment; Sexual activity: severe impairment; Standing: severe impairment; Squatting: moderate impairment; Tying shoes: moderate impairment; Using lavatory: moderate impairment; Walking: moderate impairment.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left; Spinal Percussion C1-C7: Negative; left shoulder depression: Negative; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Encounter dated 07/29/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/16/2016

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 46/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* all lower extremity sensory exams (L1-S1) were WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Reflexes:* bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-evaluation on May 26, 2016 her VAS score improved from a 3 to 2 out of 10 and her headaches are no longer as frequent or intense. In addition, her active left cervical cervical flexion improved from 45 to 50 degrees and right rotation improved from 70 to 80 degrees. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL. **Diagnosis:** M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: Mrs. Harwell's lower back condition has been more intense for the past few weeks. She denies any new injuries, accidents or trauma. Due to the pain, she has noticed increased difficulty with walking, sitting, standing, sleeping and traveling. In addition, her active lumbar flexion is now painful and limited at 45 instead of 60 degrees and left rotation at 20 instead of 30 degrees. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to reach, sit, stand, sleep, walk and lift with less pain. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural

Encounter dated 07/29/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/16/2016

foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 8 weeks; Re-examination for 8 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 left (manual traction); L5 left (manual traction); SI right PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, DC.

Friday August 5, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA														
1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TRICARE <input type="checkbox"/> DOD/DIA	CHAMPVA <input type="checkbox"/> Member ID#	GROUP <input type="checkbox"/> EXCLUDING <input type="checkbox"/> (N/A)	FEPA <input type="checkbox"/> EXCLUDING <input type="checkbox"/> (N/A)	OTHER <input type="checkbox"/> (N/A)	1a. INSURED'S ID NUMBER 013873940-0101-059	(For Program in Item 1)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> O	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - NAME -							
BARRELL, DANIELLE				08 29 1980										
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)				
56 BERESBACHEN DR														
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X						CITY		STATE		
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951								ZIP CODE		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO										
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>NOT</u>										
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)										
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.														
SIGNED <u>ON FILE</u>				DATE 01-06-2016										
SIGNED <u>ON FILE</u>														
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 1-0-31 3-0-5				15. OTHER DATE QUAL 17a. SYDNEY GRABAN, PA		MM DD YY 17b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		21. CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24b))				ICD IND.				22. RESUBMISSION CODE		ORIGINAL REF ID				
A <u>H73.1</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>			
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR		C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances)		D. CPT/HCPCS MODIFIER		E. DIAGNOSIS PICKER		F. CHARGES	G. DING OR UNITS	H. EXPEND FEE PER UNIT	I. ID. QUAL	J. RENDERING PROVIDER ID #
1 08-15-16	08-15-16	11	11	97140						55	00	0	NPI	2144462011
2 08-16-16	08-18-16	13	13	97140						55	00	3	NPI	2144462011
3 													NPI	
4 													NPI	
5 													NPI	
6 													NPI	
25. FEDERAL TAX ID NUMBER 47-0989449	SSN SSN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. BARRELL, D	27. ACCEPT ASSIGNMENTS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 110 00	29. AMOUNT PAID \$ 0 00	30. RATIO FOR NUCC USE 110 00								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE/FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPTM, NY 14043		33. BILLING PROVIDER INFO & PH# 716 725-0264		GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPTM, NY 14043						
COLLEEN MARK, IMT SIGNED 08-18-2016 DATE 1144462011														

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

2025 RELEASE UNDER E.O. 14176

Medicare Part D TRICARE Philanthropy. A participant's signature request for payment is made and without a release of any information necessary to process the claim and without a release of any information necessary to process the claim, the provider or plan may release information to the participant and to Medicare and Medicaid and other health care programs that employ the participant's group health insurance, liability, life, dental, workers' compensation or other patients which is reasonably necessary for the provision of care. The Medicare X-1000 form, which contains a statement of the participant's rights regarding the information, is attached to the participant's enrollment form. In addition, the participant's enrollment form contains a section for the participant to acknowledge that he or she has read and understood the information contained in the Medicare X-1000 form. TRICARE does not utilize a separate enrollment form for TRICARE Health Insurance coverage. TRICARE is not a health insurance plan, but rather a funding program for health benefits provided through an affiliation with the U.S. Department of Defense. The participant's enrollment form includes a statement indicating that he or she has read and understood the information contained in the Medicare X-1000 form.

第 10 章 与线程相关的类和方法

The pace will continue to accelerate, however, given by the Government's commitment to the Paris Agreement, the recent climate-related proposals and discussions during the UNFCCC Conference of the Parties in Paris.

SIGNATURE OF PHYSICIAN OR PHYSICAL THERAPIST WHO PROVIDED THIS CARE FROM AND DATE:

For THG's Blue Line, I further certify that I am my employer who rendered services are not my home. And that I am an Uninsured Driver or not an employee of the United States Government, either on contract basis or C-100-5593. The Check-List shows, I further certify that the Person(s) personally to me as above, is not listed.

On Part 101 **Line 1:** L-1171 is not to pass unless there is no other recent 3 or more valid conviction for any offense on the CAR or any

We are authorized by CISA, ISAC, and other partners to share information related to the compromise of Microsoft Exchange, Microsoft SQL Server, and Microsoft Office 365 products.

To administer our services to you, we collect certain information about you and your business to determine your eligibility. We also need to collect information about supplies you received or supplied by us, as well as information about your business.

The statements in paragraph 16 are based on information available at the time of the audit, including relevant agreements and other communications of Federal agencies, for the City's administration of the City's 1990-1991 budget. The City has not yet issued its final financial statement for the year.

PRO MONITOR CLAIMS SET FOR RELEASE UNDER THE FOIA. COMPLAINT NUMBER 04-70-0001, FILED IN THE CIRCUIT COURT OF CHAMBERS COUNTY, ALABAMA. THIS DOCUMENT IS NOT PUBLISHED.

FOR OFFICERS OF THE POLICE AND THE ATTORNEY GENERAL
REGISTRATION OF RECORDS OF SYSTEMS OF INFORMATION

PORT TRAILER 40' X 10' PORTABLE PURPOSES IS TO UTILIZE AVAILABLE TO FACILITATE EASY HANDLING AND TRANSPORTATION OF CONCRETE PAVING MATERIALS.

DODTRINEL U-16a: Information item cited in this document may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation in connection with statutory administrative responsibilities under FAR-REG-CHAR-PUB-10. Report of Abuse: for re-examination at the Secretary of Defense in our efforts to implement Revenue Drivers, private collection agencies, and consumer reporting agencies in connection with reparation claims; and to Congressional Offices in response to inquiries made at the request of the person in whose behalf a complaint has been filed. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care or medical services to individuals, data educators, fraud, program abuse, utilization review, quality assurance, case review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE: However, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failure to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of PEDA or could void this program. Failure to furnish any other information, such as names or claim number, would delay payment of the claim. Failure to provide medical documentation

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.

You should be aware that P.L. 109-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matching.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary in dispute fully true and correct to individual under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

The third metric is cost, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, copayments or similar cost-sharing amounts.

SIGNATURES OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that no-false claims laws apply to this application.

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 0938-1997. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data sources within the data needed, and complete and review the information collection if you have any comments concerning the content of the form at 21214 1050. Any comments or suggestions for improving this form please write to: CMS, 7500 Rockville Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-08-05, Baltimore, Maryland 21214-1050. The address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

08 22 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0204

Fax: (716) 725-2025

Client Name: Danielle Harrell Date: 8/15/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Dull Strength Ability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)*

Specific: Client continues to experience severe LBP & radicular

involving S/S into LLE's. Technical & thoracic pain

/ 2° Stressors. Adhesions continue to be present

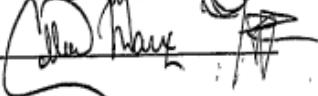
Action's Applied: (Check All that Apply) painful in all C-T-L muscles

- Heat Packs Cold Packs Sombat/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice/Heat

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0204

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 8/18/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Dull Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client g/o continued LBP & activity. g/o "pullet"

Spasming g/o left shoulder, g/o having intense

L/L headache today @ base of skull. This is likely

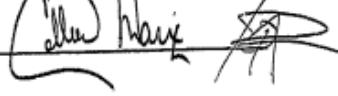
Action's Applied: (Check All that Apply) in all Suboccipital region/neck

- Heat Packs Cold Packs Sombat/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice/Heat

Therapist:



08 22 16

100% - 100% - 100%

08 22 16

Great Lakes Therapeutic Massage

Colleen Marr, LMT

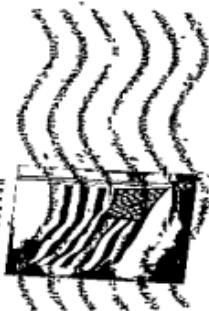
375 Dick Road, Suite #2

Buffalo, NY 14203

SUPER SIZED, NY, 242

12 AUG 2006, MM 51

USA FOREVER
20



GEICO INS CO of NY
P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403-952607



03873940010 1059

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

NUCC

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA WORKERS (W) COMP (C)		OTHER (O)		1a. INSURED'S ID NUMBER 013873940011059		(For Program In Item 1)							
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (TRICARE)		<input type="checkbox"/> (CHAMPVA)		<input type="checkbox"/> (Group Health Plan)		<input type="checkbox"/> (FECA WORKERS COMP)		<input type="checkbox"/> (Other)											
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)												3 PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE							
5 PATIENT'S ADDRESS (No., Street)												6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT							
CITY CHEKTOWAGA		STATE NY		8 RESERVED FOR NUCC USE				CITY AMHERST		STATE NY													
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951													
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980									
												b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY		c. INSURED'S DATE OF BIRTH MM DD YY 08291980									
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME												10e. CLAIM CODES (Designated by NUCC)		e. INSURANCE PLAN NAME OR PROGRAM NAME GEICO									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												10f. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
SIGNED SIGNATURE ON FILE												DATE		SIGNATURE ON FILE									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115		15. OTHER DATE QUAL. 454		16. MM DD YY 111215		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19a. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		19b. CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer A-L to service line below (24e))												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A M50.22		B M51.26		C M51.27		D M54.12		E I52.3.3XXA		F M99.01		G M99.03		H M99.02		I M99.05		J M54.2		K M54.5		L M54.6	
24. A. DATES OF SERVICE From MM DD YY 08162016		B. To MM DD YY 08162016		C. DURATION OF SERVICE EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS		E. MODIFIER		F. MODIFIER		G. DAYS ON CHARGE		H. H.R./P.R./A.R./P.R.		I. ID		J. RENDERING PROVIDER ID #					
						</																	

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 14043-1849
716-681-3333
August 23, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday August 16, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain has been more intense with headaches. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* slightly worse. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* worse. *since last visit.* *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She stated that her physical therapist attempted traction which aggravated her lower back. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* worse. *since after PT.* *Pain:* sharp, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with

**Encounter dated 08/16/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/23/2016**

pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 46/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: mild exacerbation of symptoms, continue with current treatment plan. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** worse.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2

Encounter dated 08/16/2016 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 08/23/2016

shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 6 weeks; Re-examination for 6 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI right PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

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08 29 16

Geico
P.O. Box 9507
Fredericksburg, VA 22403

MAILING PERMIT
CHICAGO CITY
345 Dick Rd.
Depew, NY 14043





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

CARRIER

PICA												PICA													
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FSA BENEFITS	CRIBER	10 INSURED'S ID-NUMBER	(For Programs in Item 1)																	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP HEALTH PLAN	<input type="checkbox"/> FSA BENEFITS	<input type="checkbox"/> CRIBER	013873940010159																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)																
Harwell, Danielle							MM 08 29 1980	M <input checked="" type="checkbox"/>	Harwell, Danielle																
5. PATIENT'S ADDRESS (No., Street)							6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)																
1131 Cleveland Drive							Self <input checked="" type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>	1131 Cleveland Drive														
CITY Cheektowaga		STATE NY		8 RESERVED FOR NUCC USE		CITY Cheektowaga		STATE NY		ZIP CODE 14225					TELEPHONE (Include Area Code) ()										
ZIP CODE 14225		TELEPHONE (Include Area Code) ()																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10 IS PATIENT'S CONDITION RELATED TO:																		
Harwell, Danielle							a EMPLOYMENT (Current or Previous)																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					b. AUTO ACCIDENT?													
DBD16761Q00												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					PLACE (State)								
b. RESERVED FOR NUCC USE												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
c. RESERVED FOR NUCC USE												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d CLAIM CODE# (Designated by NUCC)					11. INSURED'S POLICY GROUP OR PEDA NUMBER													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												a. INSURED'S DATE OF BIRTH													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below												MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>													
SIGNED <u>SIGNATURE ON FILE</u> DATE _____												b. OTHER CLAIM ID (Designated by NUCC)													
												c. INSURANCE PLAN NAME OR PROGRAM NAME													
												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?													
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.													
												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
												SIGNATURE ON FILE													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (I.M.P.)							15. OTHER DATES		MM	DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION													
							QUAL				FROM	MM	DD	YY	TO	MM	DD	YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE							17a																		
DN Jennifer McVige MD							17b	NPI	1649596495																
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES													
												FROM	MM	DD	YY	TO	MM	DD	YY						
												19. OUTSIDE LAB?													
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE													
												ORIGINAL REF. NO.													
A L R42	B L	C L	D L	E L	F L	G L	H L	I L	J L	K L	L L	M L	N L	O L	P L	Q L	R L	S L	T L	U L	V L	W L	X L	Y L	Z L
24. A. DATE(S) OF SERVICE												B. PLACE OF SERVICE		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS CODE		F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Z.		RENDERING PROVIDER NAME				
From MM DD YY	To MM DD YY	PLACE OF SERVICE EMR	CPT/HCPCS			ICD9 CODE		DIAGNOSIS CODE NUMBER		S CHARGES		G. DAYS OR UNITS		H. FEES PER DAY		I. CUM.		J. RENDERING PROVIDER NAME							
1 08 10 16	1 08 10 16	1 11	97140					A		46.00		1		NPI		225100000X		1205129921- 225100000X							
2 08 10 16	2 08 10 16	2 11	97110					A		46.00		1*		NPI		225100000X		1205129921- 225100000X							
3 08 10 16	3 08 10 16	3 11	97012					A		46.00		1*		NPI		225100000X		1205129921- 225100000X							
4 	4 	4 																							
5 	5 	5 																							
6 	6 	6 																							
25. FEDERAL TAX ID NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. TOTAL CHARGE		29. AMOUNT PAID		30. REND FOR NUCC USE													
201163729		X	103558					\$ 138.00		\$ 0.00															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If costly that the statements on the reverse apply to this bill and are made a part thereof)												32. SERVICE FACILITY LOCATION INFORMATION													
McPherson, Jacob PT, DPT												33. BILLING PROVIDER INFO & PH# Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432													
SIGNED <u>08/12/16</u>												a. 1710021001 b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. z.													

THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a crime and punishable under Title 18 and may be subject to civil penalties.

REVISER TO GOVERNMENT PROGRAMS ONLY

TRICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of my information necessary to process the claim and certifies that: (a) the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and/or dental information and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services; (b) to whom the healthcare claim is made. See 42 CFR 411.2(a). If item 8 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in it, whom assigned or (TRICARE prime) in other cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and TRICARE is responsible only for the healthcare component and non-covered services. Consurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is to whom the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain afflictions.

BLACK LUNG AND FELCA CLAIMS

I, the provider, agree to recall the claim(s) presented by the Government as provided in full. See Black Lung and FELCA instructions regarding required procedure and diagnosis coding systems.

STATEMENT OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FELCA, AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: (1) the information on this form is true, accurate and complete; (2) I have familiarized myself with all applicable laws, regulations, and program instructions which are available from the Medicare contractor; (3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; (4) this claim submission, submitted by me or on my behalf by my designated billing company, complies with all applicable laws, regulations, and program instructions for payment including but not limited to the Federal Anti-Kickback statute and Physician Self-Referral law (commonly known as Stark's law); (5) my services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employer under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; (6) my care services rendered incident to my professional service by my employer under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; (7) services to be considered "incident" to my professional service, (a) must be rendered under the physician's direct supervision or by his/her employee; (8) they may be an integral, although indefinite, part of a covered physician's service; (9) they must be of benefit commonly rendered in physician's offices; and (10) the services of non-physicians must be indicated on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black Lung claims, I further certify that the services performed were not for Black Lung-related disorders.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 440.32).

NOTICE: Any one item on this form which is false or misleading information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FELCA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE, and OMB to collect information needed in the administration of the Medicare, TRICARE, FELCA, and Black Lung programs. Authority to collect information is in section 206(b), 1402, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 49 CFR 50.6 (6), and 44 USC 3101, 41 CFR 101 et seq and 101 USC 1402, 1403 and 101 USC 3101 et seq, and 30 USC 301 et seq, 38 USC 6101 et seq, E.O. 13377.

The information we obtain is used to administer these programs in order to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be used to provide procedures of review, review, enforcement, medical review boards, health plans, and other representations or Federal agencies, for the effective administration of Federal programs, in that, in our other law, we have authority to pay primary in Federal programs and as of now we are authorized to administer these programs. For example, it may be necessary to disclose information about the benefits you have used as a hospital or doctor. Additional disclosures are made through notices sent for information contained in systems of records.

FOR MEDICARE CLAIMS: See the unique identifying system (RIN 09-07-0801, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37579, Wed. Sept. 17, 1990, as updated and republished).

FOR OMB CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28 1990. See ESA-5, ESA-6, FSA-12, FSA-15, ESA-17, as updated and republished.

FOR TRICARE CLM/BLS/PRI/PL, PUP/FORLs: To maintain "ability for medical care provided by civilian service," and to receive payment upon re-enrollment of eligibility and enrollment for the service, prior to and after the authorizing law.

ROUTINE USES: Information from this form and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation under their authority and in accordance with applicable laws under the TRICARE/CHAMPVA; to the Dept. of Justice in representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection contractors, and contractor reporting agencies in connection with nonpayment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers or carriers on matters relating to entitlement, claims adjudication, audit, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, classification of benefits, and civil and criminal litigation arising from the operation of TRICARE.

RIGHTS/REDRESS: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under those programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under those programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FELCA could be deemed a violation.

If it is mandatory that you tell us if you know that another party is responsible for paying for your treatment, Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding my payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, on payment of the amount paid by the Medicaid program for these claims submitted for payment under this program, with the exception of non-medical/dental, non-emergency, non-hospital or non-nursing care charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: It is illegal to conceal the foregoing information in this, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claim, statement, document, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0938-1197. The time required to complete the information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or if you experience any difficulty in completing this information collection, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-05 Baltimore, Maryland 21244-1840. Your comments and suggestions are welcome.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

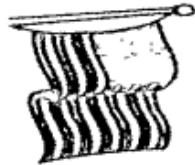
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Susan Bennett, PT, PC
Bennett Rehabilitation Institute
2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403



2240339526 8086

[REDACTED]



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARBON

PIRA <input type="checkbox"/>											
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA EXCLUDING OTHER <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (DVA/DOD) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (DVA) <input type="checkbox"/> (DOD) <input checked="" type="checkbox"/> (DVA) <input type="checkbox"/> (DOD)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARMELL, DANIELLE						3. PATIENT'S BIRTH DATE SEX MM DD YY 08 29 1980 M F <input checked="" type="checkbox"/>					
4. INSURED'S NAME (Last Name, First Name, Middle Initial) - SABRINA -						5. PATIENT ADDRESS (No., Street) 56 BERBEBEVEN DR					
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)					
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X		CITY		STATE			
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>NY</u> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME						11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <u>ON FILE</u> DATE 01-06-2016 SIGNED <u>ON P.T.R.</u>											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10-31-2015 QMUL		15. OTHER DATE QUAL		MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA		17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24E) ICD IND											
A. <u>LM79.1</u>		B. <u>L</u>		C. <u>L</u>		D. <u>D</u>		E. <u>G</u>		F. <u>H</u>	
E. <u>L</u>		F. <u>L</u>		G. <u>I</u>		H. <u>L</u>		I. <u>K</u>		J. <u>L</u>	
24. A. DATE(S) OF SERVICE MM DD YY 08 23 16		B. PLACE OF SERVICE BHG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS NDC/FEIR		D. DIAGNOSIS CODE POINTERS		E. CHARGES		F. DAYS OR UNITS H DAYS PER UNIT I ID QUAL	
2. <u>08 23 16</u>		<u>08 23 16</u>		<u>97140</u>		<u>b</u>		<u>55.00</u>		<u>3</u>	
3. <u>08 25 16</u>		<u>08 25 16</u>		<u>97140</u>		<u>b</u>		<u>55.00</u>		<u>3</u>	
4. <u> </u>		<u> </u>		<u> </u>		<u> </u>		<u> </u>		<u>NPI</u>	
5. <u> </u>		<u> </u>		<u> </u>		<u> </u>		<u> </u>		<u>NPI</u>	
6. <u> </u>		<u> </u>		<u> </u>		<u> </u>		<u> </u>		<u>NPI</u>	
25. FEDERAL TAX ID NUMBER 47-0989449		SSN BIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO HARMELL, D		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 110.00		29. AMOUNT PAID \$ 0.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARX, LMFT SIGNED DATE				32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043				33. BILLING PROVIDER INFO & PH # 716 725-0264			
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement or claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offense. Misleading claims are subject to civil penalties.

ISSN 1062-1024 • 100-200-15-033

TRICARE (MC 100-1) is the military health program designed to help all members of the armed forces and their dependents, as well as their spouses, to receive medical care and services. In the case of a member of the armed forces, the spouse is entitled to receive care and services under TRICARE. The spouse is entitled to receive care and services under TRICARE if he or she is a dependent of a member of the armed forces, as well as a dependent of a member of the armed forces' spouse. The spouse is entitled to receive care and services under TRICARE if he or she is a dependent of a member of the armed forces' spouse, as well as a dependent of a member of the armed forces' spouse's spouse.

447 MUSICA ROMANA

The author would like to thank Dr. Michael J. Lafferty and Dr. Michael J. T. Smith for their comments on this paper.

THE VITRIOL OF THE "PUNCH" OF FRENCH MEDICAL, LITERARY, POLITICAL AND SOCIAL LIFE.

In accordance with the above, I have attached my own statement of witness. Please note that I am not a medical professional and I do not practice law. So I have provided an informed and informed opinion as to what I believe to be the facts of this case. I have also provided a copy of my medical records and my prescription history, complete with all my medications and brands and their respective dates of prescriptions. I hope this will be helpful to you in your investigation. I am a retired law enforcement officer and I have no personal animosity towards anyone. I am writing this to my attorney, Mr. John S. Rutherford, Esq., of the firm of S. Rutherford & Associates, Inc., 1000 Peachtree Street, N.E., Atlanta, Georgia 30309, who has been retained by me to represent me in this matter. I am enclosing a copy of my medical records and my prescription history, complete with all my medications and brands and their respective dates of prescriptions. I hope this will be helpful to you in your investigation. I am writing this to my attorney, Mr. John S. Rutherford, Esq., of the firm of S. Rutherford & Associates, Inc., 1000 Peachtree Street, N.E., Atlanta, Georgia 30309, who has been retained by me to represent me in this matter.

For TRICARE plan B members living in the United States, the deductible is waived for the first 30 days monthly. Under TRICARE or a civilian employee of the United States Government, you are entitled to military pay (up to \$ 600.00) for dual-eligibility. If you are only dual-eligible, you will receive a flat rate of \$ 300.00 per month.

NOV 19 1967 BY THE SECRETARY OF DEFENSE TO THE CHIEF OF STAFF, AND FOR APPROVAL OF THE FORM AND USE OF WHICH HE MAY BE ADVISED OF THE INFORMATION CONTAINED THEREIN.

[NOTICES TO PATIENTS / REPORTS OF COMPLAINT AND USE OF MEDICINES, PAYMENT STATE, AND BLACK SLUG INFORMATION \(PRIVACY / CY STATEMENT\)](#)

We are authorized by CMS TRICARE and D-ASP to pay for information and services in the treatment of the following: TRICARE PEBs, and Brief, Long stays inpatients. Both our facilities are Medicare certified and have been rated at 100% for the past 10 years. We are also a member of the County Sheriff's Health Services (CSHS) and are licensed by the State of Florida (LIC# 211-2010) and #D-101, and #ACU 310145. Our 101 bed hospital is located at 10100 N. 10th Street, Suite 101, Fort Lauderdale, FL 33309.

The information given is general and does not apply to all programs. It is up to you to know your rights and to determine if the services are appropriate for you.

The same sentence is repeated in the following form: "In the U.S., it is illegal to import, sell, or possess certain controlled substances, including LSD, mescaline, psilocybin, and other hallucinogens. It is also illegal to import, sell, or possess marijuanna, hashish, hash oil, and other cannabis products. It is illegal to import, sell, or possess any controlled substance without a license from the U.S. Drug Enforcement Agency." In this sentence, the word "it" is used twice, which is incorrect. The first "it" refers to the importation of controlled substances, while the second "it" refers to the importation of marijuanna, hashish, hash oil, and other cannabis products. This creates a logical inconsistency.

PPB/PFOC/DR/CL/HC/G: See the notice issued by the No. 10-330701, incl. Carter ID and the Clerks Record "published in the Federal Register, Vol. 83 (A), 177 on 30/04/2018, incl. 14450, is considered valid and reliable."

DOI-2019-OIAR-0000; Department of the Interior, Privacy Act, 17 CFR, Regulation of the Office of Systems of records - Federal Register Vol. 85 No. 40, 10th Feb. 28, 1993, GPO E-344-F, GPO-1993-02-28-18-180, or [www.fdsys.gov](#) and regulations.

PRACTICE UPDATES: Information about new and relevant documents may be given to the Dept. of Health by the Dir. of Health and Human Services and/or the Dept. of Transportation.

However, GAO's audit, dated 2004, and our review regarding operations in connection with immigration reform, and its Congressional Office is required to evaluate and report the results of the reform, submit a report to Congress. The suggested directives may be used by other entities, state, local, foreign government agencies, private business entities, and industrial providers of care, on a regular basis, to validate claim submission, from providers to a jurisdiction, ensure quality assurance prior review, program integrity, standards, liability, accountability, benefits, and evaluate medical treatment related to the operation of TRICARE.

benefits or expenses. However, failure to timely provide documentation can result in delay in payment of my claim in addition to the costs associated therewith. Please note that failure to timely provide the requested information may result in denial of my claim. However, failure to furnish information required by the medical carriers affiliated with the amount of my claim would result in payment of claims within 10 days of receipt. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under UCA 11A-100-1002 may result in denial of my claim.

It is important that you tell us if you believe that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act, and 31 U.S.C. 3801-3812 provide generally for refunding the information.

You should be aware that Title I of the Computer Misuse and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

MEDICARE PAYMENT PROVIDER CERTIFICATION

I hereby affirm I am a drop out from school, am incapable of finding full time employment, I am entitled to income support under the State's Title XIX plan and to furnish information concerning any payment claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

Others are offered on a payment basis. The amount paid by the Member is spent in their home country for payment to the company, and the cost of the service is usually deducted from the amount paid.

SIGNATURES OF PHYSICIANS (OR SUBSTITUTED BY THE PATIENT) (If applicable) I certify that the services rendered above were medically indicated and necessary to the health of this patient and were reasonably performed by me or my medical assistants myself or my associates.

NOTICE: This form may request personal information that is protected by law and cannot be disclosed. Any award of this payment and collection of this claim will be from Federal and State funds provided by the U.S. Government. If you are a citizen or subject of a foreign nation, this may be pursued under applicable Federal or State laws.

08 30 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office (716) 725-0324

Fax (716) 725-0265

Client Name: Danielle Harwell Date: 8/23/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 (8) 10 (restricting/continuous pain)
(Check All that Apply)

- Acute Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

1st Specific: ↑ cervical + shoulder region pain 2° ease straining somewhere. Focus to upper body too. Numerous adhesions noted thru all cts.

Action's Applied: (Check All that Apply) **MUSCULATURE**

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat

Therapist:

Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office (716) 725-0324

Fax (716) 725-0265

Client Name: Danielle Harwell Date: 8/25/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 (8) 10 (restricting/continuous pain)
(Check All that Apply)

- Acute Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client unable to report cervical @ into L/L/S/R/hamstring. Adhesion (some trk) noted in above muscles. Fetal like bone p.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat

Therapist:

Danielle Harwell

08-30-16

08 30 16

Great Lakes Therapeutic Massage

Colleen Marx, LMT

375 Dick Road, Suite #2

Buffalo, NY 14043

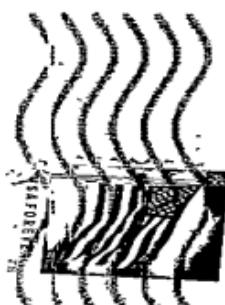
ROCHESTER NY 14

27 AUG 2016 PM 1 E

GEICO INS CO of NY
P.O. BOX 9507

FREDRICKSBURG, VA 22403

四庫全書





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PCA

PIGA

1. MEDICARE (Medicare)	MEDICAID (Medicaid)	TRICARE (DOD/DoD)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (DOD) <input type="checkbox"/> EXCLUDING (DOD)	FECA (DOD) <input type="checkbox"/> EXCLUDING (DOD)	OTHER <input type="checkbox"/>	1a. INSURED'S LD. NUMBER 013873940-0101-059 (For Program Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY 08 20 1980			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE SAINTS
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)
CITY AMBERST		STATE NY	8. RESERVED FOR NUCC USE X			CITY	STATE
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE ()	TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY N <input type="checkbox"/> F <input checked="" type="checkbox"/>	
b. RESERVED FOR NUCC USE			c. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>LNT</u>			b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE			d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME			10e. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ON FILE

DATE 01-06-2016

SIGNED ON FILE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED ON FILE

DATE 01-06-2016

SIGNED ON FILE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED ON FILE

DATE 01-06-2016

SIGNED ON FILE

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED ON FILE

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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED ON FILE

DATE 01-06-2016

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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly files a statement of claim containing any false representation or any false, incomplete or misleading information may be guilty of a criminal offence punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENT. A Medicare beneficiary accepts that payment will be made and authorizes release of any information necessary to process his claim and certifies that the information provided in Schedule 1 is true, accurate and complete. In the case of a Medicare claim, the patient is **unconditionally** authorized any entity to release all healthcare medical and non-medical information and history. If he or she is a employer group health plan member, liability, including, but not limited to, liability for claims filed by or other insurance, such as workers compensation, shall be apportioned to pay for the services. If he or she is a dependent, Schedule 2 (TRICARE enrollment) shall be used. The recipient, **unconditionally** authorizes the release of any information to the health plan company shown in Schedule 1. For TRICARE enrollment, the physician agrees to accept the claims documents of the subscriber named on TRICARE enrollment, as detailed above, and the patient is responsible for any additional charges incurred and not covered by insurance. Communication and the exchange of information between the physician and/or TRICARE enrollment, and the patient, shall be in line on legal terms. TRICARE enrollment may not have health status, age, preexisting conditions or payment for health benefits provided through enrollment in Medicare. Unclaimed Storage. Information on the patient's account may be used in the name listed on it. Instead, if no one is listed, items 1, 5, 6, 7, 8, 9 and 11,

PLACE LIVID AND RECA CLEANS...

The new code changes to the National Coding Classification system will affect all ICD-9-CM codes used in the ICD-9-CM for Hospitals, Vol. 1, Tabular List. See Box 1 for a listing of the ICD-9-CM codes affected by the changes.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNCH)

In submitting this claim to payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished myself with all applicable law, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare, and/or Medicaid laws, regulations, and program instructions for payments including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark Law); the services on this form are medically necessary and reasonably furnished by me or were furnished incident to my professional services by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 5) for each service rendered incident to my professional service, the entity (legal name and NPI, license # or SSN) of the physician individual rendering such service is reported as the designated provider for services to be considered "incident to" a physician's professional services; 6) they must be rendered under the physician's direct supervision by health care employee, 2) they must be an integral, although incidental part of a covered physician service; 6) they must be of kinds commonly furnished in physician's offices, and 7) the services of non-physician must be included in the physician's bill.

For THICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor employee of the United States Government (other civilian or military (relief to 5 USC 6508). If I make Long claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by costing law and regulations (42 CFR 421.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PAIENH: ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and QWCP to ask you for information needed in the administration of the Medicare, TRICARE, PPOA, and Black Lung programs. Authority to collect information is under section 205(g), 102-1802 and 1804 of the Social Security Act as amended, 42 CFR 411.24(a) and 428.4(a) (6), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1080, 5 U.S.C. 801(c) seq., and 39 USC 601 et seq., 39 USC 616; & D.O. 9897

The information you obtain in completing claim forms for these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to monitor proper payment methods.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans and other organizations, or Federal agencies, for the sole purpose of Federal programs, that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the location you have used to a hospital or doctor. Additionally, disclosures are made through routine use; for information contained in systems of record.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-70-0501, titled, "Corner Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1989, or as updated and republished.

FOR OWCP CLAIMS: Depiction of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb 26, 1990, See ESA-6, ESA-6, ESA-12, ESI-13, ESI-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services requested are authorized by law.

ROIA-MS (RFR-1) Information, claim status and .pdf documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities; under TRICARE-CHAMPVA to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting bureaus in connection with nonpayment claims; and to Congressional Offices in response to inquiries made of the recipient of the premium to which it paid postpaid. Appropriate notices may be made to other federal, state, local, foreign government agencies, private businesses, entities, and individual providers, or car, in matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, provider enrollment, and medical necessity related to the recipient of TRICARE.

INSCOLA/SUMIT: **Y**ourself, **Lawyer, **T**hird party, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties, user fees or other charges for refusing to supply information. However, failure to furnish information regarding the medical services furnished or the amount charged would prevent payment of claim under the program. Failure to furnish any other information, such as name or driver number, would delay payment of the claim. Failure to provide medical information required by LATA could result in denial of payment.**

It is mandatory that you tell us if you know that another party is in your state for payment for your medical care. Section 11203 of the Social Security Act and HHS 0001-1812 provide penalties for withholding this information.

You should be aware that P.L. 800-973 (or "Corporation Profits and Privacy Protection Act of 1993"), requires the government to verify information by way of cross-examination.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such information, as necessary to disclose fully for work (as covered) performed in InterimCare, under the State's Train XIX plan and to furnish information regarding any payment received for providing such services, to the State Agency or Dept. of Health and Human Services as may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under this program, with the exception of authorized deductible, co-insurance, or payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR CUPPLER): I certify that the services listed above were reasonably indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

According to the Partnership Resolution #1 of 1993, no partners are required to respond to a collection of information unless it displays a valid CmB control number. The valid CmB control number for this information collection is 0820-1597. The firm required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data, etc., and complete and return the information collection. If you have any comments concerning the accuracy or the burden of this collection of information, please send them to: CARS, 2025 St. Scotty Beauk Blvd., Altamonte Springs, FL 32714-3169. This notice is for accounting purposes only.

09 06 16

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14043
 Office: (716) 725-0324 Fax: (716) 725-0365

Client Name: Danielle Harrell Date: 9/2/16

Client Status: (Circle) Better Progressing Worse Same No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client rate's 10 since last visit. No major changes. Adhesions noted in gluteal around

C7. Client left better. M.J. tx.

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043
 Office: (716) 725-0324 Fax: (716) 725-0365

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
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 Lumbar Sacrum Coccyx Hips Glutes (R?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

09 06 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14206

Office: (716) 725-0264

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14206

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 8/25/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Ability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
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 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client came in with right shoulder/neck pain
 into L/S/hamstring. Adhesive Sensors (Tape)
 (muscle stretching applied)
 noted in abd muscles. Felt a little better.
 Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Can't Meds Ice/Heat

Therapist: Allen Mary

Client Name: Danielle Harrell Date: 8/30/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Ability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client report having an "ok" day. Nothing major c/o/P from the kidney. A slight/scapular region remains hypertonic.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

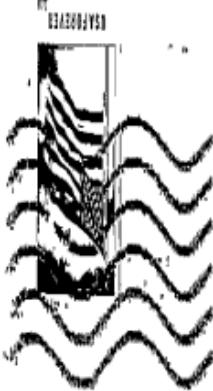
Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Can't Meds Ice/Heat

Therapist: Allen Mary

090616

09 06 16



Great Lakes Therapeutic Massage
BUFFALO NY 142

Buffalo, NY 14203

375 Dick Road, Suite #2

Colden Mart, LInC

02 SEP 2016 PM 21

22406-952607

FREDERICKSBURG, VA 22403
P.O. BOX 9507
GEICO INS CO of NY

2016-06-09



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

CARRIER

PC4

<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDERAL BUDGETING (FIM)	OTHER	1a INSURED'S ID NUMBER 0138739400101059 (For Program In Item 1)		
(Medicare)	(Medicaid)	(TRICARE)	(Member ID#)	(ID#)	(ID#)	(ID#)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle		
Harwell, Danielle			08 29 1980 M		F	X			
5. PATIENT'S ADDRESS (No. Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No. Street) 1131 Cleveland Drive		
1131 Cleveland Drive									
CITY	STATE	NY	8. RESERVED FOR NUCC USE		CITY	STATE	NY		
Cheektowaga	NY				ZIP CODE	TELEPHONE (Include Area Code)			
ZIP CODE	TELEPHONE (Include Area Code)				14225	()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO...		11. INSURED'S POLICY GROUP OR PROG NUMBER				
Harwell, Danielle			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F X				
b. OTHER INSURED'S POLICY OR GROUP NUMBER DBD16761Q00			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9e, and 9d				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below									
SIGNED SIGNATURE ON FILE				DATE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL				15. OTHER DATE QUAL		MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jennifer McVige MD				17a	17b (NP)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAST \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD 9c 0									
A L R4.2	B L	C L	D L	E L	F L	G L	H L		
I L	J L	K L	L L	M L	N L	O L	P L		
22. RESUBMISSION CODE ORIGINAL REF NO									
23. PRIOR AUTHORIZATION NUMBER 013873940010159									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. RACE OF SERVICE ENG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I D. MODIFIER E. DIAGNOSIS POINTER F. S CHARGES G. DRG OR UNITS H. PAY AMT PER UNIT I. ID QRS J. RENDERING PROVIDER ID # Z2 225100000X									
1 09 01 16	09 01 16	11	97110		A	46.00	1	NPI	1205129921
2 09 01 16	09 01 16	11	97140		A	46.00	1	NPI	225100000X
3								NPI	1205129921
4								NPI	
5								NPI	
6								NPI	
25. FEDERAL TAX ID NUMBER	SSN BIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE	29. AMOUNT PAID	30. Refd for NUCC Use		
201163729	<input type="checkbox"/> X	103558			\$ 92.00	\$ 0.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.)									
32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH# 716 8038220 Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432									
McPherson, Jacob PT, DPT SIGNED 0005/02/15									
34. 1710021001 S									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

09 09 16

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a federal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICAID AND TRICARE PAYMENTS. A patient's signature requires that payment be made and authorizes release of any information necessary to process the claim and certifies that all information provided in block 1 through 12 is true, accurate and complete. In the case of a Medicaid claim, the patient's signature authorizes any entity to release to Medicaid medical and/or financial information and whether the person has employer group health insurance, health, no-fault, worker's compensation or other insurance which is responsible to pay for the services which the Medicare claim relates to. See 42 CFR 411.2(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency whose health care assigned or TRICARE participation plan, the physician agrees to accept the change of assignment of the Medicare claim or TRICARE claim if assigned by the 1st charge and 1st provider is responsible only for its deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicaid claim or TRICARE local intermediary. If the loss is then the 2nd charge, TRICARE is not a health insurance program but makes payment for health benefits provided through certain institutions to the Uniform Service. Information on the patient's status should be provided in those areas captioned in "Insured", i.e., Items 4, 5, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding -systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICAID, TRICARE, FECA AND BLACK LUNG)

I, submitting this claim for payment from [redacted] funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to waive an informed consignment and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicaid and/or Medicare laws, regulations, and program instructions for payment including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on the form are medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicaid or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering such service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direction, supervision by his/her employee, 8) they must be an integral, although incidental part of a covered physician service; 9) they must be of kinds commonly furnished in physician's offices, and 10) the names of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 6 USC 5530). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefit may be paid unless this form is received as required by existing law and regulations (42 CFR 424.38).

NOTICE: Any person who misrepresents or falsifies or omits information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal law.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OIG to ask you for information needed in the administration of the Medicare, TRICARE, FECA and Black Lung programs. Authority to collect information is in section 205(g), 1829, 1832 and 1874 of the Social Security Act as amended, 42 CFR 411.2(a) and 491.5(a)(6), and 44 USC 3101-101 et seq and 10 USC 1079 and 1088. 4 USC 8101 et seq. and 30 USC 901 et seq. 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, clinics, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-6, ESA-6, ESA-12, ESA-18, ESA-20, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the service(s)/impairment(s) named are authorized by law.

ROUTINE USE(S): Information from claim and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory/administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service; private collection agencies; and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, for matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

NON-COBRA: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State Agency or Dept. of Health and Human Services may request.

I further agree to furnish an amount in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-payment, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21204-1700. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

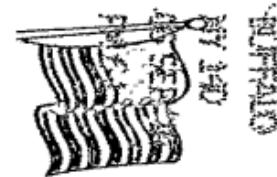
09 09 16

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Susan Bennett, PT, PC
Bennett Rehabilitation Institute
2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403



NEDERLANDS

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0812

NUCA

PICA

1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BOX LUNG		OTHER		1a INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)			
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (TRICARE)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (N/A)		<input type="checkbox"/> (N/A)		<input type="checkbox"/> (N/A)							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)												3 PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
HARWELL DANIELLE												08291980				5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			
5 PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY CHEEKETOWAGA		STATE NY		8 RESERVED FOR NUCC USE		CITY AMHERST		STATE NY											
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951											
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980					
												b AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>					
												c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b OTHER CLAIM ID (Designated by NUCC)					
												d INSURANCE PLAN NAME OR PROGRAM NAME GEICO		c INSURANCE PLAN NAME OR PROGRAM NAME GEICO					
												d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.														If yes, complete Items 9, 9a, and 9d					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.														13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the designated physician or supplier for services described below.					
SIGNED SIGNATURE ON FILE												DATE		SIGNED SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115		15. OTHER DATE MM DD YY 054 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a QH&L 431		17b 454		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
17c NPI		17d NPI		19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
20 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer A-L to service line below (24E))												22. RESUBMISSION CODE ORIGINAL REF NO							
A M50.22		B M51.26		C M51.27		D M54.12		E		F		G		H		I		J	
E I223.3XXA		F M99.01		G M99.03		H M99.02		I		J		K		L		M		N	
I M99.05		J M54.2		K M54.5		L M54.6		M		N		O		P		Q		R	
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE BMG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS CODE		F. \$ CHARGES		G. DAYS OR UNITS		H. AMOUNT PAID		I. ID QUAN.		J. RENDERING PROVIDER ID #	
1 08262016 08262016 11				98941				ABCD		32 28 1								NPI 1710014188	
2 08262016 08262016 11				97010				ABCD		10 53 1								NPI 1710014188	
3 08292016 08292016 11				98941				ABCD		32 28 1								NPI 1710014188	
4 08292016 08292016 11				97010				ABCD		10 53 1								NPI 1710014188	
5																		NPI	
6																		NPI	
25. FEDERAL TAX ID NUMBER SSN SIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 85.62		29. AMOUNT PAID \$		30. Reserved for NUCC Use									
364500165		343821229		CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and you may make a photocopy of them.) PETER GOZINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & P.H.# (716) 681-3333															
SIGNED 09072016 DATE 1235256546																			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
September 7, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday August 26, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain and headaches continue. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she also had headaches since the accidents. The headaches are now 2-3 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* achy, dull, shooting; level: 5/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* sharp, shooting, tingling, numb; level: 5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with

**Encounter dated 08/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/07/2016**

pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 46/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate to severe; TFL / ITB left moderate to severe; lumbar paraspinal right moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** worse.

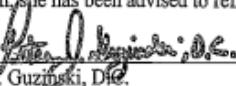
Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation)

Encounter dated 08/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/07/2016

with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 5 weeks; Re-examination for 5 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI right PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, DC

Monday August 29, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain and headaches continue. *Onset:* October 31, 2015.

Encounter dated 08/29/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/07/2016

Cause of symptoms: MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. since last visit. **Pain:** achy, dull, tingling, shooting, numb; level: 4/10. **Pain is frequent.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she also had headaches since the accidents. The headaches are now daily. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences dizziness with the headaches but she no longer experiences nausea. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. since last visit. **Pain:** achy, dull, shooting; level: 4/10. **Pain is occasional.** **Exacerbates symptoms:** movement; bending; lifting; activites of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. since last visit. **Pain:** sharp, shooting, tingling, numb; level: 4/10. **Pain is constant.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: **Range of motion:** flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** foward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 46/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Heel**

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to toe walking: WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* worse with the headaches which are now daily. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

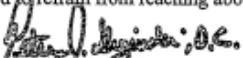
Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 5 weeks; Re-examination for 5 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left

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levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

- ADL: activities of daily living
- MVA: motor vehicle accident
- ROM: range of motion
- WNL: within normal limits



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P.O. Box 9507
Gruccio



Depew, NY 14043
345 Dick Rd.





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRCICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARBON

PICA										PICA					
1 MEDICARE <input type="checkbox"/> (Medicare)	2 MEDICAID <input type="checkbox"/> (Medicaid)	3 TRICARE <input type="checkbox"/> (DOD/DoD)	4 CHAMPAVA <input type="checkbox"/> (Member Only)	5 GROUP HEALTH PLAN <input type="checkbox"/> (GHP)	6 FEDA <input type="checkbox"/> (FED)	7 OTHER <input type="checkbox"/> (OTH)	1a. INSURED'S I.D. NUMBER (For Program In Item 1) 013873940-0101-059								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980				SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - Same -			
5. PATIENT'S ADDRESS (No., Street) 56 BERSEAVEN DR							6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)				
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X				CITY		STATE					
ZIP CODE 14226		TELEPHONE (Include Area Code) (716) 536-0951						ZIP CODE		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FEDA NUMBER				
							b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NEV				a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
							c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)				
d. INSURANCE PLAN NAME OR PROGRAM NAME							10d. CLAIM CODES (Designated by NUCC)				c. INSURANCE PLAN NAME OR PROGRAM NAME				
											d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															
SIGNED - ON FILE - DATE 01-06-2016 SIGNED - ON FILE -															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD YY) 10-31-2015				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA				17a. MM DD YY 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-H to service line below (24e)) A. <u>U79.1</u> B. <u> </u> C. <u> </u> D. <u> </u> E. <u> </u> F. <u> </u> G. <u> </u> H. <u> </u> I. <u> </u> J. <u> </u> K. <u> </u> L. <u> </u>															
22. RESUBMISSION CODE ORIGINAL REF. NO.															
23. PRIOR AUTHORIZATION NUMBER															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMR C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DQG OR UNITS H. DQG Per Ref. I. ID QUAL J. RENDERING PROVIDER ID #															
1	09-08-16	08-16-13	97140						55	100	3	MPI	1344462013		
2												NPI			
3												NPI			
4												NPI			
5												NPI			
6												NPI			
25. FEDERAL TAX ID NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO HARWELL, D		27. ACCEPT ASSIGNMENT NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>		28. TOTAL CHARGE \$ 55 100	29. AMOUNT PAID \$ 0 100	30. Paid for NUCC Use 55 100							
47-0989449	<input type="checkbox"/> X														
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMFT SIGNED DATE 09-08-2016							32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043 a. 1144462013 b. 1144462013								
							33. BILLING PROVIDER INFO & PH# 716 725-0264								

ACQUAINT THE FIRM TO BE USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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3-AG:11P07-MIC 2020 GL-0173

¹Leitura da Constituição de 1988, art. 14, § 1º, que estabelece que o Poder Executivo é exercido pelo Presidente da República.

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For **TEACHER** who is "other holder" that I am "employee who received services from an entity that is not a member of the Standard Series or a worker employee of the United States Government or a contractor employee of the United States Government, other than an entity that is C USE-537" in the State budget, if I am not a teacher, I will be a Clerk, or Clerk-Recorder.

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¹⁰ See also *Re B (A Child) (Care Proceedings) (No. 2) (Interim Care Order) (Appeal) [2010] EWHC 2070 (Fam), 2010 (1) Fam L.R. 103, 105, 107, 109, 111, 113, 115, 117, 119, 121, 123, 125, 127, 129, 131, 133, 135, 137, 139, 141, 143, 145, 147, 149, 151, 153, 155, 157, 159, 161, 163, 165, 167, 169, 171, 173, 175, 177, 179, 181, 183, 185, 187, 189, 191, 193, 195, 197, 199, 201, 203, 205, 207, 209, 211, 213, 215, 217, 219, 221, 223, 225, 227, 229, 231, 233, 235, 237, 239, 241, 243, 245, 247, 249, 251, 253, 255, 257, 259, 261, 263, 265, 267, 269, 271, 273, 275, 277, 279, 281, 283, 285, 287, 289, 291, 293, 295, 297, 299, 301, 303, 305, 307, 309, 311, 313, 315, 317, 319, 321, 323, 325, 327, 329, 331, 333, 335, 337, 339, 341, 343, 345, 347, 349, 351, 353, 355, 357, 359, 361, 363, 365, 367, 369, 371, 373, 375, 377, 379, 381, 383, 385, 387, 389, 391, 393, 395, 397, 399, 401, 403, 405, 407, 409, 411, 413, 415, 417, 419, 421, 423, 425, 427, 429, 431, 433, 435, 437, 439, 441, 443, 445, 447, 449, 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2537, 2539, 2541, 2543, 2545, 2547, 2549, 2551, 2553, 2555, 2557, 2559, 2561, 2563, 2565, 2567, 2569, 2571, 2573, 2575, 2577, 2579, 2581, 2583, 2585, 2587, 2589, 2591, 2593, 2595, 2597, 2599, 2601, 2603, 2605, 2607, 2609, 2611, 2613, 2615, 2617, 2619, 2621, 2623, 2625, 2627, 2629, 2631, 2633, 2635, 2637, 2639, 2641, 2643, 2645, 2647, 2649, 2651, 2653, 2655, 2657, 2659, 2661, 2663, 2665, 2667, 2669, 2671, 2673, 2675, 2677, 2679, 2681, 2683, 2685, 2687, 2689, 2691, 2693, 2695, 2697, 2699, 2701, 2703, 2705, 2707, 2709, 2711, 2713, 2715, 2717, 2719, 2721, 2723, 2725, 2727, 2729, 2731, 2733, 2735, 2737, 2739, 2741, 2743, 2745, 2747, 2749, 2751, 2753, 2755, 2757, 2759, 2761, 2763, 2765, 2767, 2769, 2771, 2773, 2775, 2777, 2779, 2781, 2783, 2785, 2787, 2789, 2791, 2793, 2795, 2797, 2799, 2801, 2803, 2805, 2807, 2809, 2811, 2813, 2815, 2817, 2819, 2821, 2823, 2825, 2827, 2829, 2831, 2833, 2835, 2837, 2839, 2841, 2843, 2845, 2847, 2849, 2851, 2853, 2855, 2857, 2859, 2861, 2863, 2865, 2867, 2869, 2871, 2873, 2875, 2877, 2879, 2881, 2883, 2885, 2887, 2889, 2891, 2893, 2895, 2897, 2899, 2901, 2903, 2905, 2907, 2909, 2911, 2913, 2915, 2917, 2919, 2921, 2923, 2925, 2927, 2929, 2931, 2933, 2935, 2937, 2939, 2941, 2943, 2945, 2947, 2949, 2951, 2953, 2955, 2957, 2959, 2961, 2963, 2965, 2967, 2969, 2971, 2973, 2975, 2977, 2979, 2981, 2983, 2985, 2987, 2989, 2991, 2993, 2995, 2997, 2999, 3001, 3003, 3005, 3007, 3009, 3011, 3013, 3015, 3017, 3019, 3021, 3023, 3025, 3027, 3029, 3031, 3033, 3035, 3037, 3039, 3041, 3043, 3045, 3047, 3049, 3051, 3053, 3055, 3057, 3059, 3061, 3063, 3065, 3067, 3069, 3071, 3073, 3075, 3077, 3079, 3081, 3083, 3085, 3087, 3089, 3091, 3093, 3095, 3097, 3099, 3101, 3103, 3105, 3107, 3109, 3111, 3113, 3115, 3117, 3119, 3121, 3123, 3125, 3127, 3129, 3131, 3133, 3135, 3137, 3139, 3141, 3143, 3145, 3147, 3149, 3151, 3153, 3155, 3157, 3159, 3161, 3163, 3165, 3167, 3169, 3171, 3173, 3175, 3177, 3179, 3181, 3183, 3185, 3187, 3189, 3191, 3193, 3195, 3197, 3199, 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3533, 3535, 3537, 3539, 3541, 3543, 3545, 3547, 3549, 3551, 3553, 3555, 3557, 3559, 3561, 3563, 3565, 3567, 3569, 3571, 3573, 3575, 3577, 3579, 3581, 3583, 3585, 3587, 3589, 3591, 3593, 3595, 3597, 3599, 3601, 3603, 3605, 3607, 3609, 3611, 3613, 3615, 3617, 3619, 3621, 3623, 3625, 3627, 3629, 3631, 3633, 3635, 3637, 3639, 3641, 3643, 3645, 3647, 3649, 3651, 3653, 3655, 3657, 3659, 3661, 3663, 3665, 3667, 3669, 3671, 3673, 3675, 3677, 3679, 3681, 3683, 3685, 3687, 3689, 3691, 3693, 3695, 3697, 3699, 3701, 3703, 3705, 3707, 3709, 3711, 3713, 3715, 3717, 3719, 3721, 3723, 3725, 3727, 3729, 3731, 3733, 3735, 3737, 3739, 3741, 3743, 3745, 3747, 3749, 3751, 3753, 3755, 3757, 3759, 3761, 3763, 3765, 3767, 3769, 3771, 3773, 3775, 3777, 3779, 3781, 3783, 3785, 3787, 3789, 3791, 3793, 3795, 3797, 3799, 3801, 3803, 3805, 3807, 3809, 3811, 3813, 3815, 3817, 3819, 3821, 3823, 3825, 3827, 3829, 3831, 3833, 3835, 3837, 3839, 3841, 3843, 3845, 3847, 3849, 3851, 3853, 3855, 3857, 3859, 3861, 3863, 3865, 3867, 3869, 3871, 3873, 3875, 3877, 3879, 3881, 3883, 3885, 3887, 3889, 3891, 3893, 3895, 3897, 3899, 3901, 3903, 3905, 3907, 3909, 3911, 3913, 3915, 3917, 3919, 3921, 3923, 3925, 3927, 3929, 3931, 3933, 3935, 3937, 3939, 3941, 3943, 3945, 3947, 3949, 3951, 3953, 3955, 3957, 3959, 3961, 3963, 3965, 3967, 3969, 3971, 3973, 3975, 3977, 3979, 3981, 3983, 3985, 3987, 3989, 3991, 3993, 3995, 3997, 3999, 4001, 4003, 4005, 4007, 4009, 4011, 4013, 4015, 4017, 4019, 4021, 4023, 4025, 4027, 4029, 4031, 4033, 4035, 4037, 4039, 4041, 4043, 4045, 4047, 4049, 4051, 4053, 4055, 4057, 4059, 4061, 4063, 4065, 4067, 4069, 4071, 4073, 4075, 4077, 4079, 4081, 4083, 4085, 4087, 4089, 4091, 4093, 4095, 4097, 4099, 4101, 4103, 4105, 4107, 4109, 4111, 4113, 4115, 4117, 4119, 4121, 4123, 4125, 4127, 4129, 4131, 4133, 4135, 4137, 4139, 4141, 4143, 4145, 4147, 4149, 4151, 4153, 4155, 4157, 4159, 4161, 4163, 4165, 4167, 4169, 4171, 4173, 4175, 4177, 4179, 4181, 4183, 4185, 4187, 4189, 4191, 4193, 4195, 4197, 4199, 4201, 4203, 4205, 4207, 4209, 4211, 4213, 4215, 4217, 4219, 4221, 4223, 4225, 4227, 4229, 4231, 4233, 4235, 4237, 4239, 4241, 4243, 4245, 4247, 4249, 4251, 4253, 4255, 4257, 4259, 4261, 4263, 4265, 4267, 4269, 4271, 4273, 4275, 4277, 4279, 4281, 4283, 4285, 4287, 4289, 4291, 4293, 4295, 4297, 4299, 4301, 4303, 4305, 4307, 4309, 4311, 4313, 4315, 4317, 4319, 4321, 4323, 4325, 4327, 4329, 4331, 4333, 4335, 4337, 4339, 4341, 4343, 4345, 434*

MONDAY JULY EIGHTH, 2013 PRACTICE AND PREGNANCY IN THE WORKPLACE ACT STATEMENT

We are also doing the TSCM/SEC and Q/C/P in your facility, more details in the communication of last week. TSCM, FCC, and B&K, long programs. Available online. We are also doing the TSCM/SEC and Q/C/P in your facility, more details in the communication of last week. TSCM, FCC, and B&K, long programs. Available online.

The information you have to complete this survey. These programs help us to identify you as we determine your ethnicity. It is important to decide if the surveyor, and supplier you represent are covered by these programs and to tell us if they have other programs in place.

The term "Federally-recognized tribe" means the 567 tribes, bands, and intertribal consortia that are Federally-recognized by the U.S. Government. The term "tribe" means a Native American Indian group that is organized politically as an entity, has a common name, has a common descent or cultural tradition, has a common language, has a common territory, has a common economic life, has a common government, and can maintain its political status as a member of the tribe.

FOR MEDICARE CLAIMS: See the source modify system No. 09-73 0501, titled "Centra Medicare Claims Record," published in the Federal Register, Vol. 58 No. 177, page 37478, 7/1/93, as amended and republished.

¹ Reproduction of Motion of Systems of Records. *Id.* See Reg. VIII, 55 FR 40, filed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESB-1, as amended and republished.

FIG. 1. DEPARTMENT OF PRINCIPLE AND PRACTICE. To evaluate eligibility for medical care afforded by civilian sources and to issue payment upon establishment of eligible and non-eligible cases.

NOTIFICATION OF FILING. The original or a true copy of each document may be given to the Dept. of Migration Affairs, the Dept. of Health and Human Services under the Dept. of Transportation, or to the Head of the relevant administrative or prosecutorial unit in the TRIBUNAL CHAMBERS, or to the Dept. of Justice for transmission to the Secretary of Defense, in each office, or to the Internal Revenue Service, or to a collection agency, or to another legal entity in connection with repayment claims, or to Congress - General Office in response to inquiries made as a result of the provisions of this Act and its laws. Appropriations or resources may be used to offset the cost, save for it, for legal expenses such as when private business entities and individuals, or members of Congress, or others, making the complaint, or whom addressed, incur legal expenses in connection with the filing of a complaint, or for services, or for the recovery, third-party actions, or other expenses, or losses, and damages, incurred in the course of the filing of a complaint in the TRIBUNAL.

DISCLAIMERS: We do not accept or require payment from insurance companies or third parties for services rendered by our office. We do not accept assignment of benefits. We do not accept assignment of benefits. We do not accept assignment of benefits.

This is my voluntary and true statement before I was sworn in as a member of the Board of Governors for payment for services rendered, Davison, 11/20/03 of the Small Business Act and 31 USC 3601-3612 (pertaining to the Small Business Protection Act).

Yi He - Evidence of Malfeasance 103-983, 3rd Computer Networking and Privacy Problem Set of 1285*, posted on governmental law, only information by way of computer media;

WEDICARD PAY, INC. ("WEDICARD CERTIFICATION")

I have the right to keep up with my health information to the extent that the health care provider or health plan, as applicable, has provided it to me. I also have the right to receive my health information from the health care provider or health plan, as applicable, in a format that I can understand.

Individuals who have been diagnosed with a mental health condition by a healthcare provider and are currently receiving treatment under that provider, with the exception of a physician, dentist, pharmacist, or dental hygienist.

STATEMENT OF PAY-IN-HEM (OR SUPPORTIVE): I certify that the statements made above are truthfully indicated and necessary in the health of the patient and were previously informed to me in my application. I further agree, on demand:

NOTICE: This is a copy of the foregoing statement and is true, accurate and complete. I understand the payment and disbursement of the claim will be from Federal and State funds and that all payments will be subject to audit.

According to § 8c Data Privacy Protection Act of 1998, no patients are recorded in a register or a collection of information unless it displays a valid OMB control number. The valid OMB control number for the patient data collection is 0938-0417. The time limit to complete collection is 60 days. In addition, 15 minutes per response, including the time to review responses, shall elapse from the date of collection, or the day after collection, and commence and receive the information, if any. If you have any comments concerning the accuracy of the form, "Statement of Status," or changes to this instrument, please write to CHS, 7600 Eastern Boulevard, Room 117A, Herndon, Virginia 20171, Attention: Quality Officer, Tele: 703-248-65. E-mail: cdc@cdc.gov.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0834

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 9/11/16Client Status: Better Progressing Worse Same No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports no A since last visit. No major Q/P. Adhesions noted in glute around CT. Client felt better after MT tx.

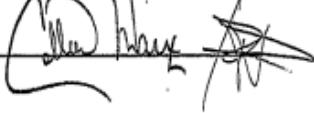
Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombral/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0834

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 9/8/16Client Status: Better Progressing Worse Same No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
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 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports feeling "unstable" & "loose"

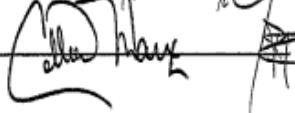
P.T. (in contraction), no A = Clinical pain. Slight

✓ In hypertonicity; @ glute, today. % cervical & Due
Action's Applied: (Check All that Apply) numbers of Blk night

Heat Packs Cold Packs Sombral/Biofreeze for no apparent
 Light Pressure Massage Moderate Pressure Massage reason. Woke
 Deep Tissue Massage Myofascial Release Friction up back and
 Manual Traction Stretching Range-of-Motion this is the return
 Stripping Compression Lymph Drainage for S/S to Subsidy
Plan/Recommendations: (Check All that Apply) for a little bit.

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:



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Great Lakes Therapeutic Massage

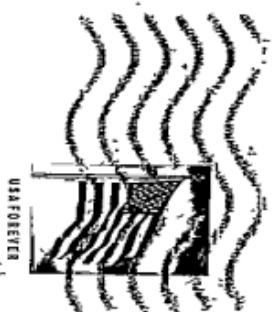
Colleen Marx, LMT

375 Dick Road, Suite #2

Buffalo, NY 14203

ROCHESTER NY 146

10 SEP 2016 FAX 21



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403-952607

||||||| ||||| ||||| ||||| ||||| ||||| ||||| ||||| ||||| ||||| ||||| |||||



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL LIMIFORM CLAIM COMMITTEE (NLCC) 09/13

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22401

2020 PCA

ENCA 100

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Lannie Mochler, MD, FAAPC
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Udit T. Malaney, PA-C
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Mehi Razo, RPA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Garsella, FNP-C
Christopher Zelewski, FNP-C

Sydney B Grabau, PA

Procedure Note Date: 09/13/2016

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 36 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Trigger point injections

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Danielle states the trigger point injections have provided relief for about 4 weeks. She has continued with regular PT once per week, massage twice per week and regular nontraditional chiropractic. She will be anticipating an epidural steroid injection in the lumbar region in about 2 weeks.

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking Naprosyn 500 mg tablet 1 tab(s) pm headache, up to BID
- Taking zanaflex 10 mg tablet 1 tab(s) pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A

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Shawn Fugler, Clinic Manager
Kaitlyn Bower
Amanda McWayne
Alice Trzcielski

INFUSION CENTERS

Christina Masi, MA, BSN, Director
Robbie Mollerig, RN, Manager

- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking: Patient is a: non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Clipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy

Vital Signs

BP sitting 126/76, HR 72, RR 16, HT 63", WT 150, BMI 26.57, BSA 1.74.

Examination**NEUROLOGICAL:**

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and

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ADMINISTRATIVE SUPPORT

Steven Ferger, Clinic Manager
 Karla Bower
 Amanda McFayden
 Alice Tocino

INFUSION CENTERS

Christie Marr, MHA, Director
 Barbara McManig, RNP, Manager

without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)

The patient will continue with regular PT, massage and chiropractic, in addition to the trigger point injections.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections:

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living. Patient counseled on the importance of healthy lifestyle. 09/13/2016.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 09/13/2016.

Exercise: Patient counseled on importance of moderate physical activity daily. 09/13/2016.

Follow Up

4 Weeks triggers

from dr mc

J

Electronically signed by Sydney Grabau , PA on 09/13/2016 at 11:27 AM EDT

Sign off status: Completed

(716) 250-2000
www.dentinstitute.com

Amherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
Orchard Park Office | Sterling Medical Park • 280 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-8515
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Shawn Fenger, Clinic Manager
Kathia Bowar
Amanda McFayden
Alice Tuszinski

INFUSION CENTERS

Christie Mann, MBA, Director
Barbara Koldberg, JUN, Manager

Patient: Harwell, Danielle | DOB: 08/29/1980 | Procedure Note

Page 4 of 4

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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Shawn Fagge, Clinic Manager
Katrien Bower
Aurilia Mafazydes
Alice Trzaski

INFUSION CENTERS

Christina Mann, MHSA, Director
Barbara McElroy, RN, Manager



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/13

GEICO
PO BOX 9507

Fredericksburg VA 22403

PICA

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

DO NOT USE THIS FORM IF USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a civil or criminal penalty under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAM ONLY

RIGHTS AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary in process the claim and certifies that the information provided in Boxes 1 through 17 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and/or medical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the care. For which the Medicare claim is made. See 42 CFR 411.2(b). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In the event a person assigned to TRICARE participation status, the physician agrees to accept the charge determination of the healthcare carrier or TRICARE local intermediary as the "all charges" and the amount is responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured" i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

"I" further agrees to pay the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedures and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (TRICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the payment to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare under Medicare laws, regulations, and program instructions for payment and does not exceed the Federal anti-kickback statute and Physician Self-Referral Law (commonly known as Stark Law); 5) the service on the form was medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the steady duty name and NPI license # (or SRR) of the primary individual rendering such services is reported in the designated section. For services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direct supervision by his/her employee, 8) they must be an integral, although incidental, part of a covered physician's practice; 8) they must be of levels commonly furnished in physician's offices; and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 6 USC 5508). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or furnishes essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1802, 1822 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 484.5(a) (6), and 44 USC §101 et seq, 10 CFR 101 et seq and 10 USC 1079 and 1088, 5 USC 8101 et seq and 30 USC 901 et seq; 30 USC 913; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, centers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the discrete administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through means such as information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying System No. 09-70-0501, Med, "Former Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Reproduction of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See EOA-5, EOA-6, EOA-12, EOA-13, EOA-30, as updated and republished.

FOR TRICARE CLAIMS: (PRINCIPLE PURPOSE(S)) To evaluate eligibility for medical care provided by civilian sources and to base payment upon establishment of eligibility and determination that the services/supplies rendered are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FICA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Tel. XIX plan and to furnish information regarding any previous claim for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid recipient for those claims submitted for payment under that program with the exception of non-covered deductible, non-benefit, or patient's or similar cost-sharing charge.

SIX WAYS TO PAY (OR SUPPLIER) (OR INSURANCE): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee and to my personal direction.

NOTICE: Those who certify that the information is inaccurate and incomplete, I understand that payment and satisfaction of this claim will be from Federal and State funds, and if it is false claims, statements, or representations of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0930-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, e.g., for the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-04, Baltimore, Maryland 21214-2604. The address is for comments on the suggestion only. DO NOT MAIL COMPLETED CL-1M FORMS TO THIS ADDRESS.

09 19 16

100% 100% 100% 100%

09 19 16

Susan Bennett, PT, PC

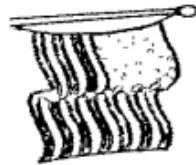
Bennett Rehabilitation Institute

2075 Sheridan Drive

Suite D

Kemmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 5812

2000 PICA

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

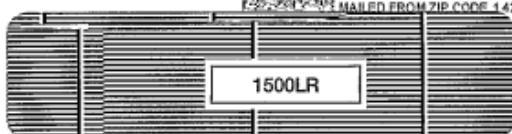
1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA (<input type="checkbox"/> Medicaid) (<input type="checkbox"/> Medicaid) (<input type="checkbox"/> DOD/DoD) (<input type="checkbox"/> Member DoD) (<input type="checkbox"/> DOD) (<input type="checkbox"/> DOD)												2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			3 PATIENT'S BIRTH DATE 08 29 1980			4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE													
												5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR			6 PATIENT RELATIONSHIP TO INSURED Sister <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7 INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR													
CITY CHEEKERTOWAGA		STATE NY		8 RESERVED FOR NUCC USE		CITY CHEEKERTOWAGA		STATE NY																							
ZIP CODE 14225		TELEPHONE (Include Area Code) ()				ZIP CODE 14225		TELEPHONE (Include Area Code) ()																							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10 IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11 INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15																			
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____ PLACE (State) _____						c. INSURED'S DATE OF BIRTH 08 29 1980 <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/>																			
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____						d. OTHER CLAIM ID (Designated by NUCC)																			
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____ If yes, complete items 9, 9a, and 9d																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below.												SIGNATURE ON FILE 02 09 16						13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefit to the undersigned physician or supplier for services described below. SIGNATURE ON FILE SIGNED													
MM DD YY		MM DD YY		MM DD YY		MM DD YY		MM DD YY		MM DD YY		MM DD YY		MM DD YY		MM DD YY															
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY Q3M		15 OTHER DATE QUAL 439 MM DD YY		16 OTHER DATE QUAL 439 MM DD YY		17a NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GZINSKI		17b LG U62607		17c NM 1710014188		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM _____ TO _____		19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD IND 0 A M791 B I C L D E L F G H I K L		22 RESUBMISSION CODE ORIGINAL REF NO											
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B PRICE OF SERVICE EWG		C D PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)		D CPT/HCPCS		E MODIFIER		F		G DAYS OR UNITS		H SPENT PER DAY		I ID QMUL		J RENDERING PROVIDER ID #													
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25 FEDERAL TAX ID NUMBER 161582336		SSN EN <input checked="" type="checkbox"/>		26 PATIENT'S ACCOUNT NO 1443733		27 ACCEPT ASSIGNMENTS <input checked="" type="checkbox"/> YES <input type="checkbox"/> ND		28 TOTAL CHARGE \$ 95 74		29 AMOUNT PAID \$ 0 00		30 Revd for NUCC Use a 1497850911 b		31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JENNIFER W MCVIGE, MD 09 15 16						32 SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727 e 1497850911 f						33 BILLING PROVIDER INFO & P.A. (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002					
SIGNED DATE												NUCC Instruction Manual available at www.nucc.org PLEASE PRINT OR TYPE CH061652 APPROVED OMB-0938-1197 FORM 1500 (02-12)																			

09 19 16

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BILLING OFFICE
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BUFFALO, NY 14226



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SEP 15 2016 MAILED FROM ZIP CODE 14226



FIRST CLASS MAIL

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**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requires that payment be made and authorizes release of any "information, on necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items contained in "Insurance," i.e., Items 1a, 1, 6, 7, 8, and 13.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from my healthcare contractor; 3) I have provided or will provide such information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 8538). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWC to ask you for information needed in the administration of the Medicare, TRICARE, FECA and Black Lung programs. Authority to collect information is in section 205(b)(1), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.23(a) and 42 CFR 5(a)(6), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 801 et seq, and 99 USC 801 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal programs and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 08-70-0501 issued, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37549, Wed Sept. 12, 1990, as updated and republished.

FOR OWC CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 35 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/H&PA, to the Dept. of Justice for representation of the Secretary of Defense in civilian actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with re-collection claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-508, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collected. If you have any comments concerning the accuracy of the estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Rm. A104, Reprogs Division, OAS, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 2746
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 09/15 07:54
 TX/RX TIME 01' 20
 PGS. 5
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

GEICO INSURANCE - NY
 NY PIP CLAIMS
 POBOX 9507
 FREDERICKSBURG VA 22403

PATIENT INFORMATION		INSURER INFORMATION	
1. MEDICARE MEDICAREN THEDATE CHAMPION CROWN MEDICAL PLAN HMO OINR <input type="checkbox"/> <input type="checkbox"/>	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE	3. PATIENT'S DATE OF BIRTH 08/29/1980	4. INSURED'S ID NUMBER 0138739400101059
5. PATIENT'S ADDRESS, Street 1131 CLEVELAND DR	6. PATIENT'S RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	7. INSURED'S ADDRESS (Last Name, First Name, Middle Initial) CLEVELAND DR	8. CITY COUNTRY STATE CLEVELAND DR NEW YORK NY
9. CITY ZIP CODE CLEVELAND DR 14225	10. TELEPHONE (Include Area Code) ()	11. CITY ZIP CODE STATE CLEVELAND DR 14225 NY	12. TELEPHONE (Include Area Code) ()
13. OTHER INSURED'S INSURER NUMBER 14. INSURANCE PLAN NAME OR PROGRAM NAME	14. IS PATIENT'S CONDITION RELATED TO: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	15. INSURER'S POLICY GROUP OR PICA NUMBER DOI 10/31/15	16. INSURER'S DATE OF BIRTH SEX 08/29/1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>
15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of general liability either to myself or to the party who people assigned below. SIGNATURE ON FILE	16. AUTO ACCIDENT? PLACE (state) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	17. OTHER CLAIM ID (Indicated by NUCC) 1710013188	18. OTHER CLAIM ID (Indicated by NUCC) 1710013188
17. ADDITIONAL CLAIM INFORMATION (Indicated by NUCC)	18. CLIA CODES (Designated by NUCC) 02 09 16	19. OUTSIDE LAB TEST CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20. INSURER'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the underlined physician or provider for services described below. SIGNATURE ON FILE
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate All in separate line below (Part II)) M7.91	22. ICD-9-CM CODE 001	23. CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24. PAYMENT INFORMATION 1649596495
25. A. DATE(S) OF SERVICE MM DD YY	26. B. PAYOR MM DD YY	27. C. PROCEDURAL SERVICES OR EQUIPMENT (Specify Universal Classification)	28. D. CHARGED POINTERS 1649596495
29. E. CHARGES MM DD YY	30. F. PAYMENT MM DD YY	31. G. PAYMENT MM DD YY	32. H. PAYMENT MM DD YY
1. 09/13/16 09/13/16 11 20553 A 95/74/1 NPI	2. 11/13/16 11/13/16 11 20553 A 95/74/1 NPI	3. 11/13/16 11/13/16 11 20553 A 95/74/1 NPI	4. 11/13/16 11/13/16 11 20553 A 95/74/1 NPI

CARRIER

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Lassio Mochtar, MD, Director
Ajay Abad, MD
Lauren Less, MD

Jennifer W McVige, MD
Nivedas Sakkal, MD

Kathy A. Bensatt, RPA-C
Rebecca Battaglia, PA-C
Sydney B Grabau, PA
Leanne Jasdziszak, RPA-C
Megan Kaschke, PA-C
Larissa Less, FNP-C

Colin T. Maloney, PA-C
Katelyn L. Murphy, FNP
Maria Rizzo, RPA-C
Elizabeth D. Smith, CPNP, ANP
Andrea Ganzella, FNP-C
Christopher Zaleski, FNP-C

Sydney B Grabau, PA

Procedure Note

Date: 09/13/2016

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 36 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Trigger point injections

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today.

Danielle states the trigger point injections have provided relief for about 4 weeks. She has continued with regular PT once per week, massage twice per week and regular nontraditional chiropractic. She will be anticipating an epidural steroid injection in the lumbar region in about 2 weeks.

Current Medications

- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking nizatidine 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A

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Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Shava Feger, Clinic Manager
Katrina Bower
Amanda McFayden
Alice Trzcienski

INFUSION CENTERS

Catherine Mann, MBA, Director
Barbara Mulderig, RN, Manager

- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs Denies.

Resides with:

Spouse: Husband. Children: Yes, x3

Working:

Employed: Stay at home mom

Marital Status:

Married Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Soda Pop: Yes.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 126/76, HR 72, RR 16, Ht 63", Wt 150, BMI 26.57, BSA 1.74.

Examination

NEUROLOGICAL:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and

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 Katrina Bower
 Amanda McFayden
 Alice Trancakis

INFUSION CENTERS
 Christine Marx, MBA, Director
 Barbara Mulking, RN, Manager

without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions

Assessments

1. Myofascial pain - M79.1 (Primary)

The patient will continue with regular PT, massage and chiropractic, in addition to the trigger point injections

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections

Trigger Point injections The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 09/13/2016

Diet Patient counseled on importance of lowering sugar intake, sodium and fats 09/13/2016.

Exercise Patient counseled on importance of moderate physical activity daily. 09/13/2016.

Follow Up

4 Weeks triggers

sydney grabau pa-c

J

Electronically signed by Sydney Grabau , PA on 09/13/2016 at 11:27 AM EDT

Sign off status: Completed

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Vernice Bates, MD	Francis M. George, PharmD	Bennett Myers, MD
Bela Ajai, MD	Sanjay Gupta, MD	Mahn Patel, MD
Alfred Belen III, MD	Tomas Hershkowitz, MD	Mohammed M. Qasayneh, MD
Horacio Capote, MD	J. Maurice Hearstka, MD	Michelle M. Russak, PharmD
Denee M. Connicki, PhD	Xigeli Li, MD	Luisa Reja, MD
Steve Doffas, MD	Leandro Moshier, MD	Nicolas Sasaki, MD
J. Ashley Dougan, PhD	Jennifer W. McVige, MD	Lizia Zhang, MD, PhD
Marc S. Frost, MD	Kenneth R. Murray, MD	Joseph V. Yitz, PhD, CEO

SEPTEMBER 15, 2016

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

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DIAGNOSTICS & SERVICES	
MEPECT	Neuropsychology
Angiogram	Pneurography
Brexit	Step Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImBERT	PNG
Inflame	

FIRST CLASS MAIL





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, Va 22401

CARRIER

PATIENT AND INSURED INFORMATION

SYNTHETIC POLY(AMINO ACID) ANALOGUE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, FREE DISPARATE INSTRUCTIONS IS ISSUED BY APPENDIX B OF THIS FORM.

NOTICE: Any person who knowingly files a statement of claim containing any untrue statement or any false, incomplete, or misleading information, and by entity of a criminal act, shall be subject to civil and/or criminal penalties.

NOTICE TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: As a health care provider, you must pay attention to laws and regulations that govern the payment of Medicare and TRICARE claims. If any information necessary to process the claim is omitted, your entity may be liable for the amount of the claim plus interest and attorney fees. In the case of Medicare claims, the provider is responsible for timely and accurate submission of claims to the program. Prompt health care providers, namely, hospitals, clinics, contractors, or other organizations which are engaged in paying for services furnished to the individual, are liable under 42 CFR 411.411(a) if they fail to respond, acknowledge, or pay within 45 days of receipt of the information or timely file a claim to the program. In addition, providers of TRICARE health care services are responsible for timely and accurate submission of claims to the program. Payment of claims is based upon the charge determined in the Medicare carrier or TRICARE provider's bill less than the amount submitted. TRICARE is not a health plan; it pays for medical treatment benefits provided through civilian medical facilities and the Uniformed Services. Information on the patient's care should be provided in those areas explained in "Insured," items 1, 4, 7, 9 and 11.

P.L. 101-123 AND HCA 010 HCS

The provider agrees to accept the amount paid by the Government as payment in full for Black Lung and PICA insurance regarding required procedure and diagnosis coding systems.

DISPARATE PAYMENT OF PHYSICIAN OR SUPPLIER (BENEFICIARY, TRICARE, PICA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I hereby state: 1) I am informed on this form I am true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have submitted or will provide sufficient information required to allow the government to make an informed equitable payment of my claim; 4) This claim is neither submitted by me or on my behalf by my deceased, bona fide, company, or company with all applicable Medicare and/or Medicaid laws, regulations, and programs or entities for physician rendering but not limited to the Patient and Family Health Physician Self-Referral Act (commonly known as Black Lung); 5) The services on this form are medically necessary and otherwise furnished to my professional service by my employee under my direct supervision except as otherwise expressly provided by Medicare or TRICARE; 6) In such cases rendered under my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering such services is recorded in the original record. For variations in my professional service, 7) physician, 8) they must be endorsed only by the physician's direct supervisor by his/her employee, 9) they must be an integral part of a physician's professional services; 10) they must be paid by funds commonly furnished by my employees; and 11) no services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I, or any employee who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government, either civilian or military (prior to 5 USC 6536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and DOD to use you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 1805(a), 1802, 1812 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(b) (6), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 801 et seq, and 38 USC 901 et seq; 33 USC 613; E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to check if the services and supplies you received are covered by these programs and to make sure that proper payment is made.

The information may also be given to other providers of services, insurance, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of these programs and to regulate other third parties prior to payment to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in authorizations of disclosure.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0601, titled, "Gamer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept. 12, 1990, or as updated and republished.

FOR OIGCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See E&A-5, E&A-6, E&A-12, E&A-13, E&A-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(R): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-455 (the Computer Matching and Privacy Protection Act of 1988) permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep my records in accordance with the requirements of the services provided to individuals under the State's Title XIX plan and to furnish information regarding any payment claimed for providing such services to the State Agency or Dept. of Health and Human Services upon request.

I further agree to submit an amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of additional deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURES OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were personally indicated and necessary to the health of this patient and were personally furnished by me or my employee(s) under my personal direction.

NOTICE: The fact that the foregoing information is false, inaccurate and incomplete, I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 the information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information on collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA-Fixups/Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21244-1850. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 9/12/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client(s) H.A @ base of skull. Feeling stiff & cooler rather today. No A-type today. ~~Continues to get temporary relief - J.M.T.~~

Action(s) Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice/Heat

Therapist:

Danielle Harrell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Jessie Harrell Date: 9/16/16

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client(s) H.A today. Had Trif injections yesterday. Continues to get temporary relief - J.M.T.

Action(s) Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

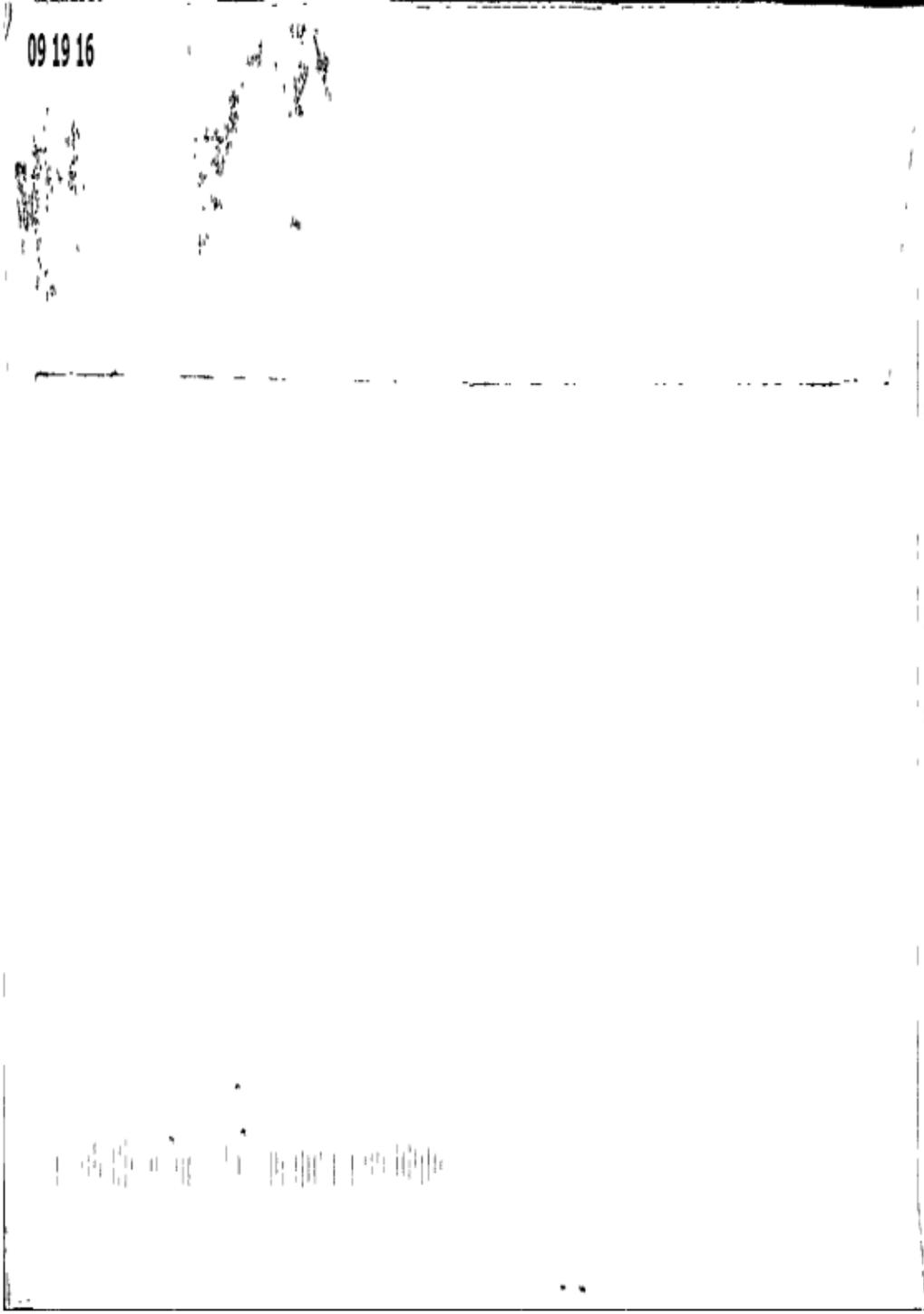
Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice/Heat

Therapist:

Jessie Harrell

091916



09 19 16

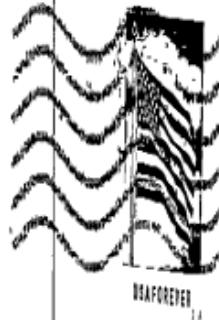
Great Lakes Therapeutic Massage

Colleen Marx, LMT

375 Dick Road, Suite #2
Buffalo, NY 14203

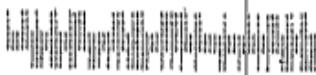
BUFFALO NY 142

16 SEP 2016 PM 11



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-952607





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

四〇九

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FICA BOILING (W-4)	OTHER (W-4)	1a INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)
(Medicare)	(Medicaid)	(DOD/DoD)	(Veteran/DoD)	MM DD YY	SEX M	<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE							3 PATIENT'S BIRTH DATE 08291980	
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE							6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
CITY CHEEKERTOWAGA		STATE NY		8 RESERVED FOR NUCC USE		CITY AMHERST		STATE NY
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10 IS PATIENT'S CONDITION RELATED TO: a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
							b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY	
							c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d INSURANCE PLAN NAME OR PROGRAM NAME							16d CLAIM CODES (Designated by NUCC)	
							11 INSURED'S POLICY GROUP OR FICA NUMBER 08291980	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							12 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below	
							13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below	
SIGNED SIGNATURE ON FILE							SIGNED SIGNATURE ON FILE	
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 QMUL 431							15 OTHER DATE MM DD YY MM DD YY 0000 454 111215	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____							16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
18 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E) ICD-9-CM A M50.22 B M51.26 C M51.27 D M54.12 E I23.3XXA F M99.01 G M99.03 H M99.02 I M99.05 J M54.2 K M54.5 L M54.6							18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY AMEDS B. SERVICE CODES BMS CPT/HCPCS C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Usual Circumstances) D. MODIFIER							20 OUTSIDE LAB? NO 5 CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
09062016 09062016 11 98941 ABCD 32 28 1 NPI 1710014188							22 DISBURSEMENT CODE ORIGINAL RIB NO.	
09062016 09062016 11 97010 ABCD 10 53 1 NPI 1710014188								
09092016 09092016 11 98941 ABCD 32 28 1 NPI 1710014188								
09092016 09092016 11 97010 ABCD 10 53 1 NPI 1710014188								
09152016 09152016 11 98941 ABCD 32 28 1 NPI 1710014188								
09152016 09152016 11 97010 ABCD 10 53 1 NPI 1710014188								
25 FEDERAL TAX ID NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO. 364500165 <input checked="" type="checkbox"/> 3438Z1230 27 ACCEPT ASSIGNMENT? (For gen. dental, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							28 TOTAL CHARGE \$ 128 43 29 AMOUNT PAID \$ 1 30 Reward for NUCC Use	
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to the bill and amounts in part thereof. PETER GOZINSKI DC							32 SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849	
							33 BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849	
SIGNED 09202016 DATE							3435256546 ^b	

Encounter dated 09/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/20/2016

MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

09 26 16



Item# 43568
Polaris Padding





~~INSURANCE~~
CHICAGO
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
September 20, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday September 6, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain has been more sore. Ice helps. Headaches have been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches have been better the last 2 days. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting; level: 4/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity

Encounter dated 09/06/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 09/20/2016

musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate to severe. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving, less headaches. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at L4-L5 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: improving, active lumbar rotation now WNL and without pain. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy

Encounter dated 09/06/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/20/2016

and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 5 weeks; Re-examination for 5 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Friday September 9, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. since last visit.

Encounter dated 09/09/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 09/20/2016

Pain: achy, dull, tingling, shooting, numb; level: 4/10. *Pain is frequent. Pain radiates to:* left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** left upper extremity. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that her headaches have been better the last 2 days. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Thoracic: Patient stated that her left shoulder blade remains sore. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, shooting; level: 4/10. *Pain is occasional.* **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She stated PT started lumbar decompression again which was tolerable at this time. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** left foot. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** None. **Changes in past medical history:** None.

Objective

Cervical: **Range of motion:** flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. **Posture:** forward head carriage; rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. **Heel to toe walking:** WNL. **Gait pattern:** normal. **Strength:** all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right

**Encounter dated 09/09/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/20/2016**

mild to moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised

Encounter dated 09/09/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/20/2016

patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Thursday September 15, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that she had injections on her neck Tuesday at DENT. She stated that initially she was really sore but better today. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, tingling, shooting, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches have been "ok." "I am still getting them 2-3 x a week but they have not been as intense". *Recent medical treatment for this condition:* DENT. *Changes in past medical history:* None.

Thoracic: Patient stated that her left shoulder blade remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting, numb; level: 4/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been better than a few weeks ago. Patient seeing Dr. Siddique on September 28, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing.

Encounter dated 09/15/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 09/20/2016

Numbness: left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Shepplemans: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate to severe. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

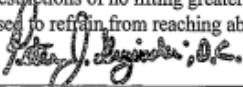
Encounter dated 09/15/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/20/2016

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.


Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA

PIRA

1 MEDICARE (Medicare)	2 MEDICAID (Medicaid)	3 TRICARE (DOD/DIA)	4 CHAMPAVA (Member ID#)	5 GROUP HEALTH PLAN (GHP) <input type="checkbox"/> (DOD)	6 FECA BUKUNG (FBI) <input checked="" type="checkbox"/> (DOD)	7 OTHER <input type="checkbox"/>	8 INSURED'S ID NUMBER 013873940-0101-059 (For Program or Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARMELL, DANIELLE			3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -
5. PATIENT'S ADDRESS (No., Street) 56 BEREAVEN DR			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)	
CITY AMHERST	STATE NY	8. RESERVED FOR NUCC USE <input checked="" type="checkbox"/>			CITY	STATE	
ZIP CODE 14226	TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE	TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER	
			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <u>DEP</u>			a. INSURED'S DATE OF BIRTH MM DD YY N <input type="checkbox"/> F <input checked="" type="checkbox"/>	
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME			104. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ON DATE

DATE 01-06-2016

SIGNED ON DATE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY) 10 31 2015	15. OTHER DATE QUAL	16. OTHER DATE QUAL	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA	18. OTHER DATE QUAL	19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB?	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below [24E]) A. <u>X</u> H79.1 B. <u> </u> C. <u> </u> D. <u> </u> E. <u> </u> F. <u> </u> G. <u> </u> H. <u> </u> I. <u> </u> J. <u> </u> K. <u> </u> L. <u> </u>	22. REDMISSION CODE	23. PRIOR AUTHORIZATION NUMBER	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PROCEUDURES, SERVICES, OR SUPPLIES E/MG C. CPT/HCPCS D. EXPLAN UNUSUAL CIRCUMSTANCES E. MODIFIER F. S CHARGES G. DRG OR UNITS H. DRG R/H I. ID J. RENDERING PROVIDER ID #
1 09 15 16 00 18 16 11	97140	h	55 1.00 3	NPI	1144462011					
2 09 22 16 03 22 16 11	97140	l	55 1.00 3	NPI	1144462011					
3 				NPI						
4 				NPI						
5 				NPI						
6 				NPI						
25. FEDERAL TAX ID NUMBER 47-0929449	26. SSN EIN <input type="checkbox"/>	27. PATIENT'S ACCOUNT NO HARWELL, D	28. ACCEPT ASSIGNMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	29. TOTAL CHARGE \$ 110 1.00 8	30. AMOUNT PAID 0 00	31. REV'd for NUCC Use 110 1.00				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMFT SIGNED DATE 09-23-2016	32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043	33. BILLING PROVIDER INFO & PH# (716) 725-0264 GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043
3 	3 	3
4 	4 	4
5 	5 	5
6 	6 	6

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO CONTINUATION PROGRAM ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authority released of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information and whether the person has employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services for which the claim is being made. See 42 CFR § 411.16(a). If item 9 is not checked, the patient's signature authorizes release of the information to the health plan or agency claim in Medicare assigned or TRICARE preferred rates; the "item 9" box does not affect the amount charged by the physician. Medicare rates are the amounts paid by Medicare for hospital care, physician services and supplies. TRICARE rates are the amounts paid by the Department of Defense for health services rendered to eligible beneficiaries. TRICARE rates are determined by the Department of Defense and the Department of Defense should be used in third party claims. Item 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 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Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0824

Fax: (716) 725-0865

Client Name: Danielle Howell Date: 9/19/16

Client Status: (Check) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: "No better, no worse" Sxs remain unchanged

Restrictions continue in proximal portion of glide

May also palpitate mm. tender along

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Somb/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretch Can't Meds Ice/Heat

Therapist:

Danielle Howell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0824

Fax: (716) 725-0865

Client Name: Danielle Howell Date: 9/21/16

Client Status: (Check) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client Repets ↓ in esp + radicular sxs2nd traction @ P.T. yesterday, No ↓ neck discomfortSlightly more tender on new today.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Somb/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

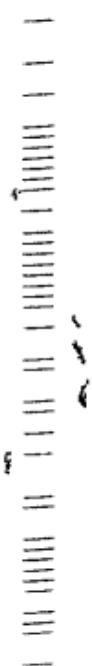
Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice/Heat

Therapist:

Danielle Howell

09 26 16

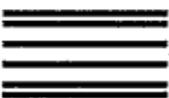


09 26 16

Great Lakes Therapeutic Massage

Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14203

DRF440
NY 14203
23 SEP '16
FM 64



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FREDERICKSBURG VA 22403-9527





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

013873940010159

PICA

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA <input type="checkbox"/> OTHER <input type="checkbox"/> 1a INSURED'S I.D. NUMBER <input type="checkbox"/> (For Program In Item 1)																						
(Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FICA) <input type="checkbox"/> (Other) <input type="checkbox"/> 013873940010159																						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle						3. PATIENT'S BIRTH DATE <input type="checkbox"/> MM DD YY <input type="checkbox"/> 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X																
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle						5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive																
6. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive						7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive																
CITY Cheektowaga		STATE NY		8. RESERVED FOR NUCC USE		CITY Cheektowaga		STATE NY		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle												
ZIP CODE 14225		TELEPHONE (Include Area Code) ()				ZIP CODE 14225		TELEPHONE (Include Area Code) ()		10. IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO												
a. OTHER INSURED'S POLICY OR GROUP NUMBER DBD16761000		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FICA NUMBER														
e. RESERVED FOR NUCC USE								a. INSURED'S DATE OF BIRTH MM DD YY <input type="checkbox"/> 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X														
d. INSURANCE PLAN NAME OR PROGRAM NAME		10e. CLAIM COCDES (Designated by NUCC)		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.														
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM																						
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below																						
SIGNED Jennifer McVige MD SIGNATURE ON FILE						DATE																
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY <input type="checkbox"/> QUAL						15. OTHER DATE QUAL MM DD YY																
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jennifer McVige MD						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)						22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.																
A <input type="checkbox"/> R42	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/> ICD 9c 0	E <input type="checkbox"/>	F <input type="checkbox"/>	G <input type="checkbox"/>	H <input type="checkbox"/>	I <input type="checkbox"/>	J <input type="checkbox"/>	K <input type="checkbox"/>	L <input type="checkbox"/>											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY						B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS						C. MODIFIER		D. DIAGNOSIS CODE		E. DIAGNOSIS PONTER		F. CHARGES	G. DAYS OF STAY IN HOSPITAL	H. STAYS PER FAMILY MEMBER	I. L. B. C. U. M. C. U.	J. RENDERING PROVIDER ID # 22 225100000X
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6 -																						
25. FEDERAL TAX I.D. NUMBER 201163729	SSN/BN <input type="checkbox"/> <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO 103558		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No		28. TOTAL CHARGE \$ 138.00		29. AMOUNT PAID \$ 0.00		30. RAdv for NUCC Use a. 1710021001 b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z.												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)						32. SERVICE FACILITY LOCATION INFORMATION Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432																
McPherson, Jacob PT, DPT SIGNED p-09/23/16						33. BILLING PROVIDER INFO & PH# a. 1710021001 b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z.																

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the claim - determination of the Medicare carrier or TRICARE fiscal intermediary as to full charge and the patient is responsible only for the deductible, co-insurance and non-covered costs. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary; this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 8, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-lobbyback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service, by my employees under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, or SSN) of the primary individual rendering such service is reported in the designated section for services to be considered "incident to" a physician's professional services; 7) they must be rendered under circumstances described above by my employee; 8) they must be integral, although incidental part of a covered physician service; 9) they must be of kinds commonly furnished in relation to office; and 10) the service is non-physician must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services was not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government either civilian or military (refer to 5 USC 3636). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 442.32).

NOTICE: Any one who gives false or inaccurate information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment, under Title 18, United States Code.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

This form is authorized by CHS, TRICARE and OMBP to: 1. You for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is under 36 CFR 203(h), 1871, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(b) and 484.5(a)(8), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1080, 41 USC 901 et seq and 30 USC 901 et seq 38 USC 613, E.O. 9397.

This information is not used to contact claimants under these programs to used to identify you and to determine your eligibility. It is also used to decide if the services you received are covered by the programs and to ensure that proper payment is made.

This information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs, that are other third parties paying to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to give this information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE: (LAW) See the notice modifying system No. 09-05-0501, Med, "Medicare Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Oct 12, 1994, as updated and republished.

FOR OMBP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See EBA-6, RSA-6, CBA-12, DVA-11, "CBA-10" as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services received are rendered by law.

DISLOSURE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation concerning title 36, statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a concern pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE PURPOSES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under this program for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claim under this program. Failure to furnish any other information such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records, as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

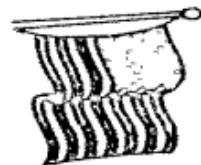
Attest: "I, [Signature], [Title], [Employer], [Address], [City], [State], [Zip] do hereby attest to respond to a collection of information unless I display a valid OMB control number. The valid OMB control number is: 10-000-0000-0000. I understand that our agency information collection is estimated to average 10 minutes per response, including the time to review instructions, research existing data, gather, enter, validate, and/or calculate and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: MRA Report Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21244-0013. This document is for electronic submission only. DO NOT MAIL COMPLETED CLAIMS TO CMS ADDRESS."

10 03 16

10 03 16

Susan Bennett, PT, PC
Bennett Rehabilitation Institute
2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

-CARRIER-

PICA												PICA	
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	GROUP NUMBER	HEALTH PLAN NAME	FECHA DE NACIMIENTO (DD/MM/YY)	OTHER (DNI)	1a. INSURED'S ID NUMBER (For Program in Item 1)					
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TRICARE)	<input type="checkbox"/> (CHAMPVA)					013873940-0101-059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY				4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARNELL, DANIELLE				08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				HARNELL, DANIELLE					
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No. Street)					
56 BERBEEVEN DR				Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE				CITY		STATE			
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X				ZIP CODE		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
10. IS PATIENT'S CONDITION RELATED TO:													
a. OTHER INSURED'S POLICY OR GROUP NUMBER													
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(NYS)</small>													
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
d. INSURANCE PLAN NAME OR PROGRAM NAME													
10d. CLAIM CODES (Designated by NUCC)													
11. INSURED'S POLICY GROUP OR FECA NUMBER													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNED <u>—ON FILE—</u> DATE 03-06-2016													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
31 2015 QUAL													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. <input type="checkbox"/> NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
SYDNEY GRABAU, PA				17b. <input type="checkbox"/> NPI									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Refer to service line below (24E) ICD Ind													
A. <u>L79.1</u> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/>				E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>				22. RESUBMISSION CODE ORIGINAL REF NO					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) PLACE OF EMG CPT/HCPCS MODIFIER				E. DIAGNOSIS PICKER F. \$ CHARGES G. DAYS OR UNITS H. AMOUNT FAMILY RATE I. ID OR DUAL J. RENDERING PROVIDER ID #					
1	09 27	16 09	27 16 11	97140					55	100	3	NPI	1144462011
2	09 30	16 09	30 16 11	97140					55	100	3	NPI	1144462011
3												NPI	
4												NPI	
5												NPI	
6												NPI	
25. FEDERAL TAX ID NUMBER	SSN	BN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE	29. AMOUNT PAID	30. RWD for NUCC Use			
47-0989449	<input type="checkbox"/>	<input checked="" type="checkbox"/>	HARNELL, D					\$ 110.00	\$ 0.00	110.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)													
32. SERVICE FACILITY LOCATION INFORMATION													
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043													
33. BILLING PROVIDER INFO & PH# (716) 725-0264													
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043													
COLLEEN MARK, LMFT 09-30-2016													

SIGNED DATE 11/22/2018

PLEASE PRINT OR TYPE

ALIMENTACIÓN, SALUD, AGUA, CLIMA Y DESARROLLO SUSTENTABLE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a document containing any misrepresentation or any false, incomplete or misleading information may be guilty of a felony and subject to criminal penalties.

REFERS TO SECTION 17(1)(B) OF THE CROWN LANDS ACT

TRICARE, **AMG TRICARE PAYMENT**: A patient's assignment request that payment be made to the provider or authorizes release of any information necessary to process the claim and certifies to us the information contained in Block 1 is true, accurate, and complete. In the case of a Major Life Claim, the patient's signature and dates any other date to release to Medicare or another payor, and Medicare and Medicaid and no other payor may make payment to the provider for medical care services, including hospital insurance, whether or not the patient's assignment request or other insurance claim is submitted by the provider to Medicare or another payor. See 2 CFR 211.23(a). If it is not completed, the patient's signature authorizes release of the information in the Block 1 claim or *Assignment of Benefits* to Medicare or another payor. In Medicaid assignments to TRICARE providers, a physician's request to access the claim's determination of liability under the TRICARE full responsibility as the full charge and the physician's responsibility for the services rendered.

By AGISI LUNG AND FANG CHAIKE

the procedure must be to record the evidence and file the same in case, as provided in law. En-Block Litigation and FTCIA method/An accounting is required procedure and discussions among auditors.

SHAPES OF RAY TRAVERSING SUPPLEMENTAL BOUNDARY, FOG, AND BLACK LUMP

In reviewing the data from your recent dental visit, I easily note 1) the information on the form is all accurate and complete; 2) I have communicated openly with all applicable law enforcement and prosecutorial systems, which is required by law; 3) no records or information is required to allow the enforcement of either a civil or criminal case; and 4) I have no knowledge of any other information or records that may be held by other entities, agencies, or departments of state or federal government that would relate to this individual. I am also on record to say that I do not believe there is any information that would relate to this individual that would be held by me or my firm, or any other entity, or any other government agency or department, as required by Evidence Rule 104(c), that might be relevant to my professional services, that may fit under MCL 330.1, MCL 330.2, or SSBH as primary individual information unless it is explicitly set forth in the information provided to me. For your review, it is my understanding that a physician's professional services, if any, can be paid and/or reimbursed by the physician's employer. It is my belief that this may be a legal although incidental part of a normal physician service, as they must be fully compensated, limited to physician office visits, by the physician's employer.

For TRICARE claim, I further recall that (or our employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government, either civilian or military (to USCG, USMC, USNavy, USAirForce, and USSpaceForce).

No Part B will allow liability to be imposed on the State if it is recovered as required by assessing the same as quadruples (42 CFR 455.30).

NOTICE: Any one who misappropriates or steals such information and/or refuses to return payment from it, shall be liable to a fine of Rs. 10,000/- and imprisonment for a term not exceeding three months.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF GENETIC, PHARMACOGENOMIC AND BEHAVIORAL INFORMATION (PRIVACY ACT STATEMENT)

This information will be used to help determine if you qualify for the program, and to identify you as a customer. It is also used to determine your eligibility. It is also used to decide if the services and supplies you received

The information may be given in relation to services or goods, a contract, other economic, personal, social or cultural aspects, and other circumstances of a personal nature, for the exercise of consumer rights or protection of consumers. It can also relate to other areas, such as health and safety, and measures to enhance these programs. For example, it may be relevant to obtain information about the service you have used to a hospital or doctor. Additionally, it may be relevant to receive information about medical conditions or treatments of a patient.

FOR MEDICARE'S SURGEON See the service modifying system item #970-0801 listed. Office Maxxam Claims Records published in the Federal Register, Inc., 35 FR 177, page 394-395, April 19, 1990 as updated and republished.

OUR POLICY OF PAYMENT IS "INTEREST-ONLY". To ensure liquidity for investors, cash payments can be delayed until the payment upon occurrence of milestones and termination date of the term. Auskin makes no cash advance by us.

REFUND POLICY: Payment for services rendered will result in a refund if payment is made by a third party or if the client cancels their appointment. Payment for services rendered will result in a refund if payment is made by a third party or if the client cancels their appointment. Payment for services rendered will result in a refund if payment is made by a third party or if the client cancels their appointment.

If it is mandatory that you tell us if you know that another party is responsible for paying for your services. Section 1103B of the Social Security Act and 31 URC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 102-583, the "Consolidated Appropriations and Budget Protection Act of 1998," permits the government to withhold information from the Office of Personnel Management.

ENROLLMENT PAYMENTS / PROVIDER CERTIFICATION

I hereby agree to keep such records as are necessary to disclose fully the amount of services provided to individuals under the State's Title XXI plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I hereby promise to accept, as payment in full, the amount paid by the Medicaid program for my claim submitted for payment under that program, with the exception of collection costs, attorney fees or expenses or similar court-allowed charges.

SIGNATURE OF PAYEE (OR CARRIER): I certify that the services listed above were marketed to individuals and/or contrary to the health of the patient and were reasonably foreseeable by my employer for my personal deviation.

NON-ICL-The City to verify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment or omission, may be pursued under applicable Federal and State laws.

According to § 87(a)(2), Park View Acquisition Ltd., as person 1, is required to appear in a civil court of jurisdiction unless it displays a valid OMB control number. The valid OMB control number for this investigation is claim 1420-1107. The time required to complete this information collection is estimated to average 10 minutes per response, including the time for review instructions, gathering relevant data resources, gathering the data needed, and completing and reviewing the information collection. If you have any comments concerning the use(s) or the time estimate(s) for this collection of information, please write to CMS 7370 Service Boulevard, Attn: PRA Report of Survey Officer, Hot Topic C4-96-0, Baltimore, Maryland 212-44-9600. This form is for comment and/or suggestions only. DO NOT MAIL COPY TO THE ADDRESSEE.



DENT
NEUROLOGIC INSTITUTE

Order Form for

Dent Tower 6th Flr

3980 Sheridan Drive, 6th Floor,
Amherst, NY, 142261727
Tel: 716-250-2000 Fax: 716-250-2045

Sydney B Grabau, PA (NPI:1013323740)

Provider Code:

State License No: 017733

Physician Assistant

Patient: Totaro, Drew A

Order Date: 09/30/2016 08:30 AM

DOB: 02/16/2002 **Sex:** Male **Phone:** 716-536-0951

Today: 09/30/2016 09:00 AM

Address: 1131 Cleveland Dr., Cheektowaga , NY, US 14225

Primary Insurance Name:

Insurance Address:

Subscriber Number:

Insured Name: Address:

DIAGNOSTIC IMAGING:

Code	Diagnostic Name	Assessment(s)	Notes	Instructions
	MASSAGE Therapy	M79.1, Myofascial pain		

from office M-A

Electronically Signed By: **Sydney B Grabau, PA**

Signature of Patient/Guardian

Patient: Totaro, Drew A DOB: 02/16/2002

10 03 16

Great Lakes Therapeutic Massage & Bodywork Practitioners

373 Dick Rd Depew, NY 14203

Office: (716) 725-0264

Fax: (716) 725-0265

D.H.

Client Name: Danielle Hanell Date: 9/30/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obligues ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports no sig Disks since last visit. Hypertension remains unchanged

↓ continues to be extremely restricted ↓

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

John May

Great Lakes Therapeutic Massage & Bodywork Practitioners

373 Dick Rd Depew, NY 14203

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Hanell Date: 9/30/16Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 5 8 10 (restricting/continuous pain)

(Check All that Apply)

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 Low Energy Pain Restlessness Restricted Sore
 Rumbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obligues ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client is having severe

Specific: Client is having severe

Felt better in tx today.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

John May

10-03-16

10-03-16
10-03-16

10 03 16

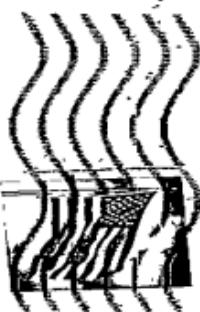
Great Lakes Therapeutic Massage

Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043

• BUFFALO NY 142

30 SEP 2016 PM 2 L

USA FOREVER
25



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-952507

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA SURVIVING (DOL)		OTHER		1a. INSURED'S ID NUMBER		(For Program in Item 1)																			
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (SDIV/DO)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (DOL)		<input type="checkbox"/> (DOL)		<input type="checkbox"/> (DOL)		013873940011059																					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
HARWELL DANIELLE												MM DD YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		HARWELL DANIELLE																			
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED																							
1131 CLEVELAND DRIVE												Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																							
CITY		STATE		ZIP CODE		TELEPHONE (Include Area Code)		8. RESERVED FOR NUCC USE		CITY		STATE		AMHERST		NY																			
CHEEKERTOWAGA		NY		14225		(716) 536 0951				CITY		STATE		AMHERST		NY																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT?																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO NY																							
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT?																							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
d. INSURANCE PLAN NAME OR PROGRAM NAME												10e. CLAIM CODES (Designated by NUCC)																							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												11. INSURED'S POLICY GROUP OR FECA NUMBER																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I subscribe the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												a. INSURED'S DATE OF BIRTH MM DD YY																							
SIGNED SIGNATURE ON FILE												08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>																							
DATE												SIGNATURE ON FILE																							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (EMP) MM DD YY												15. OTHER DATE MM DD YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
103115 QWL 431												454 111215												16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI												17b. NPI												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES											
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refine A-L to service line below (24E)												ICD Inf		0		22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. IM50 22		B. IM51 26		C. IM51 27		D. IM54 12																													
E. IS23 3XXA		F. IM99 01		G. M99 03		H. M99 02		23. PRIOR AUTHORIZATION NUMBER																											
I. IM99 05		J. IM54 2		K. IM54 5		L. IM54 6																													
24. A. DATE(S) OF SERVICE MM DD YY		B. PLACE OF SERVICE ENG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/NICPCB		E. MODIFIER		F. - 8 CHARGES		G. DAYS ON UNITS		H. COST Per Unit		I. ID QWL		J. RENDERING PROVIDER ID #																			
09202016		09202016		11		98941		ABCD		32 28		1		NPI		1710014188																			
09202016		09202016		11		97010		ABCD		10 53		1		NPI		1710014188																			
09262016		09262016		11		98941		ABCD		32 28		1		NPI		1710014188																			
09262016		09262016		11		97010		ABCD		10 53		1		NPI		1710014188																			
25. FEDERAL TAX ID NUMBER		SSN EN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? FOR GOV, CIVILIAN AND DOD <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE		29. AMOUNT PAID		30. Read for NUCC Use																							
364500165		<input type="checkbox"/> X		3438Z1231				\$ 85.62		8																									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and not made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION																							
PETER GOZINSKI DC												CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849																							
SIGNED 10042016 DATE 1235256546 b												33. BILLING PROVIDER NPI & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849																							

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
October 4, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday September 20, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches continue to be 1 to 3 x a week. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, shooting; level: 4/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. Patient seeing Dr. Siddique on September 28, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity

Encounter dated 09/20/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 10/04/2016

musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points*: left levator scapulae, bilateral upper trapezius. *Orthopedic tests*: maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings*: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s)*: C5, C6. *Subluxations detected by*: motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points*: bilateral rhomboids. *Orthopedic tests*: Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s)*: T2, T3, T6, T7, T8, T9. *Subluxations detected by* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion*: flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Heel to toe walking*: WNL. *Gait pattern*: normal. *Strength*: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation*: left SI: moderate. *Trigger points*: left gluteus maximus. *Orthopedic tests*: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s)*: L4, L5, Left SI. *Subluxations detected by*: motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, VAS score improved from a 4 to 3 out of 10. **Prognosis:** Guarded.

Post-treatment analysis: patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated

Encounter dated 09/20/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/04/2016

disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.



Peter J. Guzinski, D.C.

Monday September 26, 2016 Provider: Peter Guzinski DC

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain continues to improve. *Onset:* October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** improving, since last visit. **Pain:** achy, dull, tingling, shooting, numb; level: 2/10. **Pain is frequent.** **Pain radiates to:** left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching;

Encounter dated 09/26/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/04/2016

activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches continue to be 1 to 3 x a week. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back remains sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. Patient seeing Dr. Siddique on September 28, 2016. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; reaching; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain neck and upper back; extension: WNL 60/60 with pain neck and upper back; left rotation: 70/80 with pain neck and upper back; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees for lower back pain; Bechterew: Positive left for left lower

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back pain; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, VAS score improved from a 3 to 2 out of 10. *Prognosis:* Guarded.

Post-treatment analysis: patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

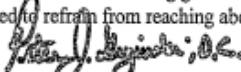
Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest

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exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck 4x day for 15 to 20 minutes per application for 5 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

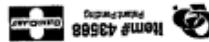


Peter J. Guzinski, D.C.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

10/10/16



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INSTITUTE
CITY OF RICHTER
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

CARRIER

PICA

<input type="checkbox"/> PICA									
1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA	OTHER			
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (Member/ID)	<input type="checkbox"/> (DME)	<input type="checkbox"/> (DMEQ)	<input type="checkbox"/> (DIN)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Harwell, Danielle			MM <input type="text"/> DD <input type="text"/> YY	OB <input type="text"/> 29 1980 N	<input checked="" type="checkbox"/> F <input type="checkbox"/>			Harwell, Danielle	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED						7. INSURED'S ADDRESS (No., Street)
1131 Cleveland Drive			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						1131 Cleveland Drive
CITY <u>Cheektowaga</u>	STATE <u>NY</u>	8. RESERVED FOR NUCC USE						CITY <u>Cheektowaga</u>	STATE <u>NY</u>
ZIP CODE <u>14225</u>	TELEPHONE (Include Area Code) <u>()</u>							ZIP CODE <u>14225</u>	TELEPHONE (Include Area Code) <u>()</u>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
a. OTHER INSURED'S POLICY OR GROUP NUMBER <u>DBD16761Q00</u>									
b. RESERVED FOR NUCC USE									
c. RESERVED FOR NUCC USE									
d. INSURANCE PLAN NAME OR PROGRAM NAME									
10e. CLAIM CODES (Designated by NUCC)									

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Jennifer McVige MD SIGNATURE ON FILE

DATE

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)	15. OTHER DATE (QUAL)	MM	DD	YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM/YY) TO (MM/YY)				
<u>MM</u> <u>DD</u> <u>YY</u>	<u>QUAL</u>				<u>MM</u> <u>DD</u> <u>YY</u> <u>MM</u> <u>DD</u> <u>YY</u>				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <u>Jennifer McVige MD</u>					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM/YY) TO (MM/YY)				
<u>179 NPI</u> <u>1649596495</u>					<u>MM</u> <u>DD</u> <u>YY</u> <u>MM</u> <u>DD</u> <u>YY</u>				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (NPI)) ICD Ind <u>0</u>					22. RESUBMISSION CODE ORIGINAL REF. NO.				
A. <u>R42</u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>
E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>	M. <u> </u>	N. <u> </u>
24. A. DATE(S) OF SERVICE From (MM/YY) To (MM/YY) B. PLAC OF SERVICE ENG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTERS					F. \$ CHARGES G. DAYS H. HRS I. IS CUM J. RENDERING PROVIDER ID #				
1. <u>09 29 16</u>	<u>09 29 16</u>	<u>11</u>	<u>97140</u>	<u> </u>	<u>A</u>	<u>45.00</u>	<u>1</u>	<u> </u>	<u>1205129921-</u>
2. <u>09 29 16</u>	<u>09 29 16</u>	<u>11</u>	<u>97110</u>	<u> </u>	<u>A</u>	<u>45.00</u>	<u>1</u>	<u>NPI</u>	<u>1205129921-</u>
3. <u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u>NPI</u>	<u> </u>
4. <u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u>NPI</u>	<u> </u>
5. <u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u>NPI</u>	<u> </u>
6. <u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u>NPI</u>	<u> </u>
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. REB FOR NUCC USE				
<u>201163729</u>	<u> </u>	<u> </u>	<u>\$ 92.00</u>	<u>\$ 0.00</u>	<u> </u>				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)					32. BILLING PROVIDER INFO & PH# <u>Susan Bennett, PT PC</u> <u>2075 Sheridan Drive Suite D</u> <u>Kenmore NY 142231432</u>				
McPherson, Jacob PT, DPT SIGNED <u>p09/30/18</u>					a. <u>1710021001</u> b.				

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offense punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, infinity, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Block 9 is completed, the patient's signature authorizes release of the information to the health plan or agency whom, if Medicare assigned or TRICARE participation exists, the physician agrees to except the charge determination of the Medicare carrier or TRICARE fiscal intermediary by the "fee charge" and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier or TRICARE fiscal intermediary if the fee less than the charge submitted. TRICARE is not a health insurance program but makes payments for health benefits provided through certain facilities with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned as "Insured"; i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare program; 3) I have provided or will provide sufficient information required in allow the government to make an informed decision and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or have been furnished incident to my professional service by my employee under my direct supervision, except or otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering such service is reported in the designated section; 7) services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 8536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to use your information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 203(d)(1), 1072 and 1074 of the Social Security Act as amended, 42 CFR 411.24(a) and 104.5(a) (5), and 44 USC 3101-31 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 8101 et seq and 38 USC 901 et seq; 38 USC 813, E.O. 13077.

The information we obtain to complete claims and/or these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs, and to insure that proper payment is made.

The information may also be given to other providers of services, or more, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payors to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in system of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Reproduction of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, 808 ESA-5, ESA-6, ESA-12, ESA-13, FSA-3U, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and reimbursement due. See the conditions described in the notice by law.

FOR DOD USHRS: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services under the Dept. of Transportation, and other relevant entities for purposes of, under Title 37 USC 1710(b)(1)(B) to the Dept. of Justice for supervision of the Secretary of Defense in civil actions in the United States, Service, Service, joint, collective, or single, and consumer reporting to others in connection with recoupment claims; and to Defense and Office in relation to its programs - mode or the conduct of this program in accordance with pertinent Appropriate disclosure may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on written, verbal, or electronic media, if one, application, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefit, cost and claims, and administrative action, related to the operation of TRICARE.

DISLOYALTY/FRAUD: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered in the amount charged would prevent payment of claim under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FEDA could be denied upon verification.

It is mandatory that you let us know if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 9801-9812 provides penalties for withholding this information.

You should be aware that P.L. 100-508, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for services furnished such individuals under the State's Agency or Dept. of Health and Human Services may request.

I further agree, if payment in full, the amount paid by the Medicaid program for these claims submitted for payment under that program, will be the exception of all my other deductible, co-insurance, co-payment, and related charges.

ON MATURE OF PHYSICIAN (OR CARRIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employees under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claim, statement, or documents, or commitment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Computer Matching and Privacy Protection Act of 1988, if you or my organization fail to respond to a collection of information unless it displays a valid OMB control number, The valid OMB control number for this collection is 1170-0127. The time limit for calculating this information is estimated to average 10 minutes per response. Including the time to review instructions, gather relevant data, and complete and review the information collection, if you have any comments concerning the accuracy of the time estimate or suggested collection, please write to: OMB, 1209 Pennsylvania Avenue, Washington, DC 20585, Attn: FOIA Report Clearance Officer, Mail Stop G-48-03, Baltimore, Maryland 20585-0048. This is a required document and must be submitted to OMB. DO NOT MAIL COMPLETED FORMS TO THIS ADDRESS.

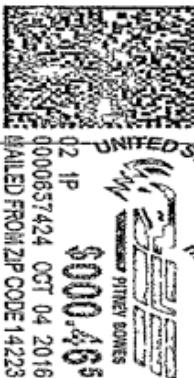
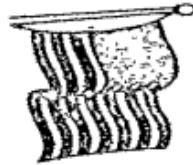
10 10 16

10 10 16

Susan Bennett, PT, PC

2075 Sheridan Drive
Suite D
Kenmore, NY 14223

GEICO
PO BOX 9507
Fredericksburg, VA 22403



Receive Date: 10/11/2016

Front End

Region 2: NY PIP MAIL**Indexing Category:**

- | | | | |
|--------------------------|-----------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | NY FPM Bills | <input type="checkbox"/> | Unreadable Original |
| <input type="checkbox"/> | PIP SHQ | <input type="checkbox"/> | Notary Seal |
| <input type="checkbox"/> | NY FPM PSR Provider Letters | <input type="checkbox"/> | Box Work |
| <input type="checkbox"/> | NY FPM PL Peer Response | <input type="checkbox"/> | No Date Sheet
Needed |



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARRIER ↑

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any故意的、虚假的、不完整的或误导性的信息可能因犯有刑事罪而受到法律制裁并可能被处以刑事处罚。

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information and whether the person has employer group health insurance. Individual, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(p). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE preferred option, the physician agrees to accept the charge determined by the Medicare carrier or TRICARE local rate "as is" as the full charge and the patient is responsible only for the resulting co-payment and co-insurance. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program; it makes payment for health benefits provided through certain affiliations with the Department of Defense. Information on the patient's sponsor should be provided in those items contained in Item 1, e.g., Items 4, 6, 7, 8, and 11.

BLOCK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Block Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions which are available from the HealthCare Connection; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, if other submitted by me or on my behalf by my designated holding company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment, including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this claim were medically necessary and personally furnished to my patient/service by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for cash service rendered incident to my professional service, the identity (legal name and NPI, license #, or SBN) of the primary individual rendering cash service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incident to, a covered physician service, 3) they must be of goods commonly furnished in physician's office, and 4) the services of non-physicians must be included in the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 8330). For Block-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and CMCW to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(g), 1612, 1612 and 1674 of the Social Security Act as amended, 42 CFR 411.24(p) and 42 CFR 40 (b), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 one 1086; 5 USC 8.01 et seq; and 30 USC 601 et seq; 30 USC 613; E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 98-70-0001, titled, "Covered Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37549, Wed. Sept. 16, 1998, or as updated and republished.

FOR CMCW CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb. 28, 1990. See ESA-5, FSA-8, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/benefits received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompense claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, or matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, contribution of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-863, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer match.

NON-CASH PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the amount of services provided to individuals under the State's TDS-XDX plan and to furnish information regarding any payment claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full the amount paid by the TDS-XDX program for those claims submitted for payment under that program, with the exception of authorized deductible, copayments, co-payment or similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUMMUR): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: The is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0388-197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Repairs Clearance Officer, Mail Stop C-28-06, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0824

Fax: (716) 725-0365

Client Name: Danielle Hanwell Date: 10/3/16

Client Status: Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 **8** 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area's of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) GL
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client/pt restriction in cervical + lumbar

Spine, % numbness in @LE's, No in hypotony, laxton. Still has ITA's & numbness in @BS's.

Musculoskeletal restriction in c-spine, thorax, lumbar, pt restriction in c-spine, thorax

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist:

Dan Hanwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0824

Fax: (716) 725-0365

Client Name: Danielle Hanwell Date: 10/4/16

Client Status: Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 **5** 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area's of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) GL
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client reports feeling a little better last

dayton. Still has ITA's & numbness in @BS's.

Continuous to be hypotonicity, null/pain, musculature.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist:

Dan Hanwell

10 11 16

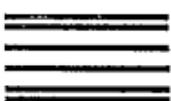
卷之三

10 11 16

Great Lakes Therapeutic Massage

Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043

GRUFFALO
NY 140
OCT '96
PERFECT
PERFECT



BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO.1010 WASHINGTON DC

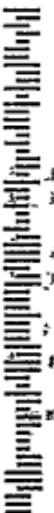
POSTAGE WILL BE PAID BY ADDRESSEE

GEICO

NY PIP

PO BOX 9507

FREDERICKSBURG VA 22403-9527



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507

Fredericksburg VA 22403

CARRIER

<input type="checkbox"/> PICA 1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FEDERAL (Medicare) (Medicaid) (DOD/DOD) (Member ID#) (Name) (Name) 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX MM DD YY 08 29 1980 M <input checked="" type="checkbox"/> Harwell, Danielle 5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive CITY STATE ZIP CODE TELEPHONE (Include Area Code) Cheektowaga NY 14225 ()												6a. INSURED'S ID. NUMBER (For Program in Item 1) 013873940010159 610 059 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive CITY STATE ZIP CODE TELEPHONE (Include Area Code) Cheektowaga NY 14225 ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle a. OTHER INSURED'S POLICY OR GROUP NUMBER DBD16261000 b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. INSURANCE PLAN NAME OR PROGRAM NAME			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												11. INSURED'S POLICY GROUP OR FEDA NUMBER 12. INSURED'S DATE OF BIRTH SEX MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME			
SIGNED _____ SIGNATURE ON FILE _____ DATE _____												SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL: _____												15. OTHER DATE (MM DD YY) QUAL: _____			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jennifer McVige MD												18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service lines below (24E)) ICD Ind: 0												22. RESUBMISSION CODE ORIGINAL REF NO A. R42 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____			
24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACES OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I E. MODIFIER												F. G. H. I. J. 5. CHARGES 6. DRG OR UNITS 7. DRG/PAY PER UNITS 8. ID 9. RENDERING PROVIDER ID # ZZ 225100000X 10 10 16 10 10 16 11 97140 A 46.00 1 NPI 1205129921 ZZ 225100000X 10 10 16 10 10 16 11 97110 A 46.00 1 NPI 1205129921 NPI NPI NPI NPI NPI			
25. FEDERAL TAX ID NUMBER SSN SSN 26. PATIENT'S ACCOUNT NO. 27. ASSIGN ASSIGNMENT 201163723 <input type="checkbox"/> X 103558 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE 29. AMOUNT PAID 30. Reserved for NUCC Use \$ 92.00 \$ 0.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)												32. SERVICE FACILITY LOCATION INFORMATION Susan Bennett, PT PC 2075 Sheridan Drive Suite D Kenmore NY 142231432			
McPherson, Jacob PT, DPT SIGNED 8/14/16												33. BILLING PROVIDER INFO & PH# (716 8038220 1710021001 P			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entry to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, auto, life, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a). If item 10 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health care provided through certain entities with the Uniformed Services. Information on the patient's sponsor should be provided in items 10a, items numbered 1-7, items 16, 4, 6, 7, 9 and 11.

BLACK LUNG AND PECOA CL-111B

The provider agrees to accept the amount paid by the Government as payment in full. See DRG Long and PECOA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, PECOA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided all information requested to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or my entity, is my designated billing company, employee and all applicable Medicare and/or Black Lung regulations, requirements, and program instructions for payment including but not limited to the Federal and State laws, Executive Orders, and regulations; 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional services, by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for such service rendered incident to my physician's services, the validity (legal name and NPI) license #, or SSN of the primary individual rendering each service is reported in the designated section. For services to be rendered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's services, 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's billings.

For TRICARE claims, I further certify that I (or any employee) who rendered services can not be an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 10 USC 50-56). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless the form is received as required by coding, law and regulations (42 CFR 430.37).

NOTICE: Any one who misrepresents or furnishes false or inaccurate information to Medicare, Medicaid, or the VA may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PECOA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by GHS, TRICARE and OWCP to collect for information provided in the administration of the Medicare, TRICARE, PECOA, and Black Lung programs. Authority to collect information is in section 206(a), 1862, 1872 and 1874 of the Social Security Act as amended; 42 CFR 411.2(f)(1) and 42 CFR 414.56; 46 CFR 101.101 et seq. and 10 USC 1079 and 1086, 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 813; E.O. 13677.

The information we obtain to complete claims under these programs is used to identify you, and determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties pay to a primary care physician... and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine use of information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 03-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Repopulation of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See EBA-5, EBA-6, EBA-12, EBA-13, EBA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPAL PURPOSE(S): To evaluate liability for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs; the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; in the Dept. of Justice in representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with nonpayment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged could prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under PECOA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3810-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State Agency or Dept. of Health and Human Services as my agent.

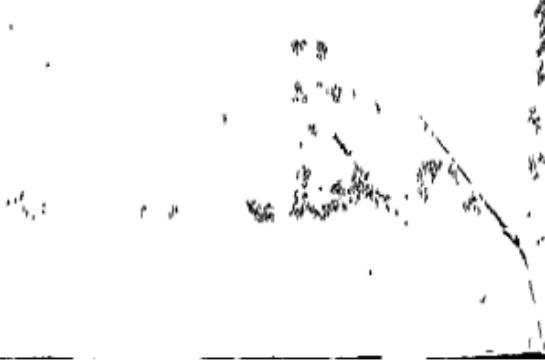
I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be punishable under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-00, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

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22403-952607

22403-952607

Fredericksburg, VA 22403
PO BOX 9607
GEICO



BUFFALO
NY 1420
Bennett Rehabilitation Institute

Susan Bennett, PT, PC
2075 Sheehan Drive
Suite D
Kennebunk, NY 14223

Sheehan

Drive

Kennebunk

NY 14223

United States



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

01381394 0010 1051												PICA					
1 MEDICARE MEXICAO TRICARE CHAMPVA GROUP HEALTH PLAN PEGA EXCELLING OTHER <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Mexicavo) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (PVA) <input type="checkbox"/> (PEGA EXCELLING) <input type="checkbox"/> (Other)													1a INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE						3 PATIENT'S BIRTH DATE MM DD YY 08221980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE						
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE						6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT								
CITY CHEEKERTOWAGA		STATE NY		8 RESERVED FOR NUCC USE				CITY AMHERST		STATE NY							
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10 IS PATIENT'S CONDITION RELATED TO: a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME											
						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) NY c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
						10d CLAIM CODES (Designated by NUCC) READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
11 SIGNED SIGNATURE ON FILE						12 DATE											
13 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 103115						14 OTHER DATE MM DD YY 111215											
15 NAME OF REFERRING PROVIDER OR OTHER SOURCE QUAL 431						16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17a											
17 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 17b NPI											
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-L to service line below (24E)						19 OUTSIDE LAB? 20 CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
A M50.22 B I51.26 C I51.27 D M54.12 E I82.3 XXXA F I99.01 G I99.03 H I99.02 I I99.05 J I54.2 K I54.5 L I54.6						21. RESUBMISSION CODE 22. ORIGINAL REF NO.											
24 A. DATES(B) OF SERVICE From MM DD YY To MM DD YY 10072016						B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER 99212						E. DIAGNOSIS ICD IND 0 F. CHARGES 20 29 1 ABCD					
G. DAYS OR UNITS H. GROSS FEE PER UNIT I. ID # J. RENDERING PROVIDER ID # NPI 1710014188																	
25 FEDERAL TAX ID NUMBER 364500165						26 PATIENT'S ACCOUNT NO 343821232						27 ACCIDENT/EMERGENCY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
28 SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849						29 TOTAL CHARGE \$ 63.10						30 AMOUNT PAID		31. Reserved for NUCC Use			
32 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to my bill and my name is shown on it.) PETER GOZINSKI DC						33 BILLING PROVIDER INFO & PH # (716) 681-3333											
34 SIGNED 10192016 DATE 1235256546 ^b						35 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849											

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
October 19, 2016

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday October 7, 2016 Provider: Peter Guzinski DC RE-EXAM

Electronically signed on 10/09/2016 at 10:30am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights, she has slight headaches which come frequently, she cannot do her usual work and her normal sleep has been moderately disturbed (1-2 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, sharp, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* left upper extremity. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 2 x a week. She states that the duration varies, sometimes they last all day. Nothing alleviates the pain. Patient also stated that she experiences occasional dizziness with the headaches but she no longer experiences nausea. *Cervical Disability Index:* 30%. *Recent medical treatment for this condition:* Physical therapy; Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement;

Encounter dated 10/07/2016 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 10/19/2016

bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Oswestry score:* 34%. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. Due to the pain, she is unable to lift heavy weights, she is unable to walk greater than 1 mile, she is unable to sit greater than 60 minutes, she is unable to stand greater than 60 minutes and she is unable to travel on journeys greater than 60 minutes. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last re-evaluation on July 29, 2016. *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 3/10. *Pain radiates to:* left posterior thigh and leg. *Exacerbating symptoms:* driving; lifting; sitting; standing; walking; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 34%. *The Keele STarT Back Screening Tool:* Medium risk. *Recent medical treatment for this condition:* Physical therapy. *Changes in past medical history:* None.

Activity of Daily Living Form Bathing/Showering: mild impairment; Bending forward/backward: moderate impairment; Driving: moderate impairment; Drying Hair: mild impairment; Household chores: moderate impairment; Laundry: moderate impairment; Lifting less than 10 lbs: mild to moderate impairment; Lifting more than 10 lbs: moderate impairment; Kneeling: mild impairment; Making Meals: mild impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Restful night's sleep: mild impairment; Seated to standing position: moderate impairment; Sexual activity: moderate impairment; Standing: mild impairment; Squatting: mild impairment; Tying shoes: mild impairment; Using lavatory: mild impairment.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain; right rotation: WNL 80/80 with pain neck and upper back; left lateral bending: 35/45 with pain neck and upper back; right lateral bending: 35/45 with pain neck and upper back. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck mostly to the left; maximum right lateral compression: Positive lower neck mostly to the left; Spinal Percussion C1-C7: Negative; left shoulder depression: Negative; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with pain lower back; extension: 10/25 with pain

**Encounter dated 10/07/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/19/2016**

lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* all lower extremity sensory exams (L1-S1) were WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Reflexes:* bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 50 degrees for lower back pain; Well leg raise: Negative right at 70 degrees; Bechterew: Negative; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for neck and middle back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-evaluation on July 29, 2016 her Neck Disability Index score improved from 42% to 30%. In addition, she is now concentrating and sleeping 1 to 2 hours longer with less pain. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL. *Diagnosis:* M50.22 (Other cervical disc displacement, mid-cervical region), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* improving, patient able to bend with less middle back pain.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last re-evaluation on July 29, 2016. Her VAS score improved from a 7 to 3 out of 10 and her Oswestry Disability Index score improved from 68% to 34%. In addition, she is now able to walk 3/4 of a mile farther and sit for 30 minutes longer with less pain. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to sit, stand, sleep, walk and lift with less pain. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Encounter dated 10/07/2016 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/19/2016

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness. *Treatment schedule:* 1x/week for 8 weeks; Re-examination for 8 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 left (manual traction); L5 left (manual traction); SI right PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); left cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; left upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to November 30, 2016 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

10 31 16

Item# 435568

com
com

10 31 16

Federal Savings & Deposit
Co. Box 9507
Gloucester

Gloucester, NY 14043
345 Dick Rd.



Submitted:
10/12/2016GEICO INSURANCE NY PIP
PO BOX 9507

FREDERICKSBURG, VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

 PICA

PICA

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA		OTHER		1a. INSURED'S ID. NUMBER		(For Program Item 1)											
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> Group Health Plan		<input type="checkbox"/> FECA		<input type="checkbox"/> Other		013873940101059													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
HARRELL, DANIELLE												MM DD YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		HARRELL, DANIELLE											
6. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED															
1131 CLEVELAND DRIVE												Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>															
CITY		STATE		ZIP CODE		TELEPHONE (Include Area Code)		CITY		STATE		ZIP CODE		TELEPHONE (Include Area Code)													
CHEERTOWAGA		NY		14225		()		CHEERTOWAGA		NY		14225		()													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:															
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)															
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? PLACE (State)															
												<input type="checkbox"/> YES <input type="checkbox"/> NO NY															
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT?															
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
d. INSURANCE PLAN NAME OR PROGRAM NAME												10e. CLAIM CODES (Designated by NUCC)															
												11. INSURED'S POLICY GROUP OR FECA NUMBER															
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												a. INSURED'S DATE OF BIRTH SEX															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>															
												b. OTHER CLAIM ID (Designated by NUCC) Y4 013873940101059															
												c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO INSURANCE NY PIP															
13. SIGNATURE ON FILE												14. IS THERE ANOTHER HEALTH BENEFIT PLAN?															
SIGNED _____ DATE 10/12/2016												<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.															
15. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (JMP) MM DD YY												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY															
10 31 15 QUA 431												QUAL 439 10 31 15															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN J PETER GUZINSKI												17a. FROM MM DD YY TO MM DD YY															
17b. NPI 1710014188												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAST \$ CHARGES															
												<input type="checkbox"/> YES <input type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (2NE) ICD IND 0												22. RESUBMISSION CODE ORIGINAL REF. NO.															
A. M54.16		B. M51.26		C. M47.816		D. M48.06																					
E. _____		F. _____		G. _____		H. _____																					
I. _____		J. _____		K. _____		L. _____																					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PLACE OF SERVICE Eng		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. MODIFIER		F. DIAGNOSIS		G. CHARGE		H. PAYMENT		I. ID. NO.		J. RENDERING PROVIDER ID. #	
1 09 28 15 09 28 16 11												99204				ABCD		119 61		1		OB 248830					
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6																								NPI			
26. FEDERAL TAX ID. NUMBER SSN EN												28. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT		28. TOTAL CHARGE		29. AMOUNT PAID		30. Revd for NUCC Use							
030445678 <input type="checkbox"/>												102251		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 119.61		\$ 0.00		=							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and we made a pen thereof.)												32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#		(716) 218-1030											
Jafar Siddiqui												UB Neurosurgery 3980A Sheridan Drive		UB Neurosurgery, Inc		PO Box 8000 Dept 883											
Signed 10/12/2016 DATE												Amherst, NY 14226		Buffalo, NY 14267													
												z 1306896220 p 248830		z 1306896220 p													

September 28, 2016

Peter Guzinski DC
345 Dick Road
Depew, NY 14043

Patient Name:	Danielle Harwell
Date of Birth:	08/29/1980
No-Fault Carrier:	NF Geico
CL#:	0138739400101059
Date of Injury:	10/31/15

Physiatry Evaluation: September 28, 2016

Chief Complaint(s): Low back, buttock and leg pain, left greater than right

Dear Dr. Guzinski:

At your kind request, I had the pleasure of seeing Danielle Harwell in our office for an initial physiatry consultation on September 28, 2016 .

IMPRESSION

36-year-old female with low back and bilateral buttock, hip and leg pain secondary to multi-level degenerative disc disease L3 to S1, multi-level lumbar facet joint arthropathy L3 to S1, disc herniations/protrusions at L4-5 and L5-S1, myofascial pain syndrome, coccydynia, bilateral sacroiliac joint dysfunction, right greater than left, and left ischial tuberosity bursitis.

The patient's symptoms are causally related to an injury sustained in a motor vehicle accident on 10/31/15.

Assessment: M54.16 - Radiculopathy, lumbar region, M51.26 - Other intervertebral disc displacement, lumbar region, M47.816 - Spondylosis without myelopathy or radiculopathy, lumbar region, M48.06 - Spinal stenosis, lumbar region

HISTORY/CHIEF COMPLAINT

Patient is a pleasant 36-year-old female who presents to the office today for a scheduled initial consultation secondary to complaints of low back, buttock, hip and leg pain, left greater than right. The patient subjectively states that she was involved in a motor vehicle accident on 10/31/15. The patient states that she was sitting in a stopped car when she was rear ended by the three cars behind her. The fourth car rear ended the third car and in a domino effect, the patient's car was also hit. She started complaining of neck and low back pain immediately. She

did have a seat belt on. She did not lose any consciousness nor were any airbags deployed. She also had pain in the left arm. She now complains of low back pain that radiates into her bilateral buttocks and hips, left greater than right, and shoots posteriorly down her lower extremities to the bottom of her feet. She is currently undergoing formal courses of physical therapy and chiropractic treatments, which have helped immensely. She continues to have persistent pain. She does undergo regular trigger point injections at the Dent Neurologic center. She states that coughing, standing, lifting and walking worsens her pain and that lying down straight on her back with knees elevated improves it. She is not using any pain medications for pain relief at this time. She currently rates her pain score a 4/10 on the visual analog scale. She is desiring intervention for pain relief. She has no other complaints at this time.

RECOMMENDATIONS

1. At this time, we recommend the patient undergo a caudal epidural steroid injection.
2. We may consider bilateral L3 to S1 facet joint injections versus lumbar transforaminal epidural steroid injections.
3. The risks, benefits, alternatives and side effects were discussed with the patient regarding this procedure to include but not limited to infection, bleeding, paralysis, increase in pain and nerve damage. The patient would like to proceed with the caudal epidural steroid injection. We will request authorization from the patient's insurance provided if needed. Otherwise, we will schedule the patient accordingly. The patient was also instructed to hold off from any aspirin, aspirin containing products, and non-selective, nonsteroidal anti-inflammatory medications such as Advil, Aleve, Ibuprofen, Motrin, Naprosyn for 5-7 days prior to the procedure.
4. She will continue with her formal course of chiropractic care with Dr. Guzinski as well as with physical therapy.
5. She will continue to maintain her current level of activity.
6. We will see the patient back for a followup evaluation after her procedure.

PAST MEDICAL HISTORY

Asthma

PAST SURGICAL HISTORY

Tonsillectomy and adenoidectomy, D & C, endoscopy and colonoscopy

ALLERGIES

Keflex, Codeine, Soma, Biaxin, Clindamycin, Penicillin, Cipro, Ranitidine

MEDICATIONS

Voltaren, Pantoprazole Sodium, Vitamin D3, Magnesium Oxide, Loratadine

FAMILY HISTORY

Diabetes, stroke and heart disease

SOCIAL HISTORY

Patient is currently married. She has never smoked cigarettes and does not drink alcohol. She denies illicit drug use.

REVIEW OF SYSTEMS

A comprehensive review of systems was conducted including questioning on cardiovascular, respiratory, integumentary, psychiatric, genitourinary, gastrointestinal, neurologic, musculoskeletal, lymphatics and constitutional symptoms. Please refer to the history of present illness for any pertinent

positives and negatives. Please refer to the chart.

PHYSICAL EXAMINATION

BP: 113/77 Pulse: 87 Resp: 16 Ht: 63" Wt: 160lb BMI: 28.3

General: Patient is sitting comfortably in no acute distress. She is awake, alert and oriented x3. She is a pleasant female.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are pink and moist. Her speech is fluent, articulate, intelligible and coherent. She is wearing eyeglasses at this time.

Cardiovascular: Normal S1, S2.

Abdomen: Soft, non-distended, nontender.

Skin: Intact. Normal skin turgor. No clubbing, cyanosis or edema.

Lymphatics: No cervical lymphadenopathy.

Neuromusculoskeletal: Patient ambulates with a normal gait and station. She does not have any difficulty rising from a seated to a standing position. She has limited range of motion at the lumbar spine in all planes for forward flexion, extension, lateral rotation and side bending bilaterally. She is able to forward flex 85° and extend up to 5°. She has components of extension based back pain. She has tenderness to palpation of the lumbar paraspinal region as well as the coccyx. She has tenderness at the bilateral sacroiliac joints, right greater than left. She has tenderness to palpation at the left ischial tuberosity and none on the right. She does not have any greater trochanteric tenderness to palpation. She has good 5/5 musculoskeletal strength throughout all myotomes of her bilateral lower extremities. Her sensation is intact to light touch throughout all dermatomes of her bilateral lower extremities. She has normal muscle tone throughout without any spasticity or rigidity. She has 1+ reflex at the bilateral patella, symmetric and intact. She has negative Flipp test bilaterally. She has negative seated and supine straight leg raise test bilaterally. She has positive Patrick's test bilaterally which reproduces her left sided low back pain.

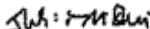
Psychiatric: Judgement and cognition appear to be within normal limits.

REVIEW OF DIAGNOSTIC STUDIES

MRI examination of the lumbar spine from Buffalo MRI on January 4, 2016 reveals disc desiccation at L3-4, L4-5 and L5-S1. There is facet arthropathy and annular bulging at L3-4. At L4-5, there is a central disc protrusion/herniation with annular tear. There is mild central canal stenosis. There is bilateral facet arthropathy and mild neural foraminal narrowing. At L5-S1, there are hypertrophic facet changes. There is a central to left paracentral disc protrusion/herniation with an annular tear at this level as well.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

Sincerely,



Electronically signed by Jafar Siddiqui, M.D. on 11/01/2016 at 11:08 pm

Jafar W. Siddiqui, M.D.

JS/pmm

CC: James Panzarella DO

Carrier Manifest

GEICO INSURANCE NY PIP

PO BOX 9507

FREDERICKSBURG, VA 224039526

Total Claims: 24**Claims per Organization:**

BUFFALO ORTHOPAEDIC GROUP, LLP : 2

Moochler Physical Therapy, PC : 1

UB Neurosurgery, Inc : 19

WESTMED Practice Partners : 2

Notice: Please do not mail correspondence to IHCFCA. All correspondence should be directed to the provider listed on each claim form. The contents of this package are confidential, and intended for the addressee only. This may contain information that is privileged or exempt from disclosure under applicable law, including the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient(s), you are notified that the dissemination, distribution, or copying of this package and/or its contents is strictly prohibited. If you receive this package in error or are not the named recipient(s), please notify IHCFCA at PO Box 2016, Morristown, NJ 07962; 973-795-1641 ext 400. Thank you. ** DATE GENERATED: 11/18/2016 **

Organization Manifest

UB Neurosurgery, Inc(19)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
00673453801011462		LEVIN, SCOTT	09/28/2016	09/28/2016
03047695501011851		MANUEL, TAMICA	09/27/2016	09/27/2016
03808139301010151		PALADINO, ANNMARIE	09/28/2016	09/28/2016
01387394001010591		HARWELL, DANIELLE	09/28/2016	09/28/2016
03874813501010722		KAUFMANN, AMANDA	09/30/2016	09/30/2016
01730813901010541		BROOKS, CATHERINE	10/03/2016	10/03/2016
03874813501010722		KAUFMANN, AMANDA	10/03/2016	10/03/2016
03047695501011851		MANUEL, TAMICA	10/04/2016	10/04/2016
04963414601010241		CARR, CANDICE	10/04/2016	10/04/2016
529G11451 2		THAUER, ASHLEY	10/04/2016	10/04/2016
03023415201010831		JAFARI, AMY	10/03/2016	10/03/2016
03874813501010722		KAUFMANN, AMANDA	10/05/2016	10/05/2016
05006310001010291		FLEMING, PAULINE	10/05/2016	10/05/2016
529G11451 1		THAUER, ASHLEY	10/06/2016	10/06/2016
04824188301010602		MORRIS-MALLON, CHARLOTTE	10/07/2016	10/07/2016
03957638901010132		KANE, KARA	10/05/2016	10/05/2016
03047695501011851		MANUEL, TAMICA	10/06/2016	10/06/2016
02757240701011031		LUCCA, BRYAN	10/06/2016	10/06/2016
03957638901010132		KANE, KARA	10/10/2016	10/10/2016

Carrier Manifest

Geico
P O BOX 9507
Fredericksburg, VA 22403-9526

Total Claims: 240 Claims per Organization:

Brain and Spine Center : 14
BUFFALO NEUROSURGERY GROUP : 2
BUFFALO ORTHOPAEDIC GROUP, LLP : 1
Buffalo Spine and Sports Institute : 1
CareMount Medical, P.C. : 16
CLINICAL PRACTICE MANAGEMENT PLAN : 64
Comprehensive Orthopedic and Spine Care : 12
Crouse Medical Practice, PLLC : 1
DRCHRONO : 1
Empower Doctors llc : 5
Empowerdr : 62
FLH Medical, PC : 2
General Diagnostic Associates : 2
Hamilton Orthopaedics and Sports Medicine : 1
John V Murphy Physical Therapy, PC : 1
Medical Pain Management Services, PLLC : 2
MONMOUTH MEDICAL IMAGING P.A. : 1
ORANGE RADIOLOGY AND MRI OF MONROE : 1
RAMAPO DIAGNOSTIC IMAGING : 5
Ramapo Imaging Assoc PC : 2

Carriers Grouped Together

Carrier Address	Pages	Carrier Address	Pages
4197 Geico P O BOX 9507 Fredericksburg, VA 22403-9526	1121	14633 GEICO INSURANCE NY PIP PO BOX 9507 FREDERICKSBURG, VA 224039526	101
14814 GEICO PO BOX 9507 FREDERICKSBURG, VA 224039998	85		

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Carrier - Leave If No Response B006	
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USPS TRACKING #	
3465-5026-9020-0429-9843-81	
Electronic Rate Approved #E3555TH0	

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ONLINE



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 2012

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PATIENT AND INSURED INFORMATION

HATFIELD ET AL.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.
NOTICE: Any person who knowingly files or causes to be filed a false claim containing any misrepresentation or any untrue statement or misleading information, is liable to a civil fine of \$10,000 per claim, or twice the amount of the false claim, whichever is greater, and/or a criminal penalty.

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EJ 2011 LOMO AND FAGE IN CPM

This paper for research purposes only and is used by the copyright owner in accordance with the terms of the ECA at section 14(2)(b), except as required in section 14(2)(d) or section 14(2)(e) of the Act.

GOV'T OF CANADA GOVERNMENT OF CANADA / GOUVERNEMENT DU CANADA

Mr. TAYLOR LEE has been re-hired by the City of Milwaukee as a required vendor item for the 2019 GPP. Mr. Lee has

9.179. A party that has applied for arbitration may file a motion to stay arbitration proceedings by the forum or upon condition he subject to the arbitration under application. Reasons shall be:

"HOWIE TO MY FRIEND ALICE AND HER CHILDREN, "THE MUSE OF FIDELITY," - DEAR SISTER, DAD, AND ALL YOU LITTLE

We also use it to complete your legal documents, to help identify you and to determine your identity. We also use it to provide services and supplies you receive. We do not sell or share your personal information with anyone else.

The information may also be given to other members of Congress, congressional committees, medical review panels, health plans, and other components of Federal agencies, for the sole administrative use of FedEx. It may also be given to a member of Congress or a congressional committee to whom any of the above information is necessary to assist their mission (legislative). For example, if a member of Congress has a question about a particular service or product offered by FedEx, he or she may request that information from FedEx.

FOR MEDICARE CLAIMS: See the unique identifying system, No. 09-00-0901, titled "Carrier Medicare Claims Record," published in the Federal Register, Vol. 51 No. 177, page 37519.

For further information, please contact the Secretary of the Board. To receive, directly or in-mail copy, documents by e-mail, request a DIF to issue payment, with establishment of delivery and delivery address, from your institution's accounting department.

and the U.S. Department of Health and Human Services under the Dept. of Transportation's Office of Safety and Security.

PROBLEMS Many large businesses have been forced to close their doors because they were unable to compete effectively with smaller companies. With this one exception, the small business sector has continued to grow.

For further information or to file a claim, contact your insurance company or the provider of services.

It is mandatory that you let us know that another party is responsible for paying for your insurance. Section 113D of the Cornelia Bailey Act and §1 UIC 350-0012 require participation in the following:

You should not release FOIA 100-807, Re: Computer Learning and Privacy Protection Act of 1995, prior to the government's voluntary information by any of the following methods:

HARLEM, DANNIE (b. 1952) American R&B singer and songwriter. He has recorded for numerous labels, including Motown, Atlantic, and Arista.

019873940-0450-6600 X

NOTICE: This is to advise that I am leaving the institution in less than 12 hours and cannot be reached by telephone or mail. Please do not delay in making arrangements to verify my location and to release me from my contract as soon as possible.

According to the Postmark, this document was received on 10/03, at 9:45 AM. The document contains 1 page(s) of unclassified information and requires a valid QDR control number. This valid QDR control number for this document is 00000000000000000000000000000000. The time spent to complete this document was estimated to average 10 minutes per person, including the time to review, analyze, and edit the data in order to prepare the document. The data is valid and accurate to the maximum. If you have any comments concerning the accuracy of the data contained in this document, please contact the CIO, NSA Security Directorate, Attn: DPA Report CIO-1000-CIO-00-00-0000000000000000.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 11/18/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client very sore today after
Shoulders and L.B. Bluscap +
shoulder tightness & to sacrum w/
L.B. Bluscap +

Actions Applied: (Check All that Apply)

SI Joints Sealing
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion PROBLEME
 Stripping Compression Lymph Drainage Only

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat

Therapist: Cheri May maf

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 11/18/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LBP w/ increased hypertonicity

+ Sacrum, SI joints glutes

Started Client home to try to ease

Actions Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat RIC

Therapist: Cheri May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0355

Client Name: Danielle Honig Date: 1/13/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Right leg has a severe foot messageStill feel a little sore w/stiffness. Fewnumbness esp. at occiput & upper back.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze Stretching Ice / Heat
 Light Pressure Massage Mod Pressure Massage Chiropractic
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: Shelley May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0355

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

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01 18 17

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Great Lakes Therapeutic Massage



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA															
1 MEDICARE <input type="checkbox"/> Medicare	2 MEDICAID <input type="checkbox"/> Medicaid	3 TRICARE <input type="checkbox"/> DOD/DIA/D	4 CHAMPVA <input type="checkbox"/> Member ID#	5 GROUP HEALTH PLAN <input type="checkbox"/> HMO	6 PEOA <input type="checkbox"/> RISK LIVING	7 OTHER <input type="checkbox"/> INDIV	8a INSURED'S ID. NUMBER 013873940-0101-059	(For Program Item 1)							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4 INSURED'S NAME (Last Name, First Name, Middle Initial) - same -								
BARNELL, DANIELLE			08 12 1980												
5 PATIENT'S ADDRESS (No., Street)			6 PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)									
56 BERSEBEVEN DR			Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												
CITY AMHERST	STATE NY	8 RESERVED FOR NUCC USE			CITY			STATE							
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951	X			ZIP CODE			TELEPHONE (Include Area Code)							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR PEOA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY									
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO UNK			b. OTHER CLAIM ID (Designated by NUCC) I									
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			d. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME			10. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															
SIGNED <u> </u> ON FILE			DATE 01-06-2016			SIGNED <u> </u> ON FILE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA			17a <input type="checkbox"/> NPI 17b <input type="checkbox"/> NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			21. CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind			22. RESUBMISSION CODE			ORIGINAL REF NO									
A <input type="checkbox"/> M79.1	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>	E <input type="checkbox"/>	F <input type="checkbox"/>	G <input type="checkbox"/>	H <input type="checkbox"/>	I <input type="checkbox"/>	J <input type="checkbox"/>	K <input type="checkbox"/>	L <input type="checkbox"/>				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMG			C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS CODE MODIFIER			F. G. H. I. J. CHARGES DUE ON UNITS ID QUM RENDERING SUPPLIER ID #			
1	01-10-17	01-10-17	31	31	97140									NPI	1111112011
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	
25. FEDERAL TAX ID NUMBER	SSN BIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? EXCEPT GOVT PAYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rev'd for NUCC Use									
47-0989449	<input type="checkbox"/>	BARNELL, D	<input type="checkbox"/>	\$ 55 00	\$ 0 00	\$ 55 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH#									
COLLEEN MARX, EMR 01-18-2017 SIGNED			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			716 725-0264			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043						
DATE 01-18-2017			a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/>			a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/>									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE T136 FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a federal crime and subject to criminal penalties.

SECRETS IN GOVERNMENT RECORDS ONLY

Medicare and I-Health P.W.M. (IHP) require insurance companies to pay for services that are reasonable and necessary for the treatment of a patient's condition. It is the responsibility of the insurance company to determine if a service is reasonable and necessary. If a service is determined to be reasonable and necessary, the insurance company will pay for it. If a service is determined to be unreasonable or unnecessary, the insurance company will not pay for it.

REFERENCES AND NOTES

The government has informed the current post by the Governor and no payment is left. Rec. GULU LUMI and FFCA indicated regarding relevant uncertainty and diagnosis related awareness.

SIGNATURE OF PHYSICIAN OR SUPPLIER (LET MEAP, TRICARE, FECA AND BLACK LUMI)

For TMC USE ONLY: I declare that I am not an employee of the United States Government or a contractor to the United States Government, either civilian or military. I have read UMO B6500, Fr. Stockholder's Guide, further details can be found at www.fsa.fsa.usda.gov.

No Pan-G100 can be better than its individual units which form a standard as to quality and value.

PC-2000. Any questions or comments should be directed to the project manager. I would appreciate it if you would respond by Friday, January 13, 2006. Thank you very much for your attention to this important matter.

NOTICE TO RIGHTHOLDERS: COLLECTION AND USE OF INFRINGING, TAKEN, PUBLIC AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are unable to file TPA-1001 and GOM-1001 as they are incomplete and do not fit the conversion rule of the Act. We believe the TRICARE PRA, and Block 1, are incomplete. Accordingly, we will not file them at this time. Instead, we will file the TRICARE PRA, and Block 1, separately. Additionally, we will file the GOM-1001 and TPA-1001 as they are incomplete. Specifically, we will file the GOM-1001 as GOM-1001, and the TPA-1001 as TPA-1001.

The information will be used to complete claims under these programs to determine your auto's eligibility. It is also used to determine if the car meets and replaces your uninsured auto insurance plan. You may cancel or change your plan at any time.

The information may also be used in other powers of attorney, carers' statements, declarations, wills, letters of wishes, health plans, or other documents or digital services. For the relevant legislation, see Part 6 of this Code. To ensure that a person's power of attorney is valid, it must be signed by the person and witnessed by two people who are not connected to the person. It may also be witnessed by a solicitor, a notary public or a justice of the peace. Additional measures are available through routine use of an attestation confirmation system or remote.

FORM 27 EDICARIA CLASSIFICATION FOR THE ACTIVE MONITORING SYSTEM. 10 CD 10 0901, 1000. *Centro Atómico de Olmos Potosí*, published by the Rogers, R. owner, 1st Ed. 53 No. 177, page 37E19.

¹⁰See also, e.g., *U.S. v. Bannister*, 50 F.3d 1132, 1136 (5th Cir. 1995) (citing *United States v. Gandy*, 452 U.S. 39, 43 (1981)).

TCR T-cell receptor; CD45RA: CD45 isoform expressed by naïve T cells; CD45RO: CD45 isoform expressed by effector memory T cells.

¹Private States, federal regulatory agencies, and consumer advocacy organizations can implement their own regulations or look to Congress or the Courts to regulate to address problems in the areas of the power in which a company operates. Appropriate disclosure may be required in state, local, state, federal, foreign, economic, political, human rights, and environmental providers of care in certain states, as a settlement, claim, determination, or recommendation from a court, quality assurance, or a review, program, audit, or inspection by the entity, organization, or entity and several entities related to the operation of TRECURE.

DOJC FRAUD: **Unlawful Interference**: If prior written information will result in delay in payment or may result in denial of claim. With the one exception discussed below there are no penalties and/or fines for refusing to release information. However, failure to furnish information in preparing the medical records involved in the claim can result in denial of payment of claims under the program. Failure to furnish any other information, such as name or claim number would delay payment of the claim. Failure to provide medical information under FD-205, could result in denial of a claim.

It is mandatory that you tell us if you know or suspect the party is responsible for your break-in. Section 118d of the Social Security Act, and 31 U.S.C. 3801-3812 (microdissemination) for withholding this information.

You should be registered IP.L. #00-503, Inc Computer Monitoring and Privacy Protection Act of 1988; giving the permission to verify information by way of computer monitor.

ENROLLMENT AND CERTIFICATION

I certify that the above record is true to the best of my knowledge and belief, and I also certify that the State of the Commonwealth of Massachusetts has been paid to me the amount of \$100.00 for my services as a Notary Public.

For more information on the system and the benefits provided by the public and private sector to combat climate change, visit the website of the United Nations Environment Programme, www.unep.org.

SIGNATURE OF PRACTITIONER (OR CNA/PLE) OR KEY INFO: The signatures listed above were initially introduced and subsequently signed in the form of his patient and were personally witnessed by me as my employee under my personal direction.

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

including, but not limited to, names, addresses, telephone numbers, e-mail addresses, fax numbers, and other contact information, including, but not limited to, names, addresses, telephone numbers, e-mail addresses, fax numbers, and other contact information, including, but not limited to, names, addresses, telephone numbers, e-mail addresses, fax numbers, and other contact information. If you have any comments or concerns regarding the accuracy of the information contained in this form, please call the CMSG 7-400 Technical Directorate, Attn: TPA Report-4, Customer Officer, Mail Stop C1 28-05, Baltimore, Maryland 21204-0205. The comments, or concerns and suggestions are only DO NOT MAIL COMINT REPORT C1 28-05 TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0234

Fax: (716) 725-0265

Client Name: Danielle Harrel Date: 1/13/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Dumbb Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Dia 1B has ↓ since foot massageStill feel a little sore w/ stiffness. Few minutes less esp. w/ Occup fit & Upper Step.Action/s Applied: (Check All that Apply) Heat across waist

- Heat Packs Cold Packs Sombra/Biofreeze Sacrum/Butt
 Light Pressure Massage Mod Pressure Massage and Trigger Points
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretchers Con't Meds Ice / Heat

Therapist: Danielle Harrel *mec*

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0234

Fax: (716) 725-0265

Client Name: Danielle Harrel Date: 1/18/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Dumbb Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Drew mom (P) ↓ to thoracicregion. ↓ cerv/low. (D) hip ↑ w/tight(D) IL. SI joint fatigued. Going forAction/s Applied: (Check All that Apply) TP Therapy tomorrow

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretchers Con't Meds Ice / Heat

Therapist: Danielle Harrel *mec*

01 26 17

Wet - 100% - 100%

100%

01 26 17

Great Lakes Therapeutic Massage

& Bodywork Practitioners

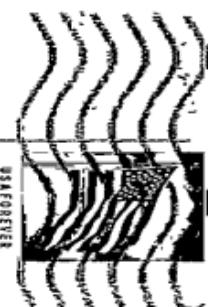
375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

BUFFALO NY 142

23 JAN 2017 PM-5-L



GEICO INS CO of NY
P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403-952607

[REDACTED]

01 26 17

0138 7394 0010 1059

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

FICA

MEDICARE [Medicare]	MEDICAID [Medicaid]	TRICARE [DOD/DoD]	CHAMPVA [Member ID#]	GROUP HEALTH PLAN [DoD]	FICA BUILDING [DoD]	OTHER [DoD]	1a. INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			3. PATIENT'S BIRTH DATE MM DD YY 08291980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT			
CITY CHEEKWTOWAGA		STATE NY	8. RESERVED FOR NUCC USE			CITY AMHERST		STATE NY	
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951					ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR FICA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 08291980			
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY			b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
SIGNED SIGNATURE ON FILE				DATE					
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 103115			15. OTHER DATE QUAL. 454		MM DD YY 111215	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE TVA TVA NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Refer A-L to service line below (34e)									
ICD-9-CM A. I50.222 B. IM51.26 C. IM51.27 D. IM54.12 E. I22.3 XXXA F. IM99.01 G. IM99.03 H. IM99.02 I. IM99.05 J. IM54.2 K. IM54.5 L. IM54.6									
22. RESUBMISSION CODE ORIGINAL REF ID NO									
23. PRIOR AUTHORIZATION NUMBER									
A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PAYOR PAYER/ SERVICE EMG	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Check One or More Circumstances)	E. MODIFIER	F. DIAGNOSIS CODING FINGER NUMBER	G. DAYS ON UNITS	H. PER UNIT AMOUNT	I. QTY QUAL	J. RENDERING PROVIDER ID #
01052017	01052017	11	98941		ABCD	32 28	1	NPI	1710014188
01052017	01052017	11	97010		ABCD	10 53	1	NPI	1710014188
01092017	01092017	11	98941		ABCD	32 28	1	NPI	1710014188
01092017	01092017	11	97010		ABCD	10 53	1	NPI	1710014188
								NPI	
								NPI	
25. FEDERAL TAX ID NUMBER 3645001165			26. PATIENT'S ACCOUNT NO 3438Z1239		27. ACCEPT ASSIGNMENT? [Initials, checkmark, or signature] <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 85.62	29. AMOUNT PAID \$ 0.00	30. Reason for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS [I certify that the statements on the reverse apply to the bill copy you made and sent me.] PETER GUZINSKI DC			32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			

SIGNED 01202017 DATE * 123

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5256546

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
January 20, 2017

Patient: Danielle Harwell #3438 DOB: 03/29/1980
Policy ID: 013873940011059

Thursday January 5, 2017 Provider: Peter Guzinski DC

Electronically signed on 01/05/2017 at 11:03am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today stating that her neck pain has been more intense. She stated that she has been sleeping on the couch with her son who has been sick which aggravated her condition. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* slightly worse. *since last 3 nights.* *Pain:* achy, dull, sharp, shooting, numb; level: 4/10. *Pain is occasional.* *Pain radiates to:* left shoulder, right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she has not had a headache since last visit. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting. *Range:* 3->4/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that her left posterior thigh continues to remain painful. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb; level: 4/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain right neck ; right rotation: 60/80 with pain right neck ; left lateral bending: 35/45 with pain right neck ; right lateral bending: 35/45 with pain right neck . *Posture:* foward head carriage; rounded

Encounter dated 01/05/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 01/20/2017

shoulders. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Moderate; Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Left Mild to Moderate; Thoracic paraspinal musculature Right Mild. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 50 degrees for lower back pain; Well leg raise: Negative right at 70 degrees; Bechterew: Negative. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: mild exacerbation of symptoms, continue with current treatment plan. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated

Encounter dated 01/05/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 01/20/2017

disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.
Treatment schedule: 1x/week for 2 weeks; 1x every 2 weeks for 2 weeks; Re-examination for 4 weeks.
Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization).
Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy.
Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec.
Home care: ice: neck / lower back prn for 20 minutes.
Additional instructions: Advised patient to monitor for any changes in their symptoms.
Short term goals: decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain.
Long term goals: decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain.
Disability status: Temporary partial starting on November 12, 2015 to January 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Monday January 9, 2017 Provider: Peter Guzinski DC

Electronically signed on 01/09/2017 at 10:13am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today stating that her neck pain remains the same. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. since last visit.

**Encounter dated 01/09/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 01/20/2017**

Pain: achy, dull, sharp, shooting, numb; level: 4/10. *Pain is constant.* **Pain radiates to:** left shoulder, right shoulder, left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she has not had a headache since last visit. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit:** **Pain:** achy, dull, sharp, shooting. **Range:** 3->4/10. **Pain is occasional.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. **since last visit:** **Pain:** achy, dull, sharp, shooting, numb; level: 4/10. **Pain is occasional.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Objective

Cervical: **Range of motion:** flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain right neck ; right rotation: 60/80 with pain right neck ; left lateral bending: 35/45 with pain right neck ; right lateral bending: 35/45 with pain right neck . **Posture:** forward head carriage; rounded shoulders. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Moderate; Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Left Mild to Moderate; Thoracic paraspinal musculature Right Mild. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise:

Encounter dated 01/09/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 01/20/2017

Negative right at 70 degrees; Bechterew: Negative. *Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: worse, pain more constant than occasional. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: improving, left SLR improved from 50 to 60 degrees. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 1 week; 1x every 2 weeks for 2 weeks; Re-examination for 3 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10

Encounter dated 01/09/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 01/20/2017

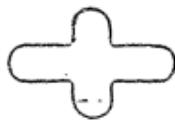
daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations:

- ADL: activities of daily living
- MVA: motor vehicle accident
- ROM: range of motion
- WNL: within normal limits

01 26 17





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

NUCC PICA

PICA book

1. MEDICARE												MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA INJURING WORK		OTHER		16. INSURED'S ID. NUMBER		(For Program in Item 1)	
<input type="checkbox"/> Medicare												<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> GROUP HEALTH PLAN		<input type="checkbox"/> FECA INJURING WORK		<input type="checkbox"/> OTHER		0138739400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
HARWELL, DANIELLE												MM DD YY		SEX		HARWELL, DANIELLE											
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)													
1131 CLEVELAND DR												Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		1131 CLEVELAND DR													
CITY						STATE						CITY						STATE									
CHEEKTONAGA						NY						CHEEKTONAGA						NY									
ZIP CODE		TELEPHONE (Include Area Code)										ZIP CODE		TELEPHONE (Include Area Code)													
14225		()										14225		()													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:															
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)															
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. AUTO ACCIDENT?									
												<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						PLACE (State)									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. OTHER ACCIDENT?									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						d. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?															
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						If yes, complete items 9, 8a, and 8d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																											
SIGNED SIGNATURE ON FILE												DATE 02 09 16															
SIGNED SIGNATURE ON FILE												SIGNED SIGNATURE ON FILE															
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)						15. OTHER DATE						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION															
MM DD YY						MM DD YY						FROM MM DD YY															
QUAL:						439 10 31 15						TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. 1G U62607						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES															
DN PETER J GUZINSKI						17b. NPI 1710014188						FROM MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LABY \$ CHARGES																					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						\$ CHARGES															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer A-L to service line below (S48))												22. RESUBMISSION CODE ORIGINAL REF. NO.															
A M791												B L C L D L															
E L F L G L H L												G L H L I L															
J L K L L L												J L K L L L															
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE (E/M)		C. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances)		D. MODIFIER		E. DIAGNOSIS CODE		F. S. CHARGES		G. DRG OR UNITS		H. DRG PER UNIT		I. ID. QUAL.		J. RENDERING PROVIDER ID. #					
From MM DD YY						To MM DD YY																					
1 01 19 17						01 19 17		11		20553				A		95.741						EI 161582336					
																						NPI 1770644528					
25. FEDERAL TAX ID. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For PDR, Submitter, and Doctor)		28. TOTAL CHARGE		29. AMOUNT PAID		30. RATIO for NUCC USE											
161582336						<input checked="" type="checkbox"/>		1537900		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 95.74		\$ 0.00													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)								32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#																	
TOMAS HOLMLUND, MD								DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727		(716) 2502010																	
01 30 17								DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002																			
SIGNED								= 1497850911 b		= 1497850911 b		= EI 161582336															



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Lazelle Mekhora, MD, Diversar
Ajay Amin, MD

Jennifer W. McVige, MD
Nicole Sakkal, MD

Karly A. Beninati, RPA-C
Sydney B. Grabau, PA
Andrea Gennella, FNP-C
Lewon Jendrzejak, RPA-C
Megan Kuechle, PA-C
Cheyli L. Lyons, ANP

Larissa Low, FNP-C
Colita T. Malasy, PA-C
Katelyn L. Murphy, FNP
Maria Rizzo, RPA-C
Grace T. Scheffler, FNP
Christopher Zalewski, FNP-C

Sydney B. Grabau, PA

Procedure Note
Date: 01/19/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 36 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- Trigger Point Injections. Headaches
- Neck pain

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. She states that she continues to benefit from her trigger point injections.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDO = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

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Orchard Park Office: Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
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Gregory Creek, Clinic Manager
Ashley Herrives
Amanda McFayden
Alies Tremlinski

INFUSION CENTER
Christine Mass, MBA, Director
Barbara Mulderig, RN, Manager

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking: Patient is a: non smoker .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Resides with:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 110/74, HR 72, RR 16, Ht 63", Wt 210.8, BMI 37.34, BSA 2.06.

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle

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 Amanda McFayden
 Alice Trzaski

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deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

The supervising physician on site is Dr. Holmlund.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Myofascial pain

MASSAGE Therapy1401192

Chiropractic therapy1401191

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 7 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness. The procedure was performed by Abbey Burdick, PA-C..

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 01/19/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 01/19/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 01/19/2017.

Follow Up

4 weeks triggers. 4 Weeks

Sydney Grabau PA-C

T. Harwell, MD

Electronically signed by Sydney Grabau , PA on 01/19/2017 at 04:39 PM EST

Sign off status: Completed

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Amanda Mellyadas
Alice Trzaski

INFUSION CENTERS
Christina Marr, MBA, Director
Barbara Mullerig, RN, Manager



W ✓ HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> TRICARE	CHAMPAVA	GROUP HEALTH PLAN	FEDERAL BUILDING	OTHER	1a. INSURED'S ID-NUMBER	(For Program in Item 1)
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	(Member ID#)	(DIN)	(ADM)	(VOM)	013873940-0101-059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARRELL, DANIELLE			MM	DD	YY	M	F	- SAME -
OB 08 29 1980								
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)	
56 BIRMINGHAM DR			Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
CITY AMEREST	STATE NY	8. RESERVED FOR NUCC USE		CITY		STATE		
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951	X		ZIP CODE		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FED. NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH	SEX	
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	MM DD YY	M <input type="checkbox"/>	F <input type="checkbox"/>
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME			d. INSURANCE PLAN NAME OR PROGRAM NAME					

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ON FILEDATE 01-06-2016SIGNED ON FILE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)	15. OTHER DATE (QUAL)	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY								
10-03-2015	QUAL										
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. <input type="checkbox"/>	17b. <input type="checkbox"/>	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
SIXTH GRADE, PA											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	19a. <input type="checkbox"/>	19b. <input type="checkbox"/>	20. OUTSIDE LAB? \$ CHARGES								
			<input type="checkbox"/> YES <input type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to A-L to service line below (24E))	21a. <input type="checkbox"/>	21b. <input type="checkbox"/>	22. RESUBMISSION CODE ORIGINAL REF. NO.								
A LMT9-T	B <input type="checkbox"/>	C <input type="checkbox"/>	E <input type="checkbox"/>	F <input type="checkbox"/>	G <input type="checkbox"/>	H <input type="checkbox"/>	I <input type="checkbox"/>	J <input type="checkbox"/>	K <input type="checkbox"/>	L <input type="checkbox"/>	
E <input type="checkbox"/>	F <input type="checkbox"/>	G <input type="checkbox"/>	H <input type="checkbox"/>	I <input type="checkbox"/>	J <input type="checkbox"/>	K <input type="checkbox"/>	L <input type="checkbox"/>				
24. A. DATE(S) OF SERVICE	B. To	C. PROCEDURES, SERVICES, OR SUPPLIES (English/Universal Circumstances)	D. CPT/HCPCS	E. MODIFIER	F. DIAGNOSIS	G. DAYS ON UNIT	H. DAYS OUT PAT	I. ID QM	J. RENDERING PROVIDER ID.#		
From MM DD YY	To MM DD YY				PTR	8 CHARGES					

1	01-23-17	01-23-17	1-7-11	97140			55-100	3	NPI	1144462011
2	01-27-17	01-27-17	1-7-11	97140			55-100	3	NPI	1144462011
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX ID NUMBER	SSN/BN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT (If you accept my assignment, my bill will be sent to my insurance company.)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Paid for NUCC Use	
47-0989449	<input type="checkbox"/>	HARRELL, D	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ 110.00	\$ 0.00	\$ 110.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.)			32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #		
COLLEEN MARX, LMT 01-29-2017 SIGNED			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPWA, NY 14043		716 725-0264		

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIMATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement or claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

TRICARE and TRICARE Prime LTHA. A patient's consent is required if payment is made and authorization issued if any information sent prior to receipt of the claim and discharge statement. Authorization provided by States 1 through 12 is also acceptable and is included in the cost of a Medicare claim; the patient's signature is required only in reference to Medicare national and supplemental insurance and that, if the person is not employer group health insurance liability, is not liable, under a combination or other insurance, for the responsibility as set forth in the contract. For claims filed after January 1, 2002, see 42 CFR 111.12(e). If item B is completed, the patient's signature will serve as evidence of the information in the bill of lading or any other document. In TRICARE assignment or TRICARE participation cases, the provider agrees to accept the exchange continuation of the life degree career or TRICARE local intermediary for the life change and to furnish its responsibility only to the deductible charge and non-covered services. Contractor and the deductible will be based upon the TRICARE local intermediary for the life change or the life degree career. TRICARE is not a health insurance program but is payment for health care provided through certain health care providers. Information may be obtained at the nearest TRICARE office or by calling 1-800-TRICARE (1-800-874-2273).

对《论语》中的“君子”与“小人”的理解

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SIMILARITIES OF RHYTHMUS OG SUPERIUS GENELOCICHE TONICALE, EBCA AND B1000 LITERATURE

For TRICARE claims, I further certify that I do not have any other service-connected injuries or disabilities, nor am I a member of the Uniformed Services or a civilian employee of the United States Government, or a current employee of the United States Congress, either civilian or military (Under 51 USC 593B). For BlueCross claims, I further certify that the same as contained in the

Mr. Post S. Elkins is a licensed engineer holding a license issued by the state of Georgia, and is registered by Georgia law and regulations (12 CFR 347.7).

WHO IS EXEMPT? Any individual who receives an annual contribution from Federal funds allocated by the IRS may upon correction be subject to the annual prepayment of amounts applied to Federal taxes.

DO NOT FORGET TO PAY THE COLLECTIVE AND INDIVIDUAL TRIBES, ETC., AND PLACE MTS. RE COLLECTIONS ON THE ACCOUNT OF THE TRIBES.

This information is often used to identify clients under these programs or used to verify you and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by the program, and to ensure proper payment is made.

The institution may also be given no other privileges or services, cameras, intercom, cameras, medical review, and/or health plans, and other organizations or Federal agencies, for the efficient administration of the institution.

We have tried to disclose all information about the products you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

World Bank Group, 1990, as updated and republished.

ES-12 ESG-13, ESG-30, or as updated and republished.

FOUR THIRTY-FIVE CORP'S PRINCIPLES ("PRINCIPLES") establish eligibility for medical care provided by civilian sources and to issue payments upon establishment of capacity and determination that the service members received are authorized by law.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failure to supply information. However, failure to furnish regarding the medical services rendered or the amount charged would prevent payment of claims under the programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 11200 of the Social Security Act and 91 USC 3001-3012 provide penalties for withholding this information.

You should be aware that P.L. 100-508, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matching.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments or rates for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, in payment in full, the amount paid by the Medicaid program for these claims submitted for payment under this program, with the exception of non-nursing domiciliary care services, as payment in full for the following others:

SIGNATURE OF PHYSICIAN (OR SUPPLYING): I certify that the supplies listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTE: It is your responsibility to verify that the information you provide is true, accurate, and complete. I understand that a perjury and/or violation of this claim will be treated as a Federal and State offense, and that any false statement, statement, or document, or component of a material fact, may be prosecuted under applicable Federal or State laws.

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 0325-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time for review instructions, search existing data resources, gather the data needed, and complete and review the information collected. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: OMB PRA Report Clearance Officer, Mail Stop 04-26-05, Baltimore, Maryland 21214-1950. This address is for comments and suggestions only. DO NOT MAIL COMPLETED FED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0834

Fax: (716) 725-0945

Client Name: Danielle Howell Date: 11/23/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client stated experiencing Leg Soreness Glute tightness Vtra
 Tension spent on perineum mm Flushed
Action's Applied: (Check All that Apply) Legs Cervical neck
 Heat Packs Cold Packs Sonova/Biofreeze
 Light Pressure Massage Mod Pressure Massage hyperactivity
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat/Infrared

Therapist: Jen May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0834

Fax: (716) 725-0945

Client Name: Danielle Howell Date: 11/27/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
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 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Legs are better hamstring
 tightness pulling on Lb. glute
 Hypertonicity. Injections are weari

Action's Applied: (Check All that Apply) off

Heat Pocks Cold Packs Sonova/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat/Infrared

Therapist: Jen May

020217

020217

02 02 17

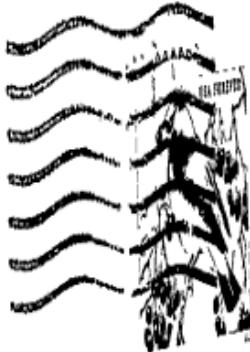
Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

2240385526 8086





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

Xxxx PICA

PICA

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA EXCLUDING <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (DOD) <input type="checkbox"/> (DOD/DoD) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (DOD) <input type="checkbox"/> (DOD)												1a INSURED'S ID. NUMBER 0138739400101059 (For Program in Item 1)							
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>				4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7 INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR			
CITY CHEEKTONWAGA			STATE NY			8 RESERVED FOR NUCC USE			CITY CHEEKTONWAGA			STATE NY							
ZIP CODE 14225			TELEPHONE (Include Area Code) ()						ZIP CODE 14225			TELEPHONE (Include Area Code) ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15			
												b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____ PLACE (State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____				c. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
b RESERVED FOR NUCC USE												d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. OTHER CLAIM ID (Designated by NUCC) e. INSURANCE PLAN NAME OR PROGRAM NAME			
c RESERVED FOR NUCC USE												10d CLAIM CODES (Designated by NUCC)				e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
d INSURANCE PLAN NAME OR PROGRAM NAME												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED SIGNATURE ON FILE												DATE 02 09 16				SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 01 19 17				15 OTHER DATE MM DD YY 01 10 31 15				16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUEZINSKI				17a U62607				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b NPI 1710014188				20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGE\$											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A M791 B L C L D L E L F L G L H L I L J L K L L L												22 RESUBMISSION CODE ORIGINAL REF NO							
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY 01 19 17 01 19 17 11												23 PRIOR AUTHORIZATION NUMBER NPI							
B PLACE OF SERVICE EMR NPI												C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 20553				D MODIFIER A			
E DIAGNOSIS CODE 95 74 1												F CHARGES 95 74 1							
G DAYS ON UNITS 0												H SPENT PER UNIT 0							
I ID QUAL NPI												J RENDERING PROVIDER ID # 161582336							
25 FEDERAL TAX ID NUMBER SSN EIN 161582336												26 PATIENT'S ACCOUNT NO 1537900				27 ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
28 TOTAL CHARGE \$ 95 74 1												29 AMOUNT PAID 0 00							
30 Reserved for NUCC Use																			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof.) TOMAS HOLMLUND, MD 01 30 17												32 SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727							
SIGNED DATE												33 BILLING PROVIDER INFO & PH # (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002							
34 1497850911												35 1497850911 EII161582336							

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.34(a) if Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 10, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal and State Stark laws; Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service; 6) my identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by health employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of funds commonly furnished in physician's offices; and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5339). For Black Lung claims, I further certify that the services performed were not for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OIGP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(g), 1892, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.2(a)(6) and 421.5(e)(6), and 44 USC 3101, 1 CFR 101 et seq. and 10 USC 1679 and 1083, 5 USC 801 et seq, and 30 USC 801 et seq; 38 USC 610; E.O. 13937

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, Med, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept 12, 1990, as updated and republished.

FOR OIGP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12 ESA-13 ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/claims received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies and consumer reporting agencies in connection with recruitment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary; however failure to provide information will result in delay in payment or may result in denial of claim. With one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged could prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1120B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988" permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Response Clearance Office, Mail Stop C4-26-05, Baltimore, Maryland 21204-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



DENT

NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Luisio Meekler, MD, Director
Amy Abad, MD

Jennifer W. McVige, MD
Nicholas Sakkas, MD

Karly A. Beaman, RPA-C
Sydney B. Grabau, PA
Andrea Gonzella, FNP-C
Lauren Jendruszak, RPA-C
Megan Kuschle, PA-C
Cheryl L. Lynn, APRN

Lorraine Liss, FNP-C
Collin T. Mulcahy, PA-C
Kathryn L. Murphy, FNP
Maria Rizzo, RPA-C
Grace T. Schmitz, FNP
Christopher Zelasko, FNP-C

Sydney B. Grabau, PA

Procedure Note

Date: 01/19/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 36 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Trigger Point Injections, Headaches
- Neck pain

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. She states that she continues to benefit from her trigger point injections.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) once a day
- Taking loratadine 10 mg capsule 1 cap(s) once a day
- Taking Melatonin 3 mg tablet 1 tab(s) once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) once a day
- Taking Lamictal 25 mg tablet 1 tab(s) 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking nizatriptan 10 mg tablet 1 tab(s) prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

(716) 250-2000
www.dentinstitute.com

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ADMINISTRATIVE SUPPORT

Gregory Cook, Clinic Manager
Ashley Herremans
Amanda McFaydes
Alice Trzaskas

INFUSION CENTERS

Christine Mann, MBA, Director
Barbara Meldeng, RN, Manager

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings alive
 1 brother(s) - healthy

Social HistoryTobacco Use:

Smoking Patient is a non smoker

Alcohol use:

Alcohol Consumption Patient does not drink alcohol.

Resides with:

Spouse Husband Children: Yes, x3.

Working:

Employed Stay at home mom.

Marital Status:

Married. Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks

Caffeine:

Other. Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy

Vital Signs

BP sitting 110/74, HR 72, RR 16, Ht 63", Wt 210.8, BMI 37.34, BSA 2.06.

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle

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deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

The supervising physician on site is Dr Holmlund.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Myofascial pain

MASSAGE Therapy 1401192

Chiropractic therapy 1401191

Procedures

Injections

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 7 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness. The procedure was performed by Abbey Burdick, PA-C .

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 01/19/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 01/19/2017.

Exercise: Patient counseled on importance of moderate physical activity daily 01/19/2017

Follow Up

4 weeks triggers 4 Weeks

Sydney Grabau PA-C

Abbey Burdick PA-C

Electronically signed by Sydney Grabau , PA on 01/19/2017 at 04:39 PM EST

Sign off status: Completed

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Barbara Muldeng, RN, Manager

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 2455
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 01/31 11:11
 TX/RX TIME 01' 05
 PGS. 5
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

XNUCCPICA

1. MEDICARE	MEDICARE	TREASURE	CHAMPVA	GROUP	COINSUR	FEDERAL	OTHER	1a. INSURED'S ID. NUMBER	(For Preprint in Item 1)
<input type="checkbox"/>	<input type="checkbox"/> Medicare	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> Member ID#	<input type="checkbox"/> N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> X	0138739400101059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE							4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARWELL, DANIELLE	MM DD YYYY							HARWELL, DANIELLE	
08 29 1980	<input type="checkbox"/> M	<input checked="" type="checkbox"/> F	<input type="checkbox"/> X						
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED							7. INSURED'S ADDRESS (No., Street)	
1131 CLEVELAND DR	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other					1131 CLEVELAND DR	

DSTY	STATE	CITY	STATE				
CHEEKSTOWAGA	NY	CHEEKSTOWAGA	NY				
ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)				
14225	()	14225	()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER	11. INSURED'S POLICY GROUP OR FECA NUMBER						
b. RESERVED FOR RUCC USE	DOI 10/31/15						
c. RESERVED FOR RUCC USE	a. INSURED'S DATE OF BIRTH						
d. RESERVED FOR RUCC USE	MM DD YY						
e. RESERVED FOR RUCC USE	08 29 1980						
f. RESERVED FOR RUCC USE	b. OTHER CLAIM ID (Designated by RUCC)						
g. INSURANCE PLAN NAME OR PROGRAM NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME						
10e. CLAIM CODES (Designated by RUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of payment benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE

DATE 02 09 16

13. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)	14. OTHER DATES	15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY	MM DD YY	MM DD YY
08 29 17	09 13 17	09 13 17
CUREL	CUREL	CUREL

16. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 1G U62607	18. HOSPITAL/DAY CARE/AMBULATORY/OUTPATIENT
DIN PETER J GUZINSKI	17b. NH 1710014188	FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by RUCC)	20. OUTSIDE LABS	21. CHARGES
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Read A/L to service line below) ICD NO. 0	22. TRANSMISSION CODE	ORIGINAL REF. NO.
A. <u>MT91</u> B. <u> </u> C. <u> </u> D. <u> </u>		
E. <u> </u> F. <u> </u> G. <u> </u> H. <u> </u>		
I. <u> </u> J. <u> </u> K. <u> </u> L. <u> </u>		

24. A. DATE(S) OF SERVICE	B. TO	C. PLACE OF SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT-OPCS	E. MODIFIER	F. DIAGNOSIS POINTERS	G. CHARGES	H. PAYOR ON LINE	I. PAYOR ID. NO.	J. RENDERING PROVIDER ID. #
MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY
01 19 17	01 19 17	11	20553		A	95 74 1			161582336

1									NP1
2									NP1
3									NP1

CARRIER

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION

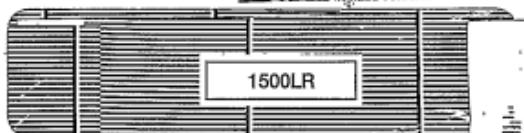
17 90 2

FIRST CLASS MAIL



02 06 17

DEMI NEUROLOGIC GROUP, LLP
ADMINISTRATIVE OFFICE
3980 SHERIDAN DR. SUITE B
BUFFALO, NY 14226



FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

NUCC												PIGA									
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BUKLUNG		OTHER		16. INSURED'S ID NUMBER		[For Program in Item 1]					
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> GROUP HEALTH PLAN		<input type="checkbox"/> FECA BUKLUNG		<input checked="" type="checkbox"/> OTHER		013873940-0101-059							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARMELE, DANIELLE												MM DD YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		- 8888 -					
08 29 1980																					
5. PATIENT'S ADDRESS (No. Street)												6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No. Street)					
56 BEREHAVEN DR												Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE		X		CITY		STATE											
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951						ZIP CODE		TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER							
												a. EMPLOYMENT (Current or Previous)		a. INSURED'S DATE OF BIRTH							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM DD YY		SEX					
												b. AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated by NUCC)							
												<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY									
												c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?							
														<input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, complete items b, c, and d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below							
SIGNED - ON FILE -												DATE 01-06-2016		SIGNED - ON FILE -							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)		15. OTHER DATE QUAL		MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		FROM MM DD YY		TO MM DD YY											
MM DD YY 01 31 2015 QUAL																					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		FROM MM DD YY		TO MM DD YY			
SIDNEY GRABAU, PA												17b. NPI _____									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate A-L to service line below [34])												20. RESUBMISSION CODE		ORIGINAL REF. NO.							
A M79.1		B _____		C _____		D. _____															
E _____		F _____		G. _____		H _____															
I. _____		J. _____		K. _____		L. _____															
24. A. DATES(S) OF SERVICE		B. SERVICE		C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Circumstances)		D. OPRHCPCS		E. MODIFIER		F. D. CHGS OR UNITS		G. H. ID OR UNIT QUAL		J. RENDERING PROVIDER ID. #							
From MM DD YY		To MM DD YY																			
01 30 17		02 30 17		31		97140		a		55.00		3		NPI 1144462013							
02 03 17		02 03 17		11		97140		a		55.00		3		NPI 1144462011							
02 05 17		02 06 17		11		97140		a		55.00		3		NPI 1144462011							
02 10 17		02 10 17		11		97140		a		55.00		3		NPI 1144462011							
5. _____																		NPI			
6. _____																		NPI			
25. FEDERAL TAX ID. NUMBER												26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE		29. AMOUNT PAID		30. REND FOR NUCC USE	
47-0989449												SSN EIN				\$ 220.00		\$ 0.00		220.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.)												32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#		(716) 725-0264					
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043		GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							
COLLEEN MARK, LMFT 02.10.2017												SIGNED DATE		S 1144462013		b					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be subject to criminal and civil penalties.

RESPONSE TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and confirms that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Veterans claim, the patient's signature authorizes any entity to release to Medicare medical and home health information and will verify the person is a carrier group health insurance, hobby, no-lit, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.2(b). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or TRICARE local office, state, city or town office and the current enrollment office for duplicate, concurrent and non-covered services. Consents and releases are based upon the change determinations in the VA/DoD carrier or TRICARE local/district authority file, and not in the change submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through commercial contracts with the Uniformed Services, whom claim is paid by the patient's sponsor or should be provided in those items captioned in "Insurance"; i.e., Items 1a, 4, 6, 7, 8 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and amounts coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, AND BLACK LUNG)

I, a physician, have read the form (and related forms) I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed, equitable and just payment decision; 4) the claim is neither submitted by me or on my behalf by my designated billing company, complete with all applicable Medicare and/or Medicaid forms, signatures, and appropriate documentation for payment, including but not limited to the Federal anti-fraud laws and Physician Self Referral law (commonly known as Stark); 5) the services on this form are not only necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise required by law; 6) I am not a member of TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license 4, or 888) of the primary individual in providing such services is reported in no decimal format. For services to be considered "incident to" a physician's professional services, it may be rendered under the physician's direction or supervision by his/her employee. 7) It may be an integral, although incidental part of a covered physician service; 8) the service must be of kind commonly furnished in physician's office, and 9) the services or non-physician must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 7332). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disease.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 414.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PAYOR/FI ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OIGCP to use you for information needed in the administration of the Medicare, TRICARE, FECA and Black Lung programs. Authority to collect information is in section 305(a), 162, 1879 and 1874 of the Social Security Act as amended, 42 CFR 411.26(a) and 424.5(a)(ii), and 44 USC 3101-3101 CFR 101.1 et seq and 10 USC 1070 and 1086, 5 USC 801-804, and 30 USC 901 - see 30 USC 613; E.O. 8897.

The information we obtain is used to compile, store and/or those programs is used to identify you and to determine your eligibility. It is also used to identify if the service(s) and supplies you received are provided by federal programs and to insure that proper payment is made.

The information may also be used to obtain payment of services, carriers, intermediaries, medical review boards, health plans, and other payors or entities or federal agencies. In the U.S. state administrative or federal programs, the relevant payor or federal agency may pay primary to Federal programs, and as otherwise necessary to administer the programs. For example, it may be necessary to disclose information about you if health providers need to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: Is in the notice preceding Form No. 00-70-0301, titled, "Carrier Medicare Claims Record" published in the Federal Register, Vol. 63 No. 177, page 37519, Vice, Sect. II, Part, or as amended and supplemented.

FOR OIGCP CLAIMS: Department of Labor, Privacy Act of 1974, "Reproduction of Pulse of Systems of Records," Federal Register Vol. 56 No. 40, Wrd L-B, 26, 1070, S-16 ESA-5, ESA-6, ESA-12, ESA-13, FSA-30, or as updated and replaced, d.

FOR TRICARE CLAIMS (PRIVACY AND CONFIDENTIALITY): To determine eligibility for medical care provided by civilian contractors and to issue payment items or bills based on eligibility and to monitor health care providers' compliance with laws and regulations authorized by law.

NOTICE TO PAYOR/FI: Information on claims and related documents, may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services, under the Dept. of Transportation contract with its statutory administrative representative, under TRICARE CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in court cases, to the Internal Revenue Service, private collectors and others, who consumer reporting agencies in connection with recompensation claims, and to Congressional offices in response to inquiries made of the agent of the payor to whom it is record or claim. Agreements or releases may be made to other federal, state, local, foreign government agencies, private health contractors, and individual providers of care, on matters relating to enrollment, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefit, and other functions related to the operation of TRICARE.

NOTICE TO PAYOR/FI: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is necessary that you fully understand that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for extraneous info submissions.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for services such as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-payment or similar cost-share charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: The fact that the foregoing information is true, accurate and complete, I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false or untrue statement, document, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Address to: U.S. Dept. of HHS, Office of Inspector General, 4500 Rockville Pike, Bethesda, MD 20892-1850. To respond to a request to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number is 1605-0001, 1605-0002, 1605-0003, 1605-0004, 1605-0005, 1605-0006, 1605-0007, 1605-0008, 1605-0009, 1605-0010, 1605-0011, 1605-0012, 1605-0013, 1605-0014, 1605-0015, 1605-0016, 1605-0017, 1605-0018, 1605-0019, 1605-0020, 1605-0021, 1605-0022, 1605-0023, 1605-0024, 1605-0025, 1605-0026, 1605-0027, 1605-0028, 1605-0029, 1605-0030, 1605-0031, 1605-0032, 1605-0033, 1605-0034, 1605-0035, 1605-0036, 1605-0037, 1605-0038, 1605-0039, 1605-0040, 1605-0041, 1605-0042, 1605-0043, 1605-0044, 1605-0045, 1605-0046, 1605-0047, 1605-0048, 1605-0049, 1605-0050, 1605-0051, 1605-0052, 1605-0053, 1605-0054, 1605-0055, 1605-0056, 1605-0057, 1605-0058, 1605-0059, 1605-0060, 1605-0061, 1605-0062, 1605-0063, 1605-0064, 1605-0065, 1605-0066, 1605-0067, 1605-0068, 1605-0069, 1605-0070, 1605-0071, 1605-0072, 1605-0073, 1605-0074, 1605-0075, 1605-0076, 1605-0077, 1605-0078, 1605-0079, 1605-0080, 1605-0081, 1605-0082, 1605-0083, 1605-0084, 1605-0085, 1605-0086, 1605-0087, 1605-0088, 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DENT
NEUROLOGIC INSTITUTE

Order Form for

Dent Tower 6th Flr

3980 Sheridan Drive, 6th Floor,
Amherst, NY, 142261727
Tel: 716-250-2000 Fax: 716-250-2045

Sydney B. Grabau, PA (NPI:1013323740)

Provider Code:

State License No: 017733

Physician Assistant

Patient: Harwell, Danielle

Order Date: 01/19/2017 02:45 PM

DOB: 08/29/1980 **Sex:** Female **Phone:** 716-536-0951

Today: 01/19/2017 03:10 PM

Address: 1131 Cleveland Dr, Cheektowaga, NY 14225

Primary Insurance Name:

Insurance Address:

Subscriber Number:

Insured Name: Address:

DIAGNOSTIC IMAGING:

Code	Diagnostic Name	Assessment(s)	Notes	Instructions
	MASSAGE Therapy	M79.1, Myofascial pain		

Sydney B. Grabau PA-C

Electronically Signed By: **Sydney B. Grabau, PA**

Signature of Patient/Guardian

Patient: Harwell, Danielle DOB: 08/29/1980

Great Lakes Therapeutic Massage & Bodywork Practitioners
373 Dick Rd Depew, NY 14043

Office: (716) 725-0824

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 1/30/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: D glute med + QL P, massage
helps release discomfort @ cerv
mm & mid thoracic tightness has

Action's Applied: (Check All that Apply) clased up a bit
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat Laser

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 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB P /discomfort still present

Neck & shoulder discomfort & LMB

mm still tight/sae but feel better

Action's Applied: (Check All that Apply) to touch Client

- Heat Packs Cold Packs Sombra/Biofreeze Staked
 Light Pressure Massage Moderate Pressure Massage message
 Deep Tissue Massage Myofascial Release Friction helps
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat Laser

Therapist: Chris Wayne

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0244

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 2/10/17Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: 'Low back feels locked' stated
client. Hard to move today.(B) SI Glute med, and Lumbosacral

Action's Applied: (Check All that Apply) Hydroclic, SI
 Heat Packs Cold Packs Sombra/Biofreeze Joint are jammed.
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat myof.

Therapist: Danielle Howell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0244

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 2/10/17Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

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 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
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 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: HBP still present w/ discomfort
going ↓ legs to knees (B). (B) Glutofighters
worked out norms. few mm to midAction's Applied: (Check All that Apply) Thoracic hot sox/light

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat myof.

Therapist: Danielle Howell

021317

021317

22403-352607

FREDRICKSBURG, VA 22403
P.O. BOX 9507
GEICO INS CO of NY



TO FEB 2017 PM 11
BUFFALO NY 142

Great Lakes Therapeutic Massage
Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14203



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

 PICA

PICA

1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP	HEALTH PLAN	FECA EXCLUDING	OTHER	16 INSURED'S ID NUMBER	(For Program In Item 1)
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input checked="" type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	013873940-0101-059	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
HARWELL, DANIELLE	MM DD YY	M <input type="checkbox"/> F <input checked="" type="checkbox"/>	- same -

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
56 BEREHEAVEN DR	Sell <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	

CITY	STATE	CITY	STATE
AMHERST	NY		

ZIP CODE	TELEPHONE (Include Area Code)	ZIP CODE	TELEPHONE (Include Area Code)
14228	(716) 536-0951		()

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO	11. INSURED'S POLICY GROUP OR FECA NUMBER
	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH

b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT?	SEX
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>

c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	b. OTHER CLAIM ID (Designated by NUCC)
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	c. INSURANCE PLAN NAME OR PROGRAM NAME

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits due to myself or to the party who accepts assignment below.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
--	---

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED - ON DATE - DATE 01-06-2016 SIGNED - ON DATE -

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)	15. OTHER DATE	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
01-31-2015	QUAL	QUAL	FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
SIXTYONE GRABAU, PA	17b. NPI	FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB?	\$ CHARGES
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))	ICD Ind.	22. REBMISSION CODE	ORIGINAL REF. NO.
A. <u>IN79.1</u>	B. <u> </u>	C. <u> </u>	D. <u> </u>
E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>
I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS	F. G. DAYS	H. I. ID	J. RENDERING	
From MM DD YY To MM DD YY	PLACE OF SERVICE ENG.	(Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	CHARGES	ON UNITS	CHARGE	PROVIDER ID #

1	02 13 17	02 13 17 11	97140			55 00	2	NPI	1144462031
2	02 20 17	02 20 17 11	97140			55 00	3	NPI	1144462031
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT FOR PAYMENT	28. TOTAL CHARGE	29. AMOUNT PAID	30. Reserved for NUCC Use
47-0989449	<input checked="" type="checkbox"/>	BARWELL, D	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ 110 00	\$ 0 00	110 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
	GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043	716 725-0264

COLLEEN MARX, LMT	02.20.2017	DATE	1144462011	1144462011
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SIGNED

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a civil and/or criminal offense under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and related information and whether the person has employer group health insurance, salary, no-salary, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency whose plan, benefits assigned or TRICARE participant the case is. The physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary for the full charge and TRICARE is responsible only for the deductible component and non-covered services. Insurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain providers of the Uniformed Services. Information in the patient's sponsor should be provided in those items captioned as "Insured" i.e., item 1a, 4, 5, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In signing this claim for patient item 1a, I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished myself with all applicable laws, regulations, and program instructions; 3) this claim, unless submitted by me or on my behalf by my designee or billing company, complies with all applicable laws, regulations, and program instructions; 4) the payment, including but not limited to the Federal rate-back, state and Physician Self-Referral, is community based as defined in the laws which immediately preceded and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly provided by Medicare, TRICARE, etc. 5) to the extent rendered incident to my professional service, the identify legal name and MBI license (or SSN) of the primary individual rendering such service is reported in the designated section. For services to be considered "incident" to a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of direct concern furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I am my employee who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 553a). For Black Lung claims I further certify that the services performed was not for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 414.32).

NOTICE: Any misstatement represents or facilitates user-made information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is: in section 205(a), 1082, 1082 and 1087 of the Social Security Act as amended, 42 CFR 411.24(a) and 494.5(a) (6), and 44 USC 3101, 1 CFR 101 et seq and 10 USC 1079 and 1085, 10 USC 3101 et seq, and 20 USC 901 et seq, 38 USC 613, E.O. 13397.

The information we obtain to complete claims and/or these programs is used to identify you and to determine your eligibility. It is also used to decide if the service(s) and supplies you request are covered by this program and to insure that proper payment is made.

This information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0901, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 60 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb 28 1990, See EBA-6, CSA 6, CSA-12, EGA-13, EBA-3, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/treatments received are authorized by law.

FOR VETERANS CLAIMS: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in actions before the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recovery claims; and to Congressional Offices in response to inquiries made at the request of the House or Senate in whom a record pertains. Appropriations disclosure may be made to other federal, state, local, foreign government agencies, private entities, contractors, and individual citizens, or, of course, on a need-to-know basis to entitlement claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, disclosure of CTC data, and current legislation related to the operation of TRICARE.

DISCLAIMER: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below there are no penalties and/or loss of payments for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under this program. Failure to furnish any other information, such as name or alias number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

Understand that under the P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

TRICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under this program, with the exception of authorized deductible, co-payment or similar cost-sharing charge.

STATEMENT OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false statement, misnomer, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

As required by 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 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather new data, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggested changes to improve this form, please write to CMS, 7500 Security Boulevard, Attn: PRA/Regulatory Clearance, OHRAC Mail Stop C4-20-05, Baltimore, Maryland 21245-1860. This address is for comment; under separate cover only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0324

Fax: (716) 725-0365

Client Name: Danielle Howell Date: 2/13/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB still feels locked. I believe my injections are wearing off.(Block P) & occiput to upper trapezius

Action/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat ner

Therapist:

Danielle Howell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0324

Fax: (716) 725-0365

Client Name: Danielle Howell Date: 2/20/17

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 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB still present around sacrum↓ leg. Client moving better today✓ looks less stiff. Block pain into

- Action/s Applied: (Check All that Apply)

Went for PT
- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.

Massage
- Follow-up w/ PT Stretches Con't Meds Ice / Heat ner

Therapist:

Danielle Howell

02 24 17

02 24 17

Great Lakes Therapeutic Massage

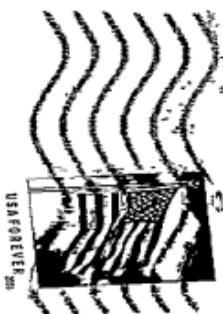
& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

BUFFALO NY 142
21 FEB 2017 PM 11



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403-952507

http://www.usps.com/uspsmailcenter



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

(NUCC)

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

NUCC

1 MEDICARE MEDICAID TRICARE CHAMPA GROUP HEALTH PLAN FEICA OTHER (Medicare) (Medicaid) (DOD/DoD) (Member ID#) (Non) (Billing) (Non) (Non)												1a INSURED'S ID NUMBER (For Program in Item 1) 013873940011059			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE						3 PATIENT'S BIRTH DATE MM DD YY 08291980						4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE						6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY CHEEKERTOWAGA			STATE NY			CITY AMHERST			STATE NY						
ZIP CODE 14225			TELEPHONE (Include Area Code) (716) 536 0951			ZIP CODE 14228			TELEPHONE (Include Area Code) (716) 536 0951						
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>NY</u>			
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d CLAIM CODES (Designated by NUCC)			
												11. INSURED'S POLICY GROUP OR FEICA NUMBER 08291980			
												a. INSURED'S DATE OF BIRTH MM DD YY M 08291980 F			
												b. OTHER CLAIM ID (Designated by NUCC)			
												c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 8, 9a, and 9d			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED SIGNATURE ON FILE												SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115												15. OTHER DATE QUAL MM DD YY 454 111215			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <u></u> 17b. <u>NPI</u>												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY <u></u>			
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY <u></u>			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to services line below (24))												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
a. M50.222 b. IM51.26 c. IM51.27 d. M54.12												22. RESUBMISSION CODE ORIGINAL REF NO			
e. I823.3XXA f. IM99.01 g. IM99.03 h. IM99.02												23. PRIOR AUTHORIZATION NUMBER			
i. IM99.05 j. IM54.2 k. IM54.5 l. IM54.6															
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B PLACE OF SERVICE ENG	C PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS	D MODIFIER	E DIAGNOSIS CODE FOOTER	F \$ CHARGES	G GROSS AMOUNT OF UNITS	H GROSS AMOUNT PER UNIT	I L ID QUAL	J PAYER ID #					
1. 02072017	02072017	11	99212	25	ABCD	20	29	1	NPI	1710014188					
2. 02072017	02072017	11	98941		ABCD	32	28	1	NPI	1710014188					
3. 02072017	02072017	11	97010		ABCD	10	53	1	NPI	1710014188					
4. 	 	 	 	 	 	 	 	 	NPI	 					
5. 	 	 	 	 	 	 	 	 	NPI	 					
6. 	 	 	 	 	 	 	 	 	NPI	 					
25. FEDERAL TAX ID NUMBER 364500165		BBN EIN 	26. PATIENT'S ACCOUNT NO 343821241		27. ACCEPT ASSIGNMENT? For govt. claims, see back <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE 63.10	29. AMOUNT PAID 5	30. Rcv'd for NUCC Use 						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in good faith.) PETER GOZINSKI DC												32. BILLING FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			
33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849															
SIGNED 02212017 DATE 1235256546^b												34. APPROVED OMB-0938-1197 FORM 1500 (02-12)			

Encounter dated 02/07/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 02/21/2017

movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Oswestry score:* 22%.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. Due to the pain, she is unable to lift heavy weights off the floor and she is unable to sit greater than 60 minutes. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since onset. *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 3/10. *Pain is* occasional. *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 22%. *The Keele STarT Back Screening Tool:* Low risk. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Activity of Daily Living Form Bending forward/backward: moderate impairment; Driving: mild impairment; Household chores: moderate impairment; Laundry: moderate impairment; Lifting less than 10 lbs: mild impairment; Lifting more than 10 lbs: moderate impairment; Kneeling: mild impairment; Making Meals: mild impairment; Prolonged Sitting more than 30 minutes: mild impairment; Putting shoes/socks on: mild impairment; Restful night's sleep: mild impairment; Seated to standing position: mild impairment; Sexual activity: mild impairment; Standing: mild impairment; Squatting: mild impairment; Tying shoes: mild impairment; Using lavatory: mild impairment.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* forward head carriage; rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck; Spinal Percussion C1-C7: Negative; left shoulder depression: Negative; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 20/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: 20/30 with pain lower back; right rotation: 20/30 with pain lower back; left lateral

Encounter dated 02/07/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/21/2017

bending: 15/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* all lower extremity sensory exams (L1-S1) were WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Reflexes:* bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 30 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative; Minor's sign: Negative; Slump Test: Positive bilateral for lower back pain; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for lower back pain on a cough or sneeze. *Spinal subluxation level(s):* L4, L5, Left SL. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Her condition has remained relatively unchanged since her last re-evaluation on December 6, 2016. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL.

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Prognosis: Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: Mrs. Harwell's lower back condition has been worse since her last re-evaluation on December 6, 2016. Active lumbar flexion decreased from 50 to 20 degrees, her left SLR decreased from 50 to 30 degrees and her right SLR decreased from 70 to 60 degrees and now with lower back pain. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to sit, bend, perform household chores and lift with less pain. *Post-treatment analysis:* patient tolerated treatment without incident.

Set backs: Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Encounter dated 02/07/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/21/2017

Treatment schedule: 1x/week for 4 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 8 weeks.
Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



Item# 43568
Patent Pending



02 24 17



345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
February 21, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday February 7, 2017 Provider: Peter Guzinski DC RE-EXAM

Electronically signed by Peter Guzinski DC on 02/12/2017 at 2:40pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver. Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights, she has moderate headaches which come infrequently, she can only do her usual work, but no more and her normal sleep has been moderately disturbed (1-2 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving. *since onset. Pain:* achy, dull, sharp, tingling, shooting, numb; level: 4/10. *Pain is occasional. Pain radiates to:* right shoulder; left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Cervical Disability Index:* 30%. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving. *since onset. Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is occasional. Exacerbates symptoms:*



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PIKA

1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN (DOD)	FECA BUILDING (DOI)	OTHER (DOI)	1a INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DoD)	<input type="checkbox"/> (Member ID)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOI)	<input type="checkbox"/> (DOI)		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
HARWELL DANIELLE			08291980					
5 PATIENT'S ADDRESS (No., Street)			6 PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT		
1131 CLEVELAND DRIVE			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
CITY CHEEKSTOWAGA	STATE NY	8 RESERVED FOR NUCC USE			CITY AMHERST			STATE NY
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951		
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR FECA NUMBER		
a OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		
b RESERVED FOR NUCC USE			b AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY			b OTHER CLAIM ID (Designated by NUCC)		
c RESERVED FOR NUCC USE			c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c INSURANCE PLAN NAME OR PROGRAM NAME GEICO		
d INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)			d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d		

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **SIGNATURE ON FILE**

DATE

14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115	15 OTHER DATE MM DD YY 0454 111215	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI 17b. NPI		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (S4E)) ICD 10 A IM50 222 B IM51 26 C IM51 27 D IM54 12 E IS23 3XXA F IM99 01 G IM99 03 H IM99 02 I IM99 05 J IM54 2 K IM54 5 L IM54 6							
22 REBEMISSION CODE ORIGINAL REF NO							
23 PRIOR AUTHORIZATION NUMBER							
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY B PLACE OF SERVICE EMR C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D CPT/HCPCS E MODIFIER F DIAGNOSIS PONTER			F \$ CHARGES	G DAYS OF WKS	H HOUR WEEKLY PER WKS	L ID QUAN.	J RENDERING PROVIDER ID #
1 01172017 01172017 11 98941 ABCD 32 28 1 NPI 1710014188							
2 01172017 01172017 11 97010 ABCD 10 53 1 NPI 1710014188							
3 01242017 01242017 11 98941 ABCD 32 28 1 NPI 1710014188							
4 01242017 01242017 11 97010 ABCD 10 53 1 NPI 1710014188							
5 NPI							
6 NPI							
25 FEDERAL TAX ID NUMBER SSN BIN 364500165 <input type="checkbox"/> 4348Z1240			26. PATIENT'S ACCOUNT NO 1235256546	27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE 85.62	29. AMOUNT PAID 8	30. Reserved for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this form are true and accurate to the best of my knowledge.) PETER GULINSKI DC			32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849	33 BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			

SIGNED **02212017** DATE**1235256546**

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
February 21, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday January 17, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 01/17/2017 at 9:39am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today stating that her neck pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, shooting, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left shoulder, right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she had a really bad headache over the weekend but she has been better since. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, shooting. Range: 3->4/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Recent medical treatment for this condition:* None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, shooting, numb; level: 3/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain left lower neck ; right lateral bending: 35/45 with pain left lower neck . *Posture:* forward head carriage; rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical

Encounter dated 01/17/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 02/21/2017

paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Mild to Moderate; Thoracic paraspinal musculature Right Mild. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Negative right at 70 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Encounter dated 01/17/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/21/2017

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 1 week; 1x every 2 weeks for 2 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Tuesday January 24, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 01/24/2017 at 10:07am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain has not been as intense. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting, numb. *Range:* 2->3/10. *Pain is constant.* *Pain radiates to:* left shoulder, right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical

Encounter dated 01/24/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 02/21/2017

activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing.
Numbness: none. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No.
Headaches: Patient stated that she had a bad headache on Sunday, but better today. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, tight; level: 4/10. **Pain is occasional.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Recent medical treatment for this condition:** None.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that the pain has been radiating into both posterior thighs and legs. "I think the shot feels like is slowly wearing off." Follow up with Dr. Siddique on February 14, 2017. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, burning, dull, tingling, numb; level: 4/10. **Pain is occasional.** **Pain radiates to:** left posterior thigh and leg, right posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** none, bilateral posterior thigh and leg. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain left lower neck ; right lateral bending: 35/45 with pain left lower neck . **Posture:** forward head carriage; rounded shoulders. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Left Mild to Moderate; Thoracic paraspinal musculature Right Mild. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by motion and static palpation.**

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well

Encounter dated 01/24/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/21/2017

leg raise: Negative right at 70 degrees; Bechterew: Negative. *Spinal subluxation level(s): L4, L5, Left SI.*
Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, VAS score improved from a 4 to 2 to 3 out of 10. *Prognosis:* Guarded.

Post-treatment analysis: patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: worse, pain now radiating into right posterior thigh and leg. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 1 week; 1x every 2 weeks for 2 weeks; Re-examination for 3 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10

Encounter dated 01/24/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/21/2017

daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to February 28, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits
VAS: Visual Analog Scale



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/15

GEICO Ins Co NY
P.O. Box 9507
Fredricksburg, VA 22401

-68-

PATIENT AND INSTITUTION INFORMATION

MÄRZ 1990 - 11

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

PARTIES: Any person who files a complaint or a motion containing any misrepresentation or any false, incomplete or misleading information may be guilty of a contempt of court and may be subject to civil penalties.

PAPERS TO GOVERNMENT PROGRAMS ONLY

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Three-Part Alignment of the Internal and External Data Sources in Order to Address and FEELs in the Future *Addressing the three data sources and defining the three parts of the alignment process will help to ensure that the system can be used effectively.*

SIGNATURE OF PATIENT OR GUARDED BY A PROXY (HICAP, TRICARE, PEOA AND BLACK LUNG)

For TRICARE claims, I further certify that (i) any employee who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government, (ii) no claim or inquiry (refer to 3 USC 853g). For Blue-Card claims, I further certify that the services performed were for Blue-Card qualified standards.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations [42 CFR 425.321].

3001CCDC: Any one who misrepresents or fabricates essential information to receive payment from Federal funds requested by this item may upon conviction subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PICA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and GMECP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to obtain information on you in section 203(h), 1872, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.3(e)(1) and 424.5(a)(6), see 1 USC Section 101 et seq. and 10 USC 1670 and 1675; 18 USC 8701 et seq. and 30 USC 601 et seq., see 38 USC 4101 et seq. E.O. 13690

This application is given in compliance with the law to identify you and to determine your eligibility. It is also used to decide if the services and supplies you require are covered by basic income and/or other social insurance programs.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the purpose of administration of Federal programs that require other third party payers to pay primary to Federal programs and as otherwise necessary to administer the programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine use for utilization control of systems of automated data processing.

PDF ID: ED-2024-CIA-0175; See the notice publishing system item No. 69-70-0501, titled, "Cancer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549.

FOR OFFICERS: Department of Labor, Privacy Act of 1974 "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28 1990, See ESA-5 ESA-6, ESA-12 CRA-10 EHA-30 as reprinted and consolidated.

FOR THIS/CASE, CLINIC/PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and continuation of care.

Individuals listed in Information item claims and related documents may be given to the Govt. of Victoria's Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation.

Revenue Services, private collection agencies, and consumer reporting agencies in connection with a consumer dispute, and to Congressional Officers in response to inquiries made by the request of the person whom a complaint pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and non-governmental entities, or can, on a needs-to-know confidential basis, disclosure be made to insurance companies, health care providers, pharmaceutical companies, and medical facilities related to the operation of TRICARE.

-850-755-1515. Verifying services, looks to provide information will result in delay as payment or may result in denial of claim. With one exception deposit of bill, there are no fees associated with this service. A physician or provider is responsible to supply information. However, failure to furnish information regarding the medical service rendered or the amount charged would prevent payment of claim, and a physician's failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information within 30 days of request will result in denial of claim.

I am unable to self-serve, hence I'm not a party to responsible for paying for your services. Section 1(b)(B) of the Small Business Act am 31 USC 3801-3812 provides:

This should be noted, that P.L. 84-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information lawfully by computer matching.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to have such records as are necessary to document fully the extent of services we provide to individuals under the State's Title XIX plan and to furnish information regarding any services and/or claims we provide, such services or the State Agency or Dept. of Health and Human Services may request.

Health care providers may be paid by the Medicaid program for their claims submitted for payment under that program, but the exception of all non-drug deductible, copayments, and other health care charges.

SIGNATURE OF PHYSICAL (OR SUPPLY)I I certify that the services listed above were medically indicated and necessary to the health of my patient and were personally furnished by me or my employee & is not for my personal protection.

(b) (5)(C) This is to certify that the foregoing information is true, accurate and complete. I further stand that payment and satisfaction of this claim will be from Federal and State funds, and nothing herein, whether true, or untrue, or the omission of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0208-1197. This form requires 6 to complete and return 10 minutes for responses, including the time for review. If you have any comments concerning the accuracy of the instructions or burden estimate, please contact the Office of Management and Budget, Paperwork Reduction Project, Washington, DC 20585, telephone (202) 501-1074.

03 03 17

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0634

Fax: (716) 725-0355

Client Name: Danielle Howell Date: 2/24/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R+L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB feels "looser", & hyperactivity
in glutes & QLs. Occipital region
tightness, some w/ R upper trap &
upper trapezius.Action's Applied: (Check All that Apply) Anne's area

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat/more

Therapist:

Donna May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0634

Fax: (716) 725-0355

Client Name: Danielle Howell Date: 2/27/17 D.H.

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R+L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client slightly "tighter," today, can
tell by how she's moving. LB slight fir
tightness of neck & glutes + sacrum. Cerv.
Action's Applied: (Check All that Apply) mm to up trap, shoulder.

- Heat Packs Cold Packs Sombra/Biofreeze Moderate Pressure Massage hyperactive
 Light Pressure Massage Moderate Pressure Massage hyperactive
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat/more

Therapist:

Donna May

03-03-17

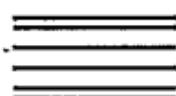
03 03 17

Great Lakes Therapeutic Massage

& Bodywork Practitioners
375 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Marx

BUFFALO
NY 142

28 FEB '17
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIMS COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA SICKLIST OTHER <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FECA) <input type="checkbox"/> (Sicklist) <input type="checkbox"/> (Other)												1a INSURED'S ID NUMBER 013873940011059			(For Program in Item 1)		
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08291980			4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT		
CITY CHEKTOWAGA		STATE NY		8 RESERVED FOR NUCC USE		CITY AMHERST		STATE NY		ZIP CODE 14225			TELEPHONE (Include Area Code) (716) 536 0951				
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO: a OTHER INSURED'S POLICY OR GROUP NUMBER b RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d INSURANCE PLAN NAME OR PROGRAM NAME			11 INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY 08291980		
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO		
												12 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other to myself or to the party who accepts assignment below					
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115												15 OTHER DATE MM DD YY QUAL 454 111215			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI												17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
18 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to section 1a to answer line below (24e)) a M50.222 b M51.26 c M51.27 d M54.12 e IS23.3XXA f M99.01 g M99.03 h M99.02 i M99.05 j M54.2 k M54.5 l M54.6												20. REBURNSSION CODE ORIGINAL REF NO.					
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY 1 02142017 02142017 11												25. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			26. DIAGNOSIS CODE POINTERS F CHARGES G H I J K L M N O P Q R S T U V W X Y Z ABCD		
27. ACCEPT ASSIGNMENT I HEREBY AGREE TO THE TERMS AND CONDITIONS PETER GOZINSKI DC 345 DICK ROAD DEPEW NY 140431849												28. TOTAL CHARGE \$ 42181.5			29. AMOUNT PAID \$		
30. FEDERAL TAX ID NUMBER 364500165												31. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849					
32. PATIENT'S ACCOUNT NO 343821242												33. SERVICE FACILITY LOCATION INFORMATION					
34. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse of this form are true and correct.) PETER GOZINSKI DC																	
35. SIGNED 03062017 DATE 1235256546												36. APPROVED OMB-0938-1197 FORM 1500 (02-12)					

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
March 6, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday February 14, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 02/14/2017 at 5:31pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since onset.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->4/10. *Pain is occasional.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since onset.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that her legs have not been as sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since onset.* *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 2->3/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy; Pain management evaluation with injection schedule for March 30, 2017. *Changes in past medical history:* None.

Objective

Encounter dated 02/14/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 03/06/2017

Cervical: Range of motion: flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. Posture: forward head carriage; rounded shoulders. Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. X-ray findings: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C5, C6, left first rib. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Mild-to Moderate. Trigger points: bilateral rhomboids. Orthopedic tests: Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: WNL 60/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: improving, Active lumbar ROM improving since last visit and her left SLR improved from 30 to 60 degrees and now without pain. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

**Encounter dated 02/14/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/06/2017**

mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

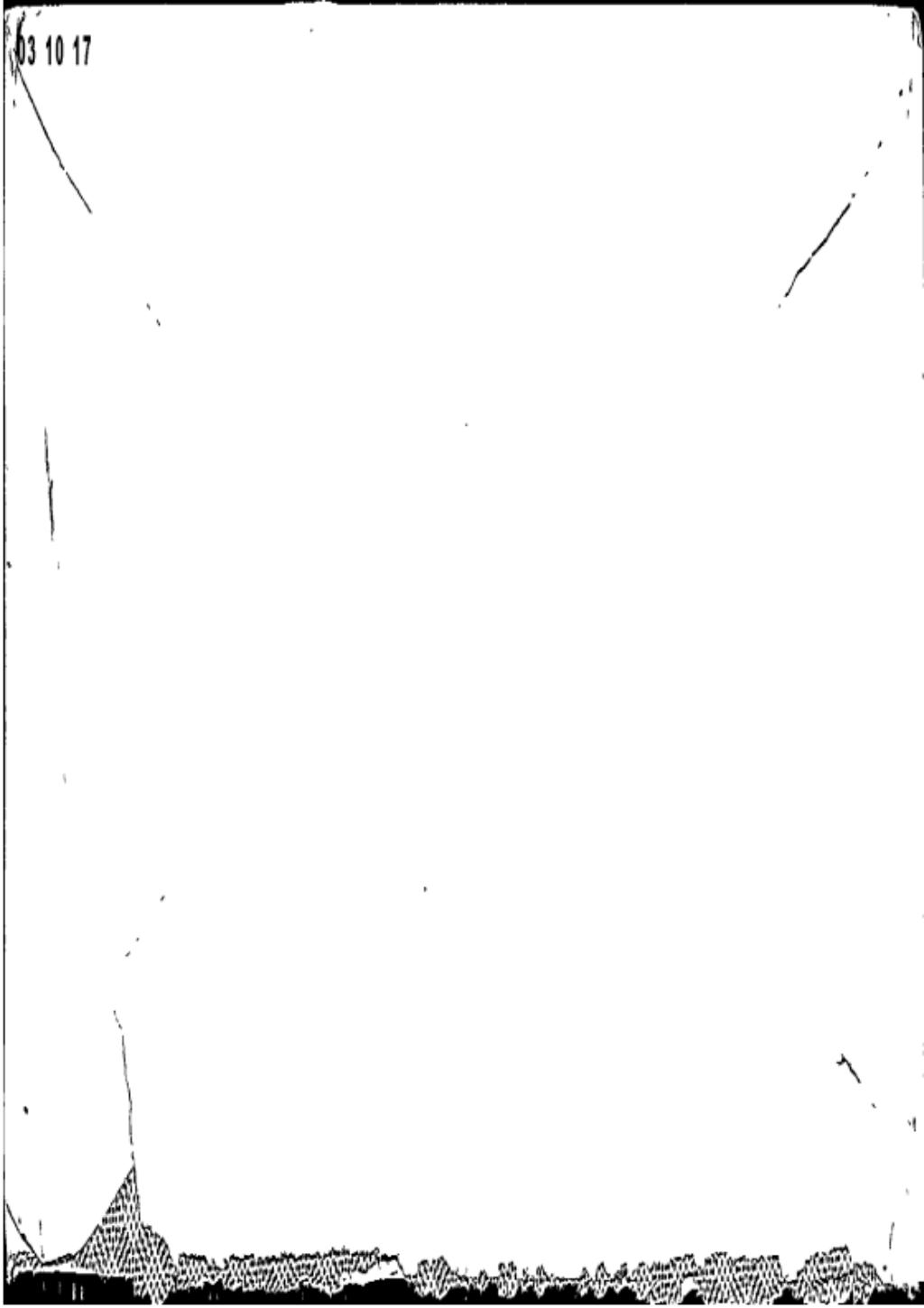
Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 3 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 7 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



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FREDERICKSBURG VA 22403-9526
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GEICO



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LANCASTER DEPEW CHIROPRACTIC
345 DICK ROAD
DEPEW NY 14243



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BENEFITS OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFITS <input type="checkbox"/> Other										1a INSURED'S ID NUMBER (For Program in Item 1) 013873940011059			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE										3 PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> 08291980			
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE										6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY CHEEKTONWAGA		STATE NY		8 RESERVED FOR NUCC USE		CITY AMHERST		STATE NY					
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951					
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>NY</u>			
										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d INSURANCE PLAN NAME OR PROGRAM NAME										11 INSURED'S POLICY GROUP OR FECA NUMBER GEICO			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d			
SIGNED SIGNATURE ON FILE DATE										SIGNED SIGNATURE ON FILE			
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115		15 OTHER DATE QUAL 454		MM DD YY 111215		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI 17b. NPI										18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refine A-L to services line below (24E) ICD IND 0										22 RESUBMISSION CODE ORIGINAL REF NO.			
A M50.222		B M51.26		C M51.27		D M54.12		23. PRIOR AUTHORIZATION NUMBER					
E I823.3XXA		F M99.01		G M99.03		H M99.02							
I M99.05		J M54.2		K M54.5		L M54.6							
24. A. DATES OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. CPT/HCPCS F. MODIFIER										G. CHARGES H. DRUGS OR UNITS I. DRUGS J. RENDING PROVIDER ID #			
1	03022017	03022017	11	98941		ABCD	32 28 1	NPI	1710014188				
2	03022017	03022017	11	97010		ABCD	10 53 1	NPI	1710014188				
3	03092017	03092017	11	98941		ABCD	32 28 1	NPI	1710014188				
4	03092017	03092017	11	97010		ABCD	10 53 1	NPI	1710014188				
5								NPI					
6								NPI					
25 FEDERAL TAX ID NUMBER 364500165		SSN BIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26 PATIENT'S ACCOUNT NO. 343821243		27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28 TOTAL CHARGE \$ 85.62		29 AMOUNT PAID \$ 0			
30. Billed for NUCC Use <input type="checkbox"/> <input checked="" type="checkbox"/>										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse of this form are true and correct.) TERESA GOLINSKI DC			
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849										33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			
SIGNED 03162017 DATE 1235256546^a										34. PLEASE PRINT OR TYPE 1235256546^b			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 14043-1849
716-681-3333
March 16, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday March 2, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 03/02/2017 at 8:37am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. She states that she has noticed increased headaches as well. She states that she feels like the room is spinning. "I feel like on a rocking boat. It comes out of nowhere." Patient saw neurologist who ordered a new cervical and head MRI. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* slightly worse, *since* last week. *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->5/10. *Pain is* occasional. *Pain radicates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she has been experiencing daily headaches. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, *since onset.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is* occasional. *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that she has an injection scheduled for March 30, 2017 with Dr. Siddique. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* slightly worse, *since* last visit. *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 3->4/10. *Pain is* occasional. *Pain radicates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Encounter dated 03/02/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 03/16/2017

Objective

Cervical: Range of motion: flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. Posture: forward head carriage; rounded shoulders. Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. X-ray findings: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C1, C2, C5, C6, left occiput, left first rib. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Mild to Moderate. Trigger points: bilateral rhomboids. Orthopedic tests: Spinal percussion T1-T12: Negative; Shepplemans: Negative bilateral. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: 40/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** worse, increased headaches. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: slightly worse, active flexion decreased from 60 to 40 degrees. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space

Encounter dated 03/02/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/16/2017

narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.
Treatment schedule: 1x/week for 2 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 6 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization); C1 left lateral flexion restriction (Instrument adjustment Arthrostim); C2 left lateral flexion restriction (Instrument adjustment Arthrostim). *Physical*

Modalities: bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Thursday March 9, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 03/09/2017 at 4:40pm

Encounter dated 03/09/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/16/2017

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. She states that the headaches remain the same. Patient saw neurologist who ordered a new cervical and head MRI. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last week.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->5/10. *Pain is occasional.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she states that she has been experiencing daily headaches. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since onset.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that she has an injection scheduled for March 30, 2017 with Dr. Siddique. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 3->4/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* forward head carriage; rounded shoulders. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C1, C2, C5, C6, left occiput, left first rib. *Subluxations detected by:* motion and static palpation.

Encounter dated 03/09/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/16/2017

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Mild to Moderate. Trigger points: bilateral rhomboids. Orthopedic tests: Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: 40/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechtere: Negative. Spinal subluxation level(s): L4, L5, Left SL. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). Cervical assessment: unchanged. Prognosis: Guarded. Post-treatment analysis: patient tolerated treatment without incident. Set backs: Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. Thoracic assessment: unchanged.

Lumbar assessment: unchanged. Post-treatment analysis: patient tolerated treatment without incident. Set backs: Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. Treatment schedule: 1x/week for 1 week; 1x every 2 weeks for 4 weeks; Re-examination for 5 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction

Encounter dated 03/09/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/16/2017

(anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization); C1 left lateral flexion restriction (Instrument adjustment Arthrostim); C2 left lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

- *Postscript* This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations

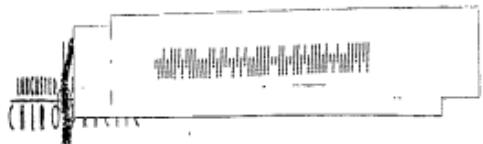
ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

03 20 17



Item# 43568
Patent Pending

03 20 17



345 Dick Rd.
Depew, NY 14043



Geico
P.O. Box 9507
Fredericksburg, VA 22403

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TRICARE <input type="checkbox"/> Other (DoD)	CHAMPVA <input type="checkbox"/> Member ID#	GROUP HEALTH PLAN <input type="checkbox"/> DOD	FICA EXCLNG <input type="checkbox"/> DOD	OTHER <input checked="" type="checkbox"/> DM	1a. INSURED'S ID. NUMBER 0138739400101059 (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY 08 29 80			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/> X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE	
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE		
CITY CHEEKTOWAGA		STATE NY	8. RESERVED FOR NUCC USE			CITY CHEEKTOWAGA		
ZIP CODE 14225	TELEPHONE (Include Area Code) ()					STATE NY	ZIP CODE 14225	TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10e. CLAIM CODES (Designated by NUCC)					

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature On File

DATE 2/28/2017

Signature On File

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

below.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

MM DD YY MM DD YY MM DD YY
10 31 15 439 10 31 15

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. 18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

DN J PETER GUZINSKI NM 1710014188

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e) ICD IND 0

a. M54.16 b. M51.26 c. l d. l e. f. g. h. i. k. l. j. l.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
NOT REQUIREDF. G. H. I. J.
\$ CHARGES G. CHARGES H. EPDS I. IO J. RENDERING
CPT/HCPCS MODIFIER Family Ref. QMPL PROVIDER ID. #

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS

MM DD YY MM DD YY ENG CPT/HCPCS MODIFIER POINTER

02 14 17 02 14 17 11 99214 AB 74 79 1 DB 248830

NPI 1023202355

NPI

Carrier Manifest

GEICO
PO BOX 9507
FREDERICKSBURG, VA 224039998

Total Claims: 20
Claims per Organization:

excelsior orthopaedics, llp : 10
Lattimore of Geneseo Physical Therapy : 3
Timothy D Groth MD PC : 5
Vericle : 2

Organization Manifest

Lattimore of Geneseo Physical Therapy(3)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03514433301010382		CULLINAN, COURTNEY	03/02/2017	03/02/2017
03514433301010383		CULLINAN, COURTNEY	02/23/2017	02/23/2017
03514433301010382		CULLINAN, COURTNEY	02/28/2017	02/28/2017

Organization Manifest

Timothy D Groth MD PC(5)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03900769101010371		MICHAEL, ANDREW	02/20/2017	02/20/2017
01875351701010831		DULLIGAN, ELIZABETH	02/20/2017	02/20/2017
01875351701010833		DULLIGAN, ELIZABETH	02/20/2017	02/20/2017
01671972701010693		SOTO, LOUIS	02/20/2017	02/20/2017
02080186201010164		JACKSON, KEVIN	02/22/2017	02/22/2017

Organization Manifest

Vericle(2)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
039370170	8	PIAMPIANO, MARIO	03/08/2017	03/08/2017
04489997601010332		DUGGAN, ROBERT	03/13/2017	03/13/2017

Organization Manifest

excelsior orthopaedics, llp(10)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03117153401010102		BUXTON, CAROL	02/15/2017	02/15/2017
02462915701010701		WOOD, KELLY	03/06/2017	03/06/2017
03129677201010322		BRYANT, CARMEN	02/15/2017	02/15/2017
02049589501010902		SMITH, ALVAR	02/17/2017	02/17/2017
04084418701010152		FOLGER, ROBERT	02/13/2017	02/13/2017
04308381601010211		GOLDEN, KIESHA	03/03/2017	03/03/2017
04084418701010152		FOLGER, ROBERT	02/15/2017	02/15/2017
04778404801010403		FORD, CROSBY	03/07/2017	03/07/2017
02631624901010941		COLE, DIAN	03/08/2017	03/08/2017
04326764101010882		SLOCUM, ROBERT	03/08/2017	03/08/2017

Carrier Manifest

Geico
P O BOX 9507
Fredericksburg, VA 22403-9526

Total Claims: 262 Claims per Organization:

Brain and Spine Center : 14
CareMount Medical, P.C. : 21
CLINICAL PRACTICE MANAGEMENT PLAN : 56
Comprehensive Orthopedic and Spine Care : 21
DRCHRONO : 1
DuBois Physical Therapy : 1
Empower Doctors llc : 6
Empowerdrs : 72
Medical Pain Management Services, PLLC : 1
ORANGE RADIOLOGY AND MRI OF NEWBURGH : 11
Quadex Healthcare Solutions, Inc : 15
RAMAPO DIAGNOSTIC IMAGING : 1
ST. JOSEPH IMAGING ASSOCIATES : 1
Timothy D Groth MD PC : 3
Total Orthopedics, Spine & Sports Medicine : 4
University Orthopaedic Services, Inc. : 16
Upstate Emergency Medicine Inc : 1
Upstate University Medical Assoc at Syr : 14
Vericle : 3

Organization Manifest

CLINICAL PRACTICE MANAGEMENT PLAN(56)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
00097308001011591		GONENN, BRENDA	03/09/2017	03/09/2017
05776381601010101		HERRERA, DALILA	02/14/2017	02/14/2017
00188244301014051		REIS, DAWN	03/06/2017	03/06/2017
03994969601012683		MONTIJO, NINA	03/01/2017	03/01/2017
01851017801011042		ALFANO, NICHOLAS	03/08/2017	03/08/2017
00470503801010891		SCOVETTA, VINCENT	03/04/2017	03/04/2017
01851017801011041		ALFANO, NICHOLAS	03/08/2017	03/08/2017
01851017801011044		ALFANO, NICHOLAS	03/07/2017	03/07/2017
04561505401010211		DEVITA, MEAGAN	03/06/2017	03/06/2017
05601619601010141		ISLAM, GOHAR	03/09/2017	03/09/2017
03084063701010481		GROCHOWSKI, DANIELLE	03/08/2017	03/08/2017
00097308001011591		GONENN, BRENDA	03/09/2017	03/09/2017
01964549001011251		TALIA, ARIONA	03/09/2017	03/09/2017
04914491601010232		MILLER, JESSICA	03/08/2017	03/08/2017
04461955701010481		HAFEEZ, ABDUL	03/03/2017	03/03/2017
05542408301010382		DATTILO, JACQUELINE	03/02/2017	03/02/2017
01851017801011043		ALFANO, NICHOLAS	03/07/2017	03/07/2017
04075786101010101		BRAY, EDWARD	03/09/2017	03/09/2017
01851017801011041		ALFANO, NICHOLAS	03/07/2017	03/07/2017
018510178010110417		ALFANO, NICHOLAS	03/07/2017	03/08/2017
03932191301010342		AFFENITA, HEATHER	02/28/2017	02/28/2017
01851017801011042		ALFANO, NICHOLAS	03/09/2017	03/09/2017
05695249201010211		PANTALEO, ELISABETH	03/01/2017	03/01/2017
04075786101010101		BRAY, EDWARD	03/09/2017	03/09/2017
04075786101010101		BRAY, EDWARD	03/10/2017	03/10/2017
01851017801011041		ALFANO, NICHOLAS	03/09/2017	03/09/2017
01851017801011041		ALFANO, NICHOLAS	03/08/2017	03/08/2017
04914491601010231		MILLER, JESSICA	02/16/2017	02/16/2017
01851017801011042		ALFANO, NICHOLAS	03/07/2017	03/07/2017
04497988201010853		FALLAR, JAMES	03/03/2017	03/03/2017

Organization Manifest

CLINICAL PRACTICE MANAGEMENT PLAN(56)

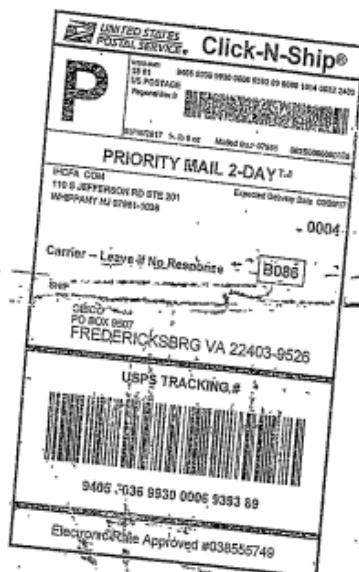
<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
05776381601010101		HERRERA, DALILA	02/04/2017	02/04/2017
03183186201010171		HOHENRATH, WALTER	02/08/2017	02/08/2017
04719156701010121		SAHADEO, DARSHANIE	02/12/2017	02/12/2017
03232617701010361		PETRIE, ELIZABETH	03/09/2017	03/09/2017
04719156701010121		SAHADEO, DARSHANIE	02/12/2017	02/12/2017
05545378601010141		MAGEE, KERISA	03/09/2017	03/09/2017
05293727901010621		ALLEN, VICTORIA	02/04/2017	02/04/2017
04497988201010851		FALLAR, JAMES	02/06/2017	02/06/2017
00188244301014051		REIS, DAWN	03/13/2017	03/13/2017
03232617701010361		PETRIE, ELIZABETH	03/09/2017	03/09/2017
04574129901010371		CHEESEWRIGHT, SUROJINIE	03/08/2017	03/08/2017
01851017801011041		ALFANO, NICHOLAS	03/09/2017	03/09/2017
05545378601010143		MAGEE, KERISA	03/08/2017	03/08/2017
05695249201010211		PANTALEO, ELISABETH	03/09/2017	03/09/2017
04719156701010121		SAHADEO, DARSHANIE	02/20/2017	02/20/2017
03912353201010321		DIFRANCESCO, DANIELLE	03/10/2017	03/10/2017
04719156701010121		SAHADEO, DARSHANIE	02/20/2017	02/20/2017
05390042501010131		THOMPSON, KIM	02/04/2017	02/04/2017
05390042501010131		CAMPBELL, ANMINE	02/04/2017	02/04/2017
04075786101010101		BRAY, EDWARD	03/11/2017	03/11/2017
04719156701010125		SAHADEO, DARSHANIE	02/12/2017	02/12/2017
05646037201010461		MUHAMMAD, LATYLAH	02/28/2017	02/28/2017
01172534601010871		RAMIREZ, MARITZA	01/25/2017	01/25/2017
05695249201010211		PANTALEO, ELISABETH	03/09/2017	03/09/2017
05545378601010141		MAGEE, KERISA	03/08/2017	03/08/2017
04719156701010121		SAHADEO, DARSHANIE	02/20/2017	02/20/2017

03 22 17



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February 14, 2017

James Panzarella, DO
1208 Niagara Falls Boulevard
Tonawanda, NY 14150

Patient Name:	Danielle Harwell
Date of Birth:	08/29/1980
No-Fault Carrier:	NF Geico
CL#:	0138739400101059
Date of Injury:	10/31/15

Physiatry Re-evaluation: February 14, 2017

Chief Complaint(s): Neck pain, low back pain and bilateral leg pain, headaches.

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle Harwell in our Park Club Lane office for a re-visit on February 14, 2017.

HISTORY/CHIEF COMPLAINT

This is a 36-year-old female presenting today for re-evaluation. She reports overall her pain seems somewhat better at today's evaluation. She rates her pain score today 4/10 on the visual analog scale. This mostly has to do with her headaches and neck pain. She does feel that her low back pain improved following a caudal epidural injection in late October 2016, but at this point is noting some of her pain is recurring. She continues with chiropractic care, as well as medical massage therapy. She is utilizing naproxen for anti-inflammatory relief. She is following with Dr. McGive at Denl Neurologic Institute for her chronic headaches. Standing, coughing, lifting and walking aggravate her symptoms. She states that frequent position changes and activity changes help to keep her pain more tolerable. Despite her pain, she does manage a home, taking care of paraplegic husband, as well as three children. She denies clumsy hands, unsteady gait, bowel or bladder dysfunction or weakness. It is to be noted the patient did have some urinary retention and numbness for about 12 hours after her last caudal injection. She would be interested in pursuing further intervention at this time. There have been no other changes to her health history.

PHYSICAL EXAMINATION

BP Sitting: 127/86 **Pulse:** 91 **Resp:** 16 **Ht:** 63" **Wt:** 165lb **BMI:** 29.2

General: This is a 36-year-old female, in no acute discomfort. She is awake, alert and appropriate. Speech is fluent and coherent.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are pink and moist.

Cardiovascular: Normal S1, S2.

Abdomen: Soft, non-distended, obese.

Neuromusculoskeletal: The patient demonstrates well-preserved strength throughout the upper and lower limbs. Sensory examination is intact. She demonstrates symmetric muscle bulk and tone. There is limited range of motion at the lumbar spine with components of extension-based back pain. There is also some tenderness to the lumbar paraspinal muscles. She ambulates with a non-antalgic gait.

Psychiatric: Judgement and cognition are within normal limits.

ASSESSMENT

M54.16 - Radiculopathy, lumbar region, M51.26 - Other intervertebral disc displacement, lumbar region

IMPRESSION/RECOMMENDATIONS:

This is a 36-year-old female with neck, low back pain and headaches status post a motor vehicle accident. Lumbar MRI is significant for multi-level lumbar degenerative disc disease and facet joint arthropathy most concentrated L3-S1, paralumbar disc protrusion/herniations L4-5 and L5-S1 with elements of sacroiliac joint dysfunction and myofascial pain syndrome. At this time we recommend the patient undergo a repeat caudal epidural steroid injection. She reports greater than 50% improvement from an injection that was completed in late October 2016. She would like to proceed. Additionally, I have recommended the patient attempt a course of aquatic physical therapy. This was also recommended to her by her chiropractor as well. A script was provided. She will continue to follow with Dent Neurologic Institute for treatment of her headaches. She will continue with her medication regimen as detailed above. She will continue with her medical massage therapy. I will see her back one month following her injection or sooner as clinically warranted.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

Sincerely,

Electronically signed by Sarah O'Mara, PA-C on 03/10/2017 at 1:21 pm
Sarah O'Mara, PA-C

Electronically signed by Jafar Siddiqui, M.D. on 03/11/2017 at 11:33 pm
Jafar Siddiqui, M.D.

SO/abb

cc: Peter Guzinski, DC

Carrier Manifest



GEICO NY PIP
PO BOX 9507
FREDERICKSBURG, VA 224039998

Total Claims: 6
Claims per Organization:

Family Care Medical Group : 1
Lattimore of Geneseo Physical Therapy : 5

Notice: Please do not mail correspondence to IHCFCA. All correspondence should be directed to the provider listed on each claim form. The contents of this package are confidential, and intended for the addressee only. This may contain information that is privileged or exempt from disclosure under applicable law, including the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient(s), you are notified that the dissemination, distribution, or copying of this package and/or its contents is strictly prohibited. If you receive this package in error or are not the named recipient(s), please notify IHCFCA at PO Box 2016, Morristown, NJ 07962; 973-795-1641 ext 400. Thank you. ** DATE ENERATED: 3/17/2017 **

Organization Manifest

Family Care Medical Group(1)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03065903301010321		RUSSELL, WANDA	03/02/2017	03/02/2017

Organization Manifest

Lattimore of Geneseo Physical Therapy(5)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
051090510101020 1		HINT, MARIE	03/02/2017	03/02/2017
051090510101020 1		HINT, MARIE	02/27/2017	02/27/2017
051090510101020 1		HINT, MARIE	02/20/2017	02/20/2017
051090510101020 1		HINT, MARIE	02/17/2017	02/17/2017
051090510101020 1		HINT, MARIE	02/22/2017	02/22/2017

Carrier Manifest

||||||||||||||||||||||||||||||||||||||

GEICO INSURANCE NY PIP
PO BOX 9507
FREDERICKSBURG, VA 224039526

Total Claims: 19
Claims per Organization:

UB Neurosurgery, Inc : 17
WEST HUDSON IMAGING ASSOCIATES PLLC. : 2

Organization Manifest

UB Neurosurgery, Inc(17)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
02638852501010331		SPEAKER, KELLY	02/07/2017	02/07/2017
04466943601010101		FENZEL, PATRICIA	02/07/2017	02/07/2017
03498301401010721		MARTEN, DENISE	02/07/2017	02/07/2017
01387394001010591		HARWELL, DANIELLE	02/14/2017	02/14/2017
03957638901010132		KANE, KARA	02/27/2017	02/27/2017
04264453101010382		COMBS, STACIE	02/27/2017	02/27/2017
05657197501010182		WEIGEL, BENJAMIN	02/28/2017	02/28/2017
05354554601010174		SCOTT, CAROL	03/02/2017	03/02/2017
03783470901010141		PODSIADLO, FELICIA	02/28/2017	02/28/2017
05063327101010371		BARAN, REBECCA	02/28/2017	02/28/2017
00673453801011462		LEVIN, SCOTT	03/01/2017	03/01/2017
03886825801010432		THOMAS, GREGORY	02/28/2017	02/28/2017
03125577901010443		O'CONNOR, RIANNA	02/28/2017	02/28/2017
01730813901010541		BROOKS, CATHERINE	02/27/2017	02/27/2017
02838188701010891		BRILL, BETH	02/27/2017	02/27/2017
03133602501010861		BAX, DANIEL	02/27/2017	02/27/2017
05354554601010174		SCOTT, CAROL	02/28/2017	02/28/2017

Organization Manifest

WEST HUDSON IMAGING ASSOCIATES PLLC. (2)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
00092009300	1	ORDONEZ, CARMEN	01/29/2017	01/29/2017
05345767301010151		ANDRADEZ, JEANMARIE	03/10/2017	03/10/2017



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0812

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA												FICA											
1. MEDICARE			MEDICAID			TRICARE			CHAMPVA			GROUP	FECA	OTHER	14. INSURED'S STD. NUMBER								
<input type="checkbox"/> Medicare			<input type="checkbox"/> Medicaid			<input type="checkbox"/> TRICARE			<input type="checkbox"/> CHAMPVA			<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> GROUP	<input type="checkbox"/> OTHER	(For Programs Item 1)								
															013873940-0101-059								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE						SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)								
BARNHILL, DANIELLE						MM DD YY						M <input type="checkbox"/> F <input checked="" type="checkbox"/>			BARNHILL, DANIELLE								
OB 29 1980															- SABRE -								
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED						7. INSURED'S ADDRESS (No., Street)											
56 BERBERBAVEN DR						<input type="checkbox"/> Self			<input type="checkbox"/> Spouse			<input type="checkbox"/> Child			<input type="checkbox"/> Other								
CITY AMEREST			STATE NY			8. RESERVED FOR NUCC USE			CITY			STATE											
ZIP CODE 14228			TELEPHONE (Include Area Code) (716) 536-0951			X			ZIP CODE			TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER																	
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)			b. INSURED'S DATE OF BIRTH			SEX														
			<input type="checkbox"/> YES <input type="checkbox"/> NO			MM DD YY			M <input type="checkbox"/> F <input checked="" type="checkbox"/>														
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(Place State)</small>			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME											
c. RESERVED FOR NUCC USE																							
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																	
						<input type="checkbox"/> YES <input type="checkbox"/> NO			If yes, complete items 9, 9a, and 9d.														
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.															13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															SIGNED — ON FILE —								
SIGNED — ON FILE — DATE 01-06-2016															SIGNED — ON FILE —								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 2015 GUL			15. OTHER DATE (MM DD YY)			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY)			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY)			19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								
SIDNEY GRABAU, PA			17a. <input type="checkbox"/> API			17b. <input type="checkbox"/> API			18a. FROM [] TO []			18b. FROM [] TO []			20. OUTSIDE LAB? \$ CHARGES								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))			22. RESUBMISSION CODE			23. PRIOR AUTHORIZATION NUMBER																	
A. <u>M79.1</u>			B. <u>L</u>			C. <u>D</u>			D. <u>I</u>			E. <u>G</u>			F. <u>H</u>								
F. <u>L</u>			G. <u>I</u>			H. <u>J</u>			I. <u>K</u>			J. <u>L</u>											
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)			D. MODIFIER			E. DIAGNOSIS CODE			F. G. H. I. J.								
From MM DD YY			To MM DD YY			CPT/HCPCS			MODIFIER			DIAGNOSIS CODE			DAYS OR UNITS CHARGES								
1 03 03 17 03 03 17 11			2 03 03 17 03 03 17 11			3 03 10 17 03 10 17 11			4 03 13 17 03 13 17 11			5 03 10 17 03 10 17 11			6 03 13 17 03 13 17 11			7 03 10 17 03 10 17 11					
97140			97140			97140			97140			97140			97140			97140					
55 1.00 3			55 1.00 3			55 1.00 3			55 1.00 3			55 1.00 3			55 1.00 3			55 1.00 3					
NPI 11444662011			NPI 11444662011			NPI 11444662011			NPI 11444662011			NPI 11444662011			NPI 11444662011			NPI 11444662011					
25. FEDERAL TAX ID NUMBER 47-0989449			SSN BIN <input type="checkbox"/> X			26. PATIENT'S ACCOUNT NO. HARMELL, D			27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. TOTAL CHARGE \$ 220.00			29. AMOUNT PAID \$ 0.00			30. REV FOR NUCC USE 220.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If only the statements on the reverse apply to this bill and are made a part thereof)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH#																	
			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPBM, NY 14043			716 725-0264						GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPBM, NY 14043											
COLLEEN MARX, LMFT SIGNED			DATE 03.15.2017			11444662011			11444662011			11444662011			11444662011			11444662011					

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION

ORGANIZE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.
WARNING: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a
felony or a civil violation.

REFERS TO GOVERNMENT REPORTS OR DOCUMENTS

SIGNING AND FORGEMENT

For example, $\text{MgO} + \text{SiO}_2 \rightarrow \text{MgSiO}_4$ (peritectic) at 1450°C , $\text{MgO} + \text{CaO} \rightarrow \text{MgCaO}_4$ (peritectic) at 1100°C , $\text{MgO} + \text{Al}_2\text{O}_3 \rightarrow \text{MgAl}_2\text{O}_4$ (peritectic) at 1000°C .

STEAMING UP: Phys. At. N. 035 Fuelless firebox case 1904-05. Each hand in action?

For TRICARE claims, I am not a member, and I am not employed by or an active duty member of the Uniformed Services - as defined in the Regulations of the Uniformed Services and the Uniform Code of Military Justice (titles 10 and 36 USC 8752). For B.C. claim claims, I am not a member of the Canadian Forces.

¹⁰ See also the section on "Sectarianism and the formation of religious groups" in the same volume.

1983, p. 4; Zeng, 1983, p. 10). Another factor may be the failure to introduce legal mechanisms to allow the market to regulate itself. In other words, by law, the market is not subject to any control or regulation.

REGULATORY INFORMATION AND USE OF MEDICARE, TRICARE, SDCM, AND PREDICT USING THE DATA ACT TO INTERFERE

We are required by CFPB TRIC RE and DWP to ask you for information needed in the administration of the programs. TRIC RE, FECA, and DWP have provided us with a form to collect this information. You can find it at www.dwp.vet. We are required by CFPB TRIC RE and DWP to ask you for information needed in the administration of the programs. TRIC RE, FECA, and DWP have provided us with a form to collect this information. You can find it at www.dwp.vet.

For more information on how to apply for the program, visit www.hrsa.gov/hsrpp. It is important to identify your organization's name, address, phone number, and fax number.

The information you give us can be given to other providers of services, carers, intermediaries, medical review boards, health plans and other organisations or agencies, for the purpose of assessing your needs and providing the support you may need to prevent further problems, and as may be necessary to coordinate these arrangements. For example, if you are receiving care from a local authority, we will share the information you have provided with the authority or other relevant organisation, as might be required by law.

PUR MEDICATIONS FOR ADULTS WITH COGNITIVE IMPAIRMENT AND DEMENTIA (Mo. 19-70-08/01, titled "Cognitive Deficit in Glucose-Related") established in the Federal Register on Vol. 65, etc., 172, page 27810

FDO L-149PC-CL-484C, Department of Labor, Privacy Act of 1974, "Reproduction of Notice of Suspension of Benefits," Federal Register Vol. 55 (No. 40), Wed Feb 2, 1990, GPO ERL 3, EPA 6

It is important to note that the above recommendations are general guidelines and should be modified by each organization to meet its specific circumstances. It is also important to remember that the rules of the game are constantly changing and may be modified by law.

At the time of the filing of the above-mentioned suit, Plaintiff was a member of the Board of Directors of Disney. At all times relevant to this action, Plaintiff was a director of Disney and had no other responsibilities under TRICARE CHAMPVA except to the Dept. of Defense in its representation of the Stockholders of Disney in their actions to the Board of Directors of Disney, as well as to the Dept. of Defense in its representation of the Stockholders of Disney in their actions to the Board of Directors of Disney.

If you are entitled to benefits under another policy it is permissible for paying for your treatment, Section 117GB of the Social Security Act 1986 (SI 1986/3812) provides protection for self-helping patients.

¹⁰ See, e.g., California's Computer Hacking and Privacy Protection Act of 1988, which permits the government to verify information by way of computer nodes; cf.

MEICIAID PAYMENTS (PROVIDER CERTIFICATION)

¹ Many states have established a mechanism for tracking the receipt of services provided to individuals under the State's Title XIX plan and for keeping information regarding such services as the State Agency or Dept. of Health and Human Services may establish.

1916 - remittance amount, as indicated in left, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of surcharges, deductible amounts, and other charges.

SURGICURE OF PATIENT'S (OR SURGERY) I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee during my personal duration.

According to the *Common Education Act* of 1985, no person is required to respond to a collection of information unless it displays a valid OEHR control number. The valid OEHR control number is:

number for this insurance collection is 0202-1357. The time required to complete this information is estimated to average 10 minutes per response, including the time to review instructions, gather all necessary data, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy or burden estimate, or suggestions for improvement in this form, please write to: CIO, TSOA, Security Boulevard, After PIA Reports Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21204-1850. This notice is for comment. Your suggestions may be used to help improve future forms.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0834

Fax: (716) 725-0855

Client Name: Danielle Howell Date: 3/3/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Cervical on rm very sore leading down left side of neck into upper trap.
Sacral stiffness w/B glute medium

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Myofascial

Therapist:

Chris Hawry

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0834

Fax: (716) 725-0855

Client Name: Danielle Howell Date: 3/7/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client stated "Low back is very stiff and had neck pain on left side leading from causing numbness"

Action's Applied: (Check All that Apply)

- Hypertonicity Myofascial Release
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage
 Plan/Recommendations: (Check All that Apply)
 ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Myofascial

Therapist:

Chris Hawry

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14043
 Office: (716) 725-0524 Fax: (716) 725-0555

Client Name: Danielle Harrel Date: 3/10/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continues pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB stiffness, Neck pain right esp on Q side bothering Q jaw & TMJ. Worked

Caput med to upper traps. B glute

Action's Applied: (Check All that Apply) and hamstring work
 Heat Packs Cold Packs Sombra/Biofreeze Ultrasound on
 Light Pressure Massage Mod Pressure Massage Stretching
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion Techniques
 Stripping Compression Lymph Drainage And Q/LP.

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat Laser

Therapist:

Danielle Harrel

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14043
 Office: (716) 725-0524 Fax: (716) 725-0555

Client Name: Danielle Harrel Date: 3/13/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continues pain)
 (Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Jaw soreness, Q discomfort leading into neck on Q side.

LB stiff but feels a little better.

Action's Applied: (Check All that Apply) Q Glute Tightness Saccus
 Heat Packs Cold Packs Sombra/Biofreeze Ultrasound on
 Light Pressure Massage Moderate Pressure Massage Stretching
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion Techniques
 Stripping Compression Lymph Drainage Hypertonicity.

Plan/Recommendations: (check All that Apply)

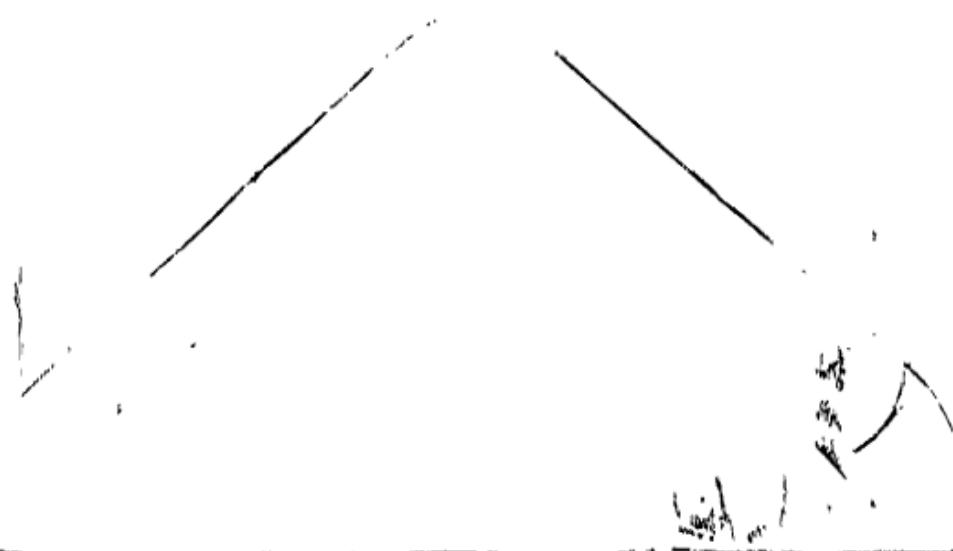
H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat Laser

Therapist:

Danielle Harrel

03 23 17

11 12 13 14 15 16 17 18 19



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375 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Mier



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

2009 PICA

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

CARRIER

PICA XXX

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FICA	OTHER	16. INSURED'S ID. NUMBER	(For Program in Item 1)			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> Group Health Plan	<input type="checkbox"/> FICA	<input checked="" type="checkbox"/> Other	0138739400101059				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
HARWELL, DANIELLE			MM	DD	YY	M	HARWELL, DANIELLE				
DB 29 1980			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)					
1131 CLEVELAND DR			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			1131 CLEVELAND DR					
CITY CHEEKTONWAGA		STATE NY	8. RESERVED FOR NUCC USE			CITY CHEEKTONWAGA		STATE NY			
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()				ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:								
			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____ PLACE (State)								
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODE# (Designated by NUCC)								
			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>If yes, complete items 8, 9a, and 9d.</small>								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED SIGNATURE ON FILE				DATE 02 09 16							
SIGNED SIGNATURE ON FILE				DATE 02 09 16							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)			15. OTHER DATE DUAL QUAL.			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
MM DD YY			439 10 31 15								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI			17a. 1G U62607			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
			17b. NP 1710014188								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGE\$											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to entries 1a-f below (24e)) ICD IND: 0											
A. M791 B. C. D. E. F. G. H. I. J. K. L.											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			24. B. PLACE OF SERVICE EMR	24. C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/MCPCS MCDFIER			24. D. DIAGNOSIS CODE	24. E. R. D. H. I. J. \$ CHARGE\$ DAYS OR UNITS H. HOSPITAL FEE PER DAY I. ID. QUAL. J. RENDERING PROVIDER ID. #			
1 03 21 17	03 21 17	11	20553				A	95	74 1	NPI	161582336
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX ID. NUMBER 161582336			25. SSN EN <input checked="" type="checkbox"/>	25. PATIENT'S ACCOUNT NO. 1577289			27. ASSIGN AGREEMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 100% MEDICAL PAYMENT	28. TOTAL CHARGE \$ 95	29. AMOUNT PAID 74 \$	30. Paid for NUCC Use 0 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof.) JENNIFER W MOVIGE, MD									32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727		
03 24 17									33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002		
BILLED DATE									e1497850911		
									*1497850911		



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Francis M. George, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note
Date: 03/21/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Trigger Point Injections. Headaches
- Neck pain

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicigia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. She reports good benefit with her trigger point injections.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

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 Orchard Park Office | Sterling Medical Park • 260 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14202 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrogram	Pantigraphy
Botz	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
In/PA/CT	VNG
Infusion	

- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker.

Fall History:

Fell in the past year? No . Feel unsteady when standing or walking? No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Resides with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 114/74, HR 72, RR 16, Ht 63", Wt 220.0, BMI 38.97, BSA 2.10.

Examination

Neurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

		DIAGNOSTICS & SERVICES
(716) 250-2000		MR/CT
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	Arthrogram	Posturegraphy
	Beta	Sleep Studies
	Doppler/TCD	SPECT
	EEG	Ultrasound
	EMG	TMS
	ImPACT	VNG
	Inflator	

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 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2043

points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site.

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 9 cc was injected with a 25-gauge needle without complication into 9 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 03/21/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 03/21/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 03/21/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 03/21/2017 at 09:26 AM EDT

Sign off status: Completed

(716) 250-2000
www.dentinstitute.com

Amherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-8315
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrograms	Positronigraphy
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNG
Inflatable	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CBICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARRIER →

PICA									
1. MEDICARE		MEDICAD		TRICARE		CHAMPVA		GROUP HEALTH PLAN	
(Medicare) <input type="checkbox"/>		(Medicad) <input type="checkbox"/>		(DOD/DIA) <input type="checkbox"/>		(Member Only) <input type="checkbox"/>		FECA BLACK LUNG (DOL) <input type="checkbox"/>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)									
BARNELL, DANIELLE									
3. PATIENT'S ADDRESS (No., Street)									
56 BEREHAVEN DR									
CITY AMHERST		STATE NY		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951			
4. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S BIRTH DATE									
MM		DD		YY		SEX			
08		29		1980		M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
6. PATIENT'S RELATIONSHIP TO INSURED									
Self <input checked="" type="checkbox"/>		Spouse <input type="checkbox"/>		Child <input type="checkbox"/>		Other <input type="checkbox"/>			
7. INSURED'S ADDRESS (No., Street)									
CITY		STATE		ZIP CODE		TELEPHONE (Include Area Code)			
8. RESERVED FOR NUCC USE									
X									
9. RESERVED FOR NUCC USE									
10. IS PATIENT'S CONDITION RELATED TO:									
a. EMPLOYMENT? (Current or Previous)									
<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO							
b. AUTO ACCIDENT?									
<input type="checkbox"/> YES		<input type="checkbox"/> NO		PLACE (State) <input type="checkbox"/> NY					
c. OTHER ACCIDENT?									
<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME									
10d CLAIM CODES (Designated by NUCC)									
11. INSURED'S POLICY GROUP OR FECA NUMBER									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
SIGNED - ON FILE - DATE 01-06-2016									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)									
MM		DD		YY		15. OTHER DATE		MM DD YY	
10		31		2015		QUAL			
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
MM		DD		YY		FROM		MM DD YY	
10		31		2015		TO			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE									
17a						17b			
SYDNEY GRABAU, PA									
17b. NPI									
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
19. OUTSIDE LAB?									
<input type="checkbox"/> YES		<input type="checkbox"/> NO				\$ CHARGES			
20. DIAGNOSES OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (S4E) ICD Ind. <input type="checkbox"/>									
A M79.1		B		C L		D			
E		F		G L		H			
I		J		K L		L			
21. DATE(S) OF SERVICE									
From MM DD YY		To MM DD YY		C PLACE OF SERVICE BMS		D PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS		E DIAGNOSES POINTER MODIFIER	
03 17 17 03 17 17		11		97140				F S CHARGES DAYS OR UNITS H PAYER I ID. J FAMILY MEMBER K NAME L RELATIONSHIP PROVIDER ID #	
03 20 17 03 20 17		11		97140				55 00 3 NPI 1144462011	
03 24 17 03 24 17		11		97140				55 00 3 NPI 1144462011	
22. PERMISSION CODE <input type="checkbox"/> ORIGINAL REF NO									
23. PRIOR AUTHORIZATION NUMBER									
24. FEDERAL TAX I.D. NUMBER SSN EIN									
47-0989449		<input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? I.G.H. RELEASE ON MED		28. TOTAL CHARGE	
47-0989449		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		BARNELL, D				\$ 165.00 \$ 0.00	
29. AMOUNT PAID									
30. Paid for NUCC Use 165.00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER									
INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part thereof)									
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043									
32. SERVICE FACILITY LOCATION INFORMATION									
33. BILLING PROVIDER INFO & PH # (716) 725-0264									
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043									
34. COLEEN MARX, INT 03-24-2017									
35. 1144462011 a 1144462011 b									

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

(c)(6)(B) Any person who knowingly files a statement containing any misrepresentation or any false, incomplete or misleading information may be guilty of a felony if such individual is not subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

BLACK LIMS AND BECA CHAMPS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Line and FSCA instruction regarding required procedure and diversion of funding.

SPEC NATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable law, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the contractor to make an informed decision regarding my claim; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional services by my employee under my direct supervision, except as otherwise provided by Medicare or TRICARE; 6) for each service furnished incident to my professional services, the identifying (legal name and NPI) license(s) or SSN(s) of the primary physician or entity in which the service is furnished is included in the third-party identification section for services to be reimbursed incident to a physician's professional services; 7) they must be rendered under the physician's direct supervision by his/her employee; 2) they may be an integral, although incidental part of a covered physician service; 3) they must be of a kind commonly furnished in physician's offices; and 4) no service, including laboratory services, is being submitted for payment.

F. TRICARE claim: I, the beneficiary listed on my employment contract, who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government, a contractor employee of the United States Government, either civilian or military (refer to 5 USC §8505). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No P-411 Merckam benches may be paid unless the following is received as required by existing law and regulations (42 CFR 464.37):

HOTLINE: Any person may make a false or fictitious statement or furnish erroneous information to receive payment from Federal funds requested by this form must, upon conviction, be subject to fine, imprisonment, or both.

NOTICE TO PATIENTS ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We also authorized by Title TRICARE and QMC to act for you in information needed in the administration of the Medicare, TRICARE, FED, and Black Lung programs. Authority to collect information is in section 205(m) 1882, and 407(e) of the Social Security Act as amended, 42 CFR 411.26(a) and 248(a)(8), and 44 USC 3101.41 CFR 101-11.999 and 10 USC 1019

The information is used to complete claims under these programs as well as to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by the program and to issue those payments or refunds.

This information may also be given to other providers of services, clients, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties (e.g., payers) to pay primary to Federal programs, and as otherwise necessary to administer those programs. For example, it may be necessary to disclose information about the services you have paid to a hospital or doctor. Additional disclosures are made through no, one uses for information contained in systems of records.

FOR "SEDICARE CLINIC": See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed., Sept. 15, 1990, areas outlined are redacted.

FOR OFFICERS OF THE DEPARTMENT OF LABOR: Privacy Act of 1974, "Regulation of Notice of Systems of Records," Federal Register Vol. 55 No. 40, M&D Feb. 28, 1990, See E&A-5, E&A-6, E&A-12, L-14-13, E&A-30, as so amended and as published.

FCC, TRIBUNAL CLAIMS: PURPOSE(S): To establish eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services rendered are reasonable and necessary.

POLITICAL PARTIES: Information from claims and related documentation may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation in accordance with the Freedom of Information Act, or to Congress, the Office of the Inspector General, or to the appropriate congressional committee under Title II-B of S. 1375 (CHAMPVA). In the case of the Dept. of Transportation, information may be given to the Dept. of Transportation in accordance with the Freedom of Information Act, or to Congress, the Office of the Inspector General, or to the appropriate congressional committee under Title II-B of S. 1375 (CHAMPVA).

Private Barriers, private collection agencies, and consumer reporting agencies in connection with recompence claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record relates. Agency disclosures may be made to state/federal, state, local, investigating government, genocides, private business entities, and individual consumers; or to state/federal, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, consultation of law, attorney and general litigation related to the operation of TRICARE.

regarding medical treatment, however, failure to provide information will result in early payment or may result in denial of claim. With the one exception discussed below, there are no minimum dollar amounts for which you must furnish supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under this program. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be disastrous to your claim.

I am sending my check to you from [REDACTED] responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 UCF 3801-3312 provide penalties

You shall have the right to inspect, copy, or receive a copy of your personal information held by us, and we will provide such information to you in an electronic format if feasible, unless doing so would interfere with our operations or would violate applicable law.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I have agreed to waive my rights as an enrollee to decline fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding payments claimed or paid on patients such as the State Agency or Dept. of Health and Human Services may request.

I further agree to pay my account in full, the amount paid by the *Kidz Card* program for the items submitted for payment under this program, with the *less* option of cashback as available.

SIGNATURE OF PHYSICIAN (OR CARRIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were furnished by me or my employee under my personal direction.

NOTICE: I acknowledge that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false statement, or concealment, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

A company or individual may file a FOIA request for records that are held by the FBI. No person is 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 1190-0119. The time estimate to complete this information collection is estimated to average 10 minutes per response, including the time to review and verify the accuracy of the information submitted, and complete and review the information collection. If you have any comments concerning the accuracy of this time estimate, please contact the FBI, 7500 Security Boulevard, FBI PRA Requests Clearance Office, Mail Stop Q4-03-03, Baltimore, Maryland 21244.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dixie Rd Depew, NY 14204

Office: (716) 725-0824

Fax: (716) 725-0355

Client Name: Danielle Howell Date: 3/17/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling
Observed Areas of Problem/Dysfunction: (Check All that Apply)
- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: "I don't feel right today." Stabbing
 (P)elvis/bra/kne on (C) side, tight from
 head to (L) Cervic restricted in all areas

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: Danielle Howell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dixie Rd Depew, NY 14204

Office: (716) 725-0824

Fax: (716) 725-0355

Client Name: Danielle Howell Date: 3/20/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client hurts from neck
 to L.B. from all areas. Walking
 very slowly due to discomfort

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: Danielle Howell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 3/24/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunctions: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliques ASIS PSIS
- Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client feels better. Still sore/achy. Moderate pressure in above areas to give tissue a buzz.

Action/s Applied: (Check All that Apply) and heel.

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretchers Cool Meds Ice / Heat/Zero

Therapist: Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliques ASIS PSIS
- Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

03 27 17

卷之三

03 27 17

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

BUFFALO

NY 140

24 MAR '17

FNSL

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 1M10 WASHINGTON DC

POSTAGE WILL BE PAID BY ADDRESSEE

GEICO.

NY PIP
PO BOX 9507
FREDERICKSBURG VA 22403-9527



*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO.	4357
DESTINATION ADDRESS	18562945154
SUBADDRESS	
DESTINATION ID	Geico PIP Claims
ST. TIME	03/24 07:48
TX/RX TIME	01' 02
PGS.	4
RESULT	OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

1. MEDICARE [Name(s)]	2. MEDICAID [Name(s)]	3. TRICARE [Name(s)]	4. CHAMPVA [Name(s)]	5. GROUP HEALTHPLAN [Name(s)]	6. FECA REGULAR [Name(s)]	7. OTHER [Name(s)]	8. INSURED'S I.D. NUMBER 0138739400101059 (For Programs In Part I)
2. PATIENT'S NAME [Last Name, First Name, Middle Initial] HARRELL, DANIELLE		3. PATIENT'S BIRTH DATE 08 29 1980 M F		4. INSURED'S NAME [Last Name, First Name, Middle Initial] HARRELL, DANIELLE			
5. PATIENT'S ADDRESS [No., Street] 1131 CLEVELAND DR		6. PATIENT RELATIONSHIP TO INSURED SPOUSE CHILD OTHER		7. INSURED'S ADDRESS [No., Street] 1131 CLEVELAND DR			
CITY CHEEKTONWAGA	STATE NY	8. RESERVED FOR NUCC USE		CITY CHEEKTONWAGA	STATE NY	9. RESERVED FOR NUCC USE	
ZIP CODE 14225-1257	TELEPHONE (Include Area Code) ()			ZIP CODE 14225-1257	TELEPHONE (Include Area Code) ()		
10. OTHER INSURED'S NAME [Last Name, First Name, Middle Initial]		11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15					
12. OTHER INSURED'S POLICY OR GROUP NUMBER -		13. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M F					
14. RESERVED FOR NUCC USE		15. OTHER CLAIM ID (Designated by NUCC)					
16. RESERVED FOR NUCC USE		17. INSURANCE PLAN NAME OR PROGRAM NAME					
18. INSURANCE PLAN NAME OR PROGRAM NAME		19. CLAIM CODES (Designated by NUCC)				20. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 8, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who is entitled to such benefit below. SIGNED SIGNATURE ON FILE DATE 02 09 16							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 04 01 16		15. OTHER DATE QUARTER 439 10 53 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 04 01 16 TO 04 01 16			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR PETER J GUEINSKI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 17/04/16 TO 17/04/16		19. OUTSIDE LABS YES NO NO			
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) M791							
21. DISEASE/S OR NATURE OF ILLNESS OR INJURY Please A-L is same as below (B-D) M791		22. ICD-9-CM CODE 001.0		23. ORIGINAL RBR-NO 0000000000			
A. <u> </u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>
I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>	24. PRIOR AUTHORIZATION NUMBER 1645598495			
25. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 21 17 TO 03 21 17		B. DURATION OF SERVICE IN MONTHS 11		C. PROCEUDURE, SERVICES, OR SUPPLIES (List all services claimed) 20553		D. MODIFIER OPT/HCPCS	
E. CHARGES A		F. CHARGES 95 74 1		G. CHARGES NPI		H. CHARGES NPI	
I. PAYMENT 1645598495		J. PAYMENT 1645598495		K. PAYMENT NPI		L. PAYMENT NPI	

CARRIER

PATIENT AND INSURED INFORMATION

UPPER INFORMATION



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

NUCC PICA

RICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <small>(Medicare) (Medicaid) (DOD/DoD) (Member ID#) (Plan Name) (NDM) (NDM) (NDM)</small>												1a. INSURED'S ID NUMBER <input type="text"/> (For Program in Item 1) 0138739400101059		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE <input type="text"/> MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		
5. PATIENT'S ADDRESS (No. Street) 1131 CLEVELAND DR												6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
CITY CHEEKIWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY CHEEKIWAGA		STATE NY						
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()				ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC) READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
SIGNED <input type="text"/> SIGNATURE ON FILE												DATE <input type="text"/> 02 09 16 SIGNED <input type="text"/> SIGNATURE ON FILE		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) MM DD YY QMUL <input type="checkbox"/>												15. OTHER DATE QMUL <input type="text"/> 4391 MM DD YY MM DD YY 17a. <input type="text"/> LIG U62607 DN <input type="text"/> PETER J GUZINSKI 17b. <input type="text"/> NPI 1710014188		
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <input type="text"/> TO <input type="text"/>												17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <input type="text"/> TO <input type="text"/>		
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) M791 A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/>												22. RESUBMISSION CODE <input type="text"/> ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER <input type="text"/>		
24. A. DATE(S) OF SERVICE From <input type="text"/> To <input type="text"/> MM DD YY MM DD YY		B. PLACE OF SERVICE EMG <input type="checkbox"/>		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS <input type="text"/> MODIFIER		D. DIAGNOSIS POINTER		F. CHARGES G. DAYS ON SETS H. PERCENT PAY		I. ID QMUL		J. RENDERING PROVIDER ID # <input type="text"/> 161582336		
1	03 21 17	03 21 17	11	20553			A	95	74	1	NPI	1649596495		
2											NPI			
3											NPI			
4											NPI			
5											NPI			
6											NPI			
25. FEDERAL TAX ID NUMBER <input type="text"/> SSN/BN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO <input type="text"/> 1577289		27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>		28. TOTAL CHARGE <input type="text"/> \$ 95 74 5		29. AMOUNT PAID <input type="text"/> \$ 0 00		30. RWD FOR NUCC USE <input type="text"/> \$ 0 00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small> JENNIFER W MCVIGE, MD												32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727		
33. BILLING PROVIDER INFO & PH # <input type="text"/> (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002														
SIGNED <input type="text"/> DATE <input type="text"/> 03 24 17		a. <input type="text"/> 1497850911 b. <input type="text"/> 1497850911 b.												

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.28(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health services provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5636). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWC to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1962, 1972 and 1974 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6); and 44 USC 1101.41 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 1101 et seq; and 30 USC 901 et seq; 38 USC 813, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties pay to primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No 177, page 37549, Wed. Sept. 12, 1990, as updated and republished.

FOR OWC CLAIMS: Department of Labor, Privacy Act of 1974. "Republication of Notice of Systems of Records," Federal Register Vol. 55 No 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/benefits received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompensation claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21244-1690. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



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Veronica Bates, MD	Sanjay Gupta, MD	Malini Patel, MD
Bela Ajtai, MD	Tomas Holmlund, MD	Mohammad M. Qasimyeh, MD
Alfred Balen III, MD	J. Maurice Houriase, MD	Michelle M. Rainka, PharmD
Horacio Capote, MD	Anupama M. Kale, MD	Luisa Rojas, MD
Ara N. Cervantes, MD	Xiali Li, MD	Nicolas Sakall, MD
Donna M. Csaneck, PhD	Laszlo Mechler, MD	Lixin Zhang, MD, PhD
J. Andrew Bonnes, PhD	Jennifer W. McVige, MD	Joseph V. Fritz, PhD, CEO
Marc S. Frost, MD	Kenneth R. Murray, MD	
Francis M. Gengo, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note

Date: 03/21/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 36 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Trigger Point Injections Headaches
- Neck pain

History of Present Illness

General.

Danielle is a 36-year-old patient with a history of migraine headaches, cervicigia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. She reports good benefit with her trigger point injections.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally pm headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

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DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrograms	Posturography
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
In/Out CT	VNG
Defarane	

- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy

Social History

Tobacco Use:

Smoking Patient is a: non smoker.

Fall History:

Fell in the past year? No Feel unsteady when standing or walking? No .

Alcohol use:

Alcohol Consumption. Patient does not drink alcohol.

Resides with:

Spouse Husband Children Yes, x3. Self: Yes.

Working:

Employed Stay at home mom

Marital Status:

Married: Yes

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other. Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy

Vital Signs

BP sitting 114/74, HR 72, RR 16, Ht 63", Wt 220.0, BMI 38.97, BSA 2.10

Examination

Neurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger

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(716) 250-2000		MR/CT
www.dentinstitute.com		Neuropsychology
		Arthrograms
		Posturegraphy
		Botox
		Sleep Studies
		Dogdson/TCD
		SPECT
		EEG
		Ultrasound
		EMG
		TMS
		InPACT
		VNG
		Inflator

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points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site.

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 9 cc was injected with a 25-gauge needle without complication into 9 areas in the back within the trapeziel and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING. Healthy Living: Patient counseled on the importance of healthy lifestyle 03/21/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 03/21/2017

Exercise: Patient counseled on importance of moderate physical activity daily. 03/21/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 03/21/2017 at 09:26 AM EDT

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
MRI/CT	Neurophysiology
Arthrogram	Pain/Physical
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infrared	



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Marc S. Fronc, MD	Kenneth R. Murray, MD	Joseph V. Price, PhD, CEO

MARCH 24, 2017

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

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DIAGNOSTICS & SERVICES	
MRI/CT	Neurophysiology
Arterograms	Pneurography
Breast	Sleep Studies
Doppler/PCD	SPECT
EEG	Ultrasound
EMG	VNG
EvPCT	TMS
Injections	

03-26-17

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BUFFALO, NY 14226



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO INSURANCE - NF

NY PTP CLAIMS

PO BOX 9507

FREDERICKSBURG, VA 22403

CARRIER -

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



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Marc S. Frost, MD	Kenneth R. Murray, MD	
Francis M. Gengen, PharmD	Barnett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note

Date: 02/16/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 36 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Migraines
- Trigger point injections. Headaches
- Neck pain

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. She reports about 1-1/2-2 weeks of relief with her trigger point injections.

Daniel also reports increased headache activity, also now with associated vertigo. She describes episodes of "room spinning". It will occur either before or along with her headaches. It generally does not occur without a headache. It has affected her to the point where she has had to pull over while driving. She did undergo full battery VNG testing 2 years ago which was normal. She had been going to physical therapy regularly which she believes did also include vestibular therapy, however she was discharged from this 3 months ago. She has found that the exercises she was taught to do for dizziness has not been helpful.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally pm headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 IU units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

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DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrograms	Posturography
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InPACT	PNG
Inflates	

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Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a: non smoker .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Radiation:

Spouse: Husband. Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain, headaches, vertigo, nausea. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

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 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Posturography
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infrared	

Vital Signs

BP sitting 112/70, HR 68, RR 16, Ht 63", Wt 215.4, BMI 38.15, BSA 2.08.

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)
2. Vestibular dysfunction - H83.2X9
3. Concussion, without loss of consciousness, sequela - S06.0X0S
4. Cervical radicular pain - M54.12

Danielle reports worsening of her symptoms at today's trigger point injection appointment. Due to worsening headache activity and associated vertigo and nausea, he would like to obtain imaging including MRI brain and cervical spine, as these have not been obtained in over a year. Her previous MRI brain was normal and her previous MRI cervical spine showed some disc protrusions with no narrowing of canal. We would also like her to return to vestibular therapy. We will see her in 1 month for repeat trigger point injections. If her symptoms continue to worsen, she will likely need to be referred back to the dizziness clinic and possibly for repeat vestibular testing.

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment**1. Vestibular dysfunction**

VESTIBULAR THERAPY1436286

2. Concussion, without loss of consciousness, sequela

MRI BRAIN WO1436290Reval 05/07 exp also C-Spine **LM 03/10/17 GR

3. Cervical radicular pain

MRI C-SPINE WO1436289Reval 05/07 exp also Brain **LM 03/10/17 GR

Procedures**Injections:**

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 9 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was

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DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrograms	Posturography
Botax	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNG
Influsion	

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Patient: Harwell, Danielle | DOB: 08/29/1980 | Procedure Note

Page 4 of 4

maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 02/16/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 02/16/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 02/16/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 03/27/2017 at 10:04 PM EDT

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
<i>MRI/CT</i>	<i>Neurophysiology</i>
<i>Arthrographies</i>	<i>Posturography</i>
<i>BioRx</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>ImPACT</i>	<i>VNG</i>
<i>Infusion</i>	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO INSURANCE - NY
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22401

PICA

-CARRIER

PATIENT AND INSURED INFORMATION											
PHYSICIAN OR SUPPLIER INFORMATION											
<p>1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA SICKLNG OTHER</p> <p>(For Program in Item 1)</p> <p><input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member/DSN <input type="checkbox"/> MM DD <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (DSN)</p> <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</p> <p>HARWELL, DANIELLE</p> <p>3. PATIENT'S BIRTH DATE</p> <p>MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/></p> <p>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>HARWELL, DANIELLE</p> <p>5. PATIENT'S ADDRESS (No. Street)</p> <p>1131 CLEVELAND DR</p> <p>6. PATIENT RELATIONSHIP TO INSURED</p> <p>Sel <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></p> <p>7. INSURED'S ADDRESS (No. Street)</p> <p>1131 CLEVELAND DR</p> <p>CITY STATE ZIP CODE TELEPHONE (Include Area Code)</p> <p>CHEEKTONWAGA NY 14225-1257 ()</p> <p>8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</p> <p>a. OTHER INSURED'S POLICY OR GROUP NUMBER</p> <p>b. RESERVED FOR NUCC USE</p> <p>c. RESERVED FOR NUCC USE</p> <p>d. INSURANCE PLAN NAME OR PROGRAM NAME</p> <p>10. IS PATIENT'S CONDITION RELATED TO:</p> <p>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (STREET) _____</p> <p>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>11. INSURED'S POLICY GROUP OR FECA NUMBER</p> <p>DOT 10/31/15</p> <p>a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/></p> <p>b. OTHER CLAIM ID (Designated by NUCC) _____</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</p> <p>SIGNED SIGNATURE ON FILE DATE 02-09-16</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) 15. OTHER DATE MM DD YY 08 29 1980 04 439 10 31 15</p> <p>16. GATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NP 1G U62607 DN JENNIFER W MCVIGE MD 17b. NP 1649596495</p> <p>18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p> <p>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (S4-E)) ICD-9-CM 0</p> <p>A. B060X0S B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____</p> <p>24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS From MM DD YY To MM DD YY E/M CPT/HCPCS MODIFIER POINTERS</p> <p>03 27 17 03 27 17 11 70551 A 702 861</p> <p>03 27 17 03 27 17 11 72141 A 707 111</p> <p>F. G. H. I. J. CHARGES DATE PAYMENT AMOUNT PAID RENDERING PROVIDER ID #</p> <p>25. FEDERAL TAX I.D. NUMBER SSN SIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT 161582336 <input checked="" type="checkbox"/> X 1580693 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ 1409 97 8 0 00</p> <p>28. TOTAL CHARGE 29. AMOUNT PAID 30. Reserved for NUCC Use</p> <p>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on this reverse apply to this bill and are made a part thereof.</p> <p>LASZLO MECHTLER, FAAN</p> <p>32. SERVICE FACILITY LOCATION INFORMATION</p> <p>DENT TOWER 1ST FLR 3980 SHERIDAN DRIVE 1ST FLOOR AMHERST NY 14226-1727</p> <p>33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002</p>											

To: MCVIGE MD, JENNIFER W. From: Dent Neurologic Institute



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Offices
MAIN TELEPHONE NUMBER
P# 716-250-2000; F# 716-250-1020

Orchard Park Office
Sterling Medical Park
200 Sterling Drive
Orchard Park, NY 1427

PATIENT: DANIELLE HARWELL

DOB: 8/29/1980

EXAM DATE: 3/27/2017

Referring: JENNIFER W. MCVIGE MD JAMES PANZARELLA DO

PROCEDURE: MRI OF THE CERVICAL SPINE

TECHNIQUE: An MRI scan of the cervical spine was obtained utilizing T1 weighted and T2 weighted scan sequences in the axial plane. The study also included T1 weighted scan sequences in the sagittal plane and STIR sequences in the sagittal plane.

This study is of good quality.

COMPARISON: OUTSIDE EXAMS, MR, MRI C-SPINE WO, 1/04/2016, 12:55.

INDICATIONS: History of disc protrusions with no narrowing of canal.

FINDINGS: The vertebral bodies are relatively normal in height and signal intensity. Only some subtle anterior spondylitic spurring is seen at C4-5 and C5-6. There is evidence of dextroscoliosis of the upper cervical spine. No definite evidence of spondylolisthesis or vertebral body compression is noted.

On the STIR sequences, no abnormal signal intensities are seen within the vertebral bodies.

The cervical cord is normal in size and signal intensity.

CONCLUSION: Abnormal serial MRI of the cervical spine demonstrating:

1. A mild degree of dextroscoliosis of the cervical spine without evidence of definite spondylolisthesis or vertebral body compression.
2. Posterior uncovertebral spur disc complexes seen at C4-5, C5-6 without foraminal or spinal stenosis.
3. The cervical cord is normal in size and signal intensity.
4. When compared to the study from 01/04/2016 there has not been a significant change.

Laszlo Mechtiler MD

Laszlo L. Mechtiler, MD, FAAN

Dictated by: Laszlo L. Mechtiler, MD, FAAN on 3/28/2017 at 9:29

Monica Ferguson on 3/28/2017 at 12:08

Approved by: Laszlo L. Mechtiler, MD, FAAN, FASN on 3/28/2017 at 15:40

To: MCVIGE MD, JENNIFER W. From: Dent Neurologic Institute



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Jennifer McVige, MD

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NEUROIMAGING FELLOWS
Mirza Bulig, DO
Yoshiaki Haralau, MD

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MAIN TELEPHONE NUMBER
P# 716-250-2000; F# 716-250-1020

Orchard Park Office
Sterling Medical Park
200 Sterling Drive
Orchard Park, NY 1427

PATIENT: DANIELLE HARWELL

DOB: 8/29/1980

EXAM DATE: 3/27/2017

Referring: JENNIFER W. MCVIGE MD JAMES PANZARELLA DO

PROCEDURE: MRI OF THE BRAIN

TECHNIQUE: An MRI scan of the brain was obtained utilizing T1 weighted, T2 weighted, FLAIR, diffusion weighted, and susceptibility weighted sequences in the axial plane. The study also included a FLAIR sequence in the sagittal plane.

The study is of good quality.

COMPARISON: None.

INDICATIONS: Worsening headache activity and associated vertigo and nausea.

FINDINGS: The ventricular system is normal for the patient's age without any shift or distortion.

On the FLAIR axial images no definite parenchymal abnormalities are noted.

The basal cisterns, sulci, and fissures are normal for the patient's age.

The signal voids within the anterior posterior arterial circulation are present. Superior sagittal sinus is patent.

The diffusion-weighted images are unremarkable.

No abnormalities are seen in the orbits, sinuses, or mastoids.

CONCLUSION: Normal MRI scan of the brain without contrast.

Laszlo Mechtler MD

Laszlo L Mechtler, MD, FAAN

Dictated by: Laszlo L Mechtler, MD, FAAN on 3/28/2017 at 9:32

Monica Ferguson on 3/28/2017 at 9:09

Approved by: Laszlo L Mechtler, MD, FAAN, FASN on 3/28/2017 at 15:58



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

1 MEDICARE	2 MEDICAID	3 TRICARE	4 CHAMPVA	5 GROUP HEALTH PLAN	6 FECA EXCLUDING STATE	7 OTHER	8 INSURED'S ID NUMBER (For Program in Item 1)
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> Member ID#	<input type="checkbox"/> ADP	<input type="checkbox"/> DOD	<input checked="" type="checkbox"/> SOA	0138739400101059

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)

HARWELL, DANIELLE

5 PATIENT'S ADDRESS (No., Street)

1131 CLEVELAND DR

CITY

CHEEKTONWAGA

STATE

NY

ZIP CODE

TELEPHONE (Include Area Code)

14225-1257

()

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

HARWELL, DANIELLE

a OTHER INSURED'S POLICY OR GROUP NUMBER

b RESERVED FOR NUCC USE

c RESERVED FOR NUCC USE

d INSURANCE PLAN NAME OR PROGRAM NAME

10 IS PATIENT'S CONDITION RELATED TO

11 INSURED'S POLICY GROUP OR FECA NUMBER

12 IS PATIENT'S CONDITION RELATED TO

13 INSURED'S POLICY GROUP OR FECA NUMBER

14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)

15 OTHER DATE (MM/DD/YY)

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/DD/YY)

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY)

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? \$ CHARGES

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))

22 RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE

From MM DD YY To MM DD YY

B. PLACE OF SERVICE EMR

C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)

DPT/HCPCS

E. MODIFIER

F. DIAGNOSIS CODE

G. DAYS ON UNITS

H. PAYMENT PER UNITS

I. ID CODE

J. RENDERING PROVIDER ID #

1 02 16 17 02 16 17 11 20553 A 95 74 1 NPI 161582336

2 02 16 17 02 16 17 11 99212 25 ABCD 40 40 1 NPI 161582336

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX ID NUMBER SSN EIN

161582336 X

26. PATIENT'S ACCOUNT NO

1554514

27. ACCEPT ASSIGNMENT?

X YES NO

28. TOTAL CHARGE

5 136 14 5 0 00

29. AMOUNT PAID

30. Reserved for NUCC Use

SIGNED 03 29 17

* 1497850911 *

* 1497850911 *

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature waives release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health services provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on the form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 1101 et seq; and 39 USC 801 et seq; 38 USC 613, E.O. 9397.

The information we obtain to compile claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37548, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

BOUTINFLUSFOR: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, liaison, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3601-3612 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER) I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1996, 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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



DENT
NEUROLOGIC INSTITUTE

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Marc S. Frost, MD	Kenneth R. Murray, MD	
Francis M. Gengo, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note
Date: 02/16/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- No-Fault - Requires Opinion
- Migraines
- Trigger point injections Headaches
- Neck pain

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. She reports about 1-1/2-2 weeks of relief with her trigger point injections.

Daniel also reports increased headache activity, also now with associated vertigo. She describes episodes of "room spinning". It will occur either before or along with her headaches. It generally does not occur without a headache. It has affected her to the point where she has had to pull over while driving. She did undergo full battery VNG testing 2 years ago which was normal. She had been going to physical therapy regularly which she believes did also include vestibular therapy, however she was discharged from this 3 months ago. She has found that the exercises she was taught to do for dizziness has not been helpful.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally pm headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

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DIAGNOSTICS & SERVICES	
<i>MRI/CT</i>	<i>Neuropsychology</i>
<i>Arthrogram</i>	<i>Pertigraphy</i>
<i>Botox</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>InPACT</i>	<i>VNG</i>
<i>Jugulane</i>	

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy

Social HistoryTobacco Use:

Smoking: Patient is a non smoker.

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs. Denies.

Resides with:

Spouse: Husband Children: Yes, x3.

Working:

Employed: Stay at home mom.

Marital Status:

Married Yes.

Driving:

Does Patient Drive. Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain, headaches, vertigo, nausea. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

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DIAGNOSTICS & SERVICES	
MRVCT	Neuropsychology
Arthrogram	Posturography
Bones	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infusion	

Vital Signs

BP sitting 112/70, HR 68, RR 16, Ht 63", Wt 215.4, BMI 38.15, BSA 2.08

Examination**Neurological:**

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1 (Primary)
2. Vestibular dysfunction - H83.2X9
3. Concussion, without loss of consciousness, sequela - S06.0X0S
4. Cervical radicular pain - M54.12

Danielle reports worsening of her symptoms at today's trigger point injection appointment. Due to worsening headache activity and associated vertigo and nausea, he would like to obtain imaging including MRI brain and cervical spine, as these have not been obtained in over a year. Her previous MRI brain was normal and her previous MRI cervical spine showed some disc protrusions with no narrowing of canal. We would also like her to return to vestibular therapy. We will see her in 1 month for repeat trigger point injections. If her symptoms continue to worsen, she will likely need to be referred back to the dizziness clinic and possibly for repeat vestibular testing.

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr McVige is the supervising physician on site

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment**1. Vestibular dysfunction**

VESTIBULAR THERAPY1436286

2. Concussion, without loss of consciousness, sequela

MRI BRAIN WO1436290Reval 05/07 exp also C-Spine **LM 03/10/17 GR

3. Cervical radicular pain

MRI C-SPINE WO1436289Reval 05/07 exp also Brain **LM 03/10/17 GR

Procedures**Injections:**

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 9 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was

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DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrograms	Positronigraphy
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infusion	

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maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 02/16/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 02/16/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 02/16/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 03/27/2017 at 10:04 PM EDT

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
<i>MR/CT</i>	<i>Newropsychology</i>
<i>Arthrography</i>	<i>Posturography</i>
<i>Botox</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>EPIC/T</i>	<i>PING</i>
<i>Infusion</i>	

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 4501
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Clales
 ST. TIME 03/29 07:35
 TX/RX TIME 02'12
 PGS. 5
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/92

NUCC/PCA

PCA

CARRIER													
GEICO INSURANCE - NY NY PIP CLAIMS POBOX 9507 FREDERICKSBURG VA 22403													
(Per Paragraphs in Item 1)													
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP PLAN		INDIVIDUAL PLAN			
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> GROUP PLAN		<input type="checkbox"/> INDIVIDUAL PLAN			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
HARWELL, DANIELLE B		MM DD YY 08 29 1980		HARWELL, DANIELLE B									
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT'S RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)									
1131 CLEVELAND DR		<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		1131 CLEVELAND DR									
CITY		STATE		CITY		STATE							
CHEEKTONAGA		NY		CHEEKTONAGA		NY							
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)							
14225-1257		()		14225-1257		()							
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)													
9. IS PATIENT'S CONDITION RELATED TO:													
10. INSURED'S POLICY GROUP OR PECOA NUMBER													
11. INSURED'S POLICY GROUP OR PECOA NUMBER													
12. EMPLOYMENT (Current or Previous)													
13. DOB 10/31/15													
14. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 <input type="checkbox"/> M <input type="checkbox"/> F													
15. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____													
16. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO _____													
17. INSURANCE PLAN NAME OR PROGRAM NAME													
18. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 10, and 11.													
19. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNED SIGNATURE ON FILE DATE 02-09-16						SIGNED SIGNATURE ON FILE							
20. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)		21. OTHER DATES (MM DD YY)		22. PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YY) TO (MM DD YY)									
MM DD YY GUL		MM DD YY GUL		MM DD YY									
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE		24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM (MM DD YY) TO (MM DD YY)											
DR. PETER J GUZINSKI		MM DD YY											
25. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		26. OUTPATIENT LAB TEST CHARGES											
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
27. DIAGNOSES OR NATURE OF ILLNESS OR INJURY Refer to service line below (ICD)		28. RESUBMISSION CODE ORIGINAL REF. NO.											
A. M791		B. I883.2X0											
C. I439.09		D. M5412											
E. _____		F. _____											
G. I. _____		H. L. _____											
29. A. DATES OF SERVICE FROM (MM DD YY) TO (MM DD YY)		B. PLACE OF SERVICE ENR		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Usual Quantities)		E. DIAGNOSIS CODES		F. CHARGES		G. DATES OF PAYMENTS		H. L. RENEWAL ID. #	
1 02 16 17 02 16 17 11		20553		A		05 741		M		161592396			
2 02 16 17 02 16 17 11		98212 25		ABCD		40 401		NPI		1649596495			
3												161592396	
												1649596495	

SUPPLIER INFORMATION

FIRST CLASS MAIL

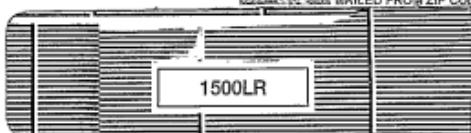


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**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO INSURANCE - NF

NY PIP CLAIMS

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FREDERICKSBURG VA 22403

CARRIER

PICA												PICA																	
1. MEDICARE <input type="checkbox"/> Medicare		MEDICAID <input type="checkbox"/> Medicaid		TRICARE <input type="checkbox"/> DOD/DoD		CHAMPVA <input type="checkbox"/> Member ID#		GROUP HEALTH PLAN <input type="checkbox"/> NPA		FECA BENEFITS <input type="checkbox"/> DOB		OTHER <input checked="" type="checkbox"/> DOD		1a INSURED'S ID NUMBER 0138739400101059		(For Progress in Items 1)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE													
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR															
CITY CHEEKTONWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY CHEEKTONWAGA		STATE NY		ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																	
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																	
												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items b, b-a, and b-d																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																	
SIGNED <u>SIGNATURE ON FILE</u>												SIGNED <u>SIGNATURE ON FILE</u>																	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY Q3 2014		15. OTHER DATE MM DD YY Q3 14 439 10 31 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DIN JENNIFER W MCIVIGE MD												17a U62607		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												17b NPI 1649596495		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) A <u>8060X05</u> B <u> </u> C <u> </u> D <u> </u> E <u> </u> F <u> </u> G <u> </u> H <u> </u> I <u> </u> J <u> </u> K <u> </u> L <u> </u>		22. RESUBMISSION CODE ORIGINAL REF. NO. 161582336											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 27 17 03 27 17												B. PLACE OF SERVICE EMR 11		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 70551		D. MODIFIER 		E. DIAGNOSIS CODE POINTERS A		F. CHARGES \$ 702.861		G. DAYS ON HOSPITAL BEDS 97		H. AMOUNT PAID 0.00		I. ID QUAL NPI 1710978598		J. RENDERING PROVIDER ID # BT 161582336	
1	03 27 17		03 27 17		11		70551		A		702.861		97		0.00		NPI 1710978598		BT 161582336										
2	03 27 17		03 27 17		11		72141		A		707.111		1		0.00		NPI 1710978598		BT 161582336										
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6	 		 		 		 		 		 		 		 		NPI		 										
25. FEDERAL TAX ID NUMBER 161582336	SSN/IN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO 1580693		27. ACCEPT ASSIGNMENTS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 1409		29. AMOUNT PAID 97		30. Revd for NUCC Use 0.00																		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If copy of the statements on the reverse apply to the bill and are made a part thereof.) LASZLO MECHTLER, FAAN,												32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 1ST FLR 3980 SHERIDAN DRIVE 1ST FLOOR AMHERST NY 14226-1727												33. BILLING PROVIDER INFO & PH# (716) 2502010		DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002			
SIGNED 03 29 17												34. DATE b 1497850911		35. AMOUNT PAID b 1497850911		36. REV'D FOR NUCC USE b BT 161582336													

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. Sec 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if it is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on the form is true, accurate and complete, 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment inclusion but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 8) for each service rendered incident to my professional service, the identity (legal name and NPI), license #, or SSN of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 421.32).

NOTICE: Any one who misrepresents or omits essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 8101 et seq, and 30 USC 801 et seq; 38 USC 613, E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, Mid, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37548, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with repayment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 9301-9312 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21246-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 4590
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 03/30 07:48
 TX/RX TIME 00' 57
 PCS. 3
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF
 NY PIP CLAIMS
 POBOX 9507
 FREDERICKSBURG VA 22403

CARRIER

NUCC

NUCC

1. MEMBER		MEDICARE		MEDICARE		TRICARE		CHAMPVA		GROUP		HEALTH PLAN		FEDERAL		OTHER		16. INSURED'S LD. NUMBER		(For Program in Item 1)	
<input type="checkbox"/> (Last Name) HARWELL, DANIELLE		<input type="checkbox"/> (First Name) DANIELLE		<input type="checkbox"/> (Middle Initial) H		<input type="checkbox"/> (Last Name) HARWELL, DANIELLE		<input type="checkbox"/> (First Name) DANIELLE		<input type="checkbox"/> (Middle Initial) H		<input type="checkbox"/> (Last Name) HARWELL, DANIELLE		<input type="checkbox"/> (First Name) DANIELLE		<input type="checkbox"/> (Middle Initial) H		0139739400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE														4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARWELL, DANIELLE		09 / 29 / 1980		N		M		F		Y		HARWELL, DANIELLE		HARWELL, DANIELLE		HARWELL, DANIELLE					
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT'S RELATIONSHIP TO INSURED														7. INSURED'S ADDRESS (No., Street)					
1131 CLEVELAND DR		<input type="checkbox"/> SPOUSE		<input type="checkbox"/> CHILD		<input type="checkbox"/> OTHER										1131 CLEVELAND DR					
CITY CHEERTOWAGA		STATE NY		6. RESERVED FOR NUCC USE												CITY CHEERTOWAGA		STATE NY			
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()														ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()			
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. PATIENT'S CONDITION RELATED TO:														11. INSURED'S POLICY GROUP OR FED NUMBER					
		<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO												DOT 10/31/15					
10. OTHER INSURED'S POLICY OR GROUP NUMBER		11. EMPLOYMENT? (Current or Past)														12. INSURED'S DATE OF BIRTH		SEX			
		<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO												MM / DD / YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
12. OTHER ACCIDENT?		<input type="checkbox"/> YES		<input type="checkbox"/> NO		PLACE (State)										13. OTHER CLAIM ID (Assigned by NUCC)					
		<input type="checkbox"/> YES		<input type="checkbox"/> NO		I.															
14. RESERVED FOR NUCC USE		15. OTHER ACCIDENT?														14. INSURANCE PLAN NAME OR PROGRAM NAME					
		<input type="checkbox"/> YES		<input checked="" type="checkbox"/> NO																	
16. INSURANCE PLAN NAME OR PROGRAM NAME		17. CLAIM CODES (Designated by NUCC)														15. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
																<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		I've completed Items 2, 3a, and 3d.			
18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits directly to myself or to the party who excepted assignment of benefits.		19. OTHER DATE														16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
		MM / DD / YY		MM / DD / YY		MM / DD / YY		MM / DD / YY		MM / DD / YY		MM / DD / YY		MM / DD / YY		FROM MM / DD / YY TO MM / DD / YY					
20. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. LG U92607		17b. MP 1549596493		18. HOSPITALIZATION DATES EXCLUDED TO CURRENT SERVICES										FROM MM / DD / YY TO MM / DD / YY					
21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. OUTSIDE LAB?				23. RESUBMISSION CODE				24. PRIOR AUTHORIZATION NUMBER				25. CHARGES							
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																			
26. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. D. PROCEDURES, SERVICES, OR SUPPLIES (English Unless Otherwise Specified) ORTHOPODI		E. MODIFIER		F. DIAGNOSIS CODE		G. DRG CODE		H. PAY PER UNIT		I. L. ID QUAL		J. BILLING PROVIDER ID #					
From DD / YY MM / DD / YY To DD / YY MM / DD / YY		NAME		70551				A		702 861				B		161502336					
1 03 / 27 / 17 03 / 27 / 17 11																NPI 1710978598					
2 03 / 27 / 17 03 / 27 / 17 11				72141				A		707 111				B		161502336					
3																NPI 1710978598					

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION



DENT
IMAGING CENTERS

NEUROLOGY
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Offices
MAIN TELEPHONE NUMBER
P# 716-250-2000; F# 716-250-1020

Oxford Park Office
Sterling Medical Park
200 Sterling Drive
Oxford Park, NY 14127

PATIENT: DANIELLE HARWELL

DOB: 8/29/1980

EXAM DATE: 3/27/2017

Referring: JENNIFER W. MCVIGE MD JAMES PANZARELLA DO

PROCEDURE: MRI OF THE CERVICAL SPINE

TECHNIQUE: An MRI scan of the cervical spine was obtained utilizing T1 weighted and T2 weighted scan sequences in the axial plane. The study also included T1 weighted scan sequences in the sagittal plane and STIR sequences in the sagittal plane.

This study is of good quality.

COMPARISON: OUTSIDE EXAMS, MR, MRI C-SPINE WO, 1/04/2016, 12:55.

INDICATIONS: History of disc protrusions with no narrowing of canal.

FINDINGS: The vertebral bodies are relatively normal in height and signal intensity. Only some subtle anterior spondylitic spurring is seen at C4-5 and C5-6. There is evidence of dextroscoliosis of the upper cervical spine. No definite evidence of spondylolisthesis or vertebral body compression is noted.

On the STIR sequences, no abnormal signal intensities are seen within the vertebral bodies.

The cervical cord is normal in size and signal intensity.

CONCLUSION: Abnormal serial MRI of the cervical spine demonstrating:

1. A mild degree of dextroscoliosis of the cervical spine without evidence of definite spondylolisthesis or vertebral body compression.
2. Posterior uncovertebral spur disc complexes seen at C4-5, C5-6 without foraminal or spinal stenosis.
3. The cervical cord is normal in size and signal intensity.
4. When compared to the study from 01/04/2016 there has not been a significant change.

Laszlo Mechler, MD

Laszlo L. Mechler, MD, FAAN

Dictated by: Laszlo L. Mechler, MD, FAAN on 3/28/2017 at 9:29

Monica Ferguson on 3/28/2017 at 12:08

Approved by: Laszlo L. Mechler, MD, FAAN, FASN on 3/28/2017 at 15:40



DENT
IMAGING CENTERS

NEUROLOGY
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Offices
MAIN TELEPHONE NUMBER
P# 716-250-2000; F# 716-250-1020

Orchard Park Office
Sterling Medical Park
200 Sterling Drive
Orchard Park, NY 14127

PATIENT: DANIELLE HARWELL

DOB: 8/29/1980

EXAM DATE: 3/27/2017

Referring: JENNIFER W. MCVIGE MD JAMES PANZARELLA DO

PROCEDURE: MRI OF THE BRAIN

TECHNIQUE: An MRI scan of the brain was obtained utilizing T1 weighted, T2 weighted, FLAIR, diffusion weighted, and susceptibility weighted sequences in the axial plane. The study also included a FLAIR sequence in the sagittal plane.

The study is of good quality.

COMPARISON: None.

INDICATIONS: Worsening headache activity and associated vertigo and nausea.

FINDINGS: The ventricular system is normal for the patient's age without any shift or distortion.

On the FLAIR axial images no definite parenchymal abnormalities are noted.

The basal cisterns, sulci, and fissures are normal for the patient's age.

The signal voids within the anterior posterior arterial circulation are present. Superior sagittal sinus is patent.

The diffusion-weighted images are unremarkable.

No abnormalities are seen in the orbits, sinuses, or mastoids.

CONCLUSION: Normal MRI scan of the brain without contrast.

Laszlo Mechtiler MD

Laszlo L Mechtiler, MD, FAAN

Dictated by: Laszlo L Mechtiler, MD, FAAN on 3/28/2017 at 9:32

Monica Ferguson on 3/28/2017 at 9:09

Approved by: Laszlo L Mechtiler, MD, FAAN, FASN on 3/28/2017 at 15:58



DENT

NEUROLOGIC INSTITUTE

Venice Bates, MD	François M. Gengen, Ph.D.	Bennett Myers, MD
Bela Ajtay, MD	Sanjay Gupta, MD	Math Patel, MD
Alfred Belkin III, MD	Tomas Hofmann, MD	Mehmanzad M. Qasimyeh, MD
Honoria Capote, MD	J. Maurice Houchane, MD	Michelle M. Ralicka, Ph.D.
Donna M. Czerniecki, PhD	Xiaoli Li, MD	Lizan Rajan, MD
Steve DeFax, MD	Laurel Meekler, MD	Nicolas Sakla, MD
J. Ashley Duperre, PhD	Jennifer W. McVige, MD	Lixia Zhang, MD, PhD
Marc S. Frost, MD	Kenneth R. Murray, MD	Joseph V. Fritz, PhD, CEO

MARCH 30, 2017

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

(716) 250-2000
www.dentinstitute.com

Ambulatory Offices | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 259-2845
Orchard Park Office | Sterling Medical Park • 205 Sterling Drive • Orchard Park, NY 14227 | Fax: (716) 251-0315
Batavia Office | 33 Batavia City Center • Batavia, NY 14020 | Fax: (716) 259-2045

DIAGNOSTICS & SERVICES	
MEET	Neurophysiology
Argosgrams	Posturography
BANS	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImEHT	PNG
Dyskinics	

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CLASS

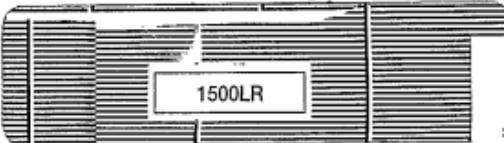


04 03 17

DENTHEMOROLOGIC CROWN, LLP
ADMISTRATIVE OFFICE
3980 S. PARKWAY DR SUITE B
BUFFALO, NY 14226



UNITED STATES POSTAGE
FIRST CLASS MAIL
02 1P \$ 002.68
0003214492 MAR 30 2017
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PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIKA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA EXCLNG OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Group Health Plan <input type="checkbox"/> FECA <input checked="" type="checkbox"/> EXCLNG <input type="checkbox"/> OTHER <input type="checkbox"/> <input type="checkbox"/>												1a. INSURED'S ID. NUMBER (For Program Item 1) 013873940-0101-059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY HARRELL, DANIELLE 08 29 1980 M F X						4. INSURED'S NAME (Last Name, First Name, Middle Initial) = SADIE =			
5. PATIENT'S ADDRESS (No., Street) 56 BERBEEAVEN DR						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street) CITY ZIP CODE TELEPHONE (Include Area Code)			
CITY AMERST			STATE NY			8. RESERVED FOR NUCC USE X			CITY			STATE			
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER			
						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) NY						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			
						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)			
d. INSURANCE PLAN NAME OR PROGRAM NAME						10e. CLAIM CODES (Designated by NUCC)						c. INSURANCE PLAN NAME OR PROGRAM NAME			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 8a, and 8d.			
SIGNED - ON FILE - DATE 01-06-2016												SIGNED - ON FILE -			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 2015 QUA			15. OTHER DATE MM DD YY QUA			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SIDNEY GRABAU, PA			17a. 17b. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-E to service line below (24E) ICD Ind												22. RESUBMISSION CODE ORIGINAL REF. NO.			
A LM79.1	B L	C L	D O.	E F	G L	H L	I L	J K L	P	Q	R	S	T	U	
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY PLAC OF SERVICE SNS C D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS POINTERS												F G H I J \$ CHARGES DAYS OR UNITS SPAY Family Plan ID NPI QUA RENDERING PROVIDER ID. #			
1 03 27 17 03 27 17 11 971.40												55 00 3 NPI 1144462011			
2												NPI			
3												NPI			
4												NPI			
5												NPI			
6												NPI			
25. FEDERAL TAX ID NUMBER 47-0989449			SSN ENR <input checked="" type="checkbox"/>			26. PATIENT'S ACCOUNT NO. BARRELL, D			27. ACCEPT ASSIGNMENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			28. TOTAL CHARGE \$ 55 00		29. AMOUNT PAID \$ 0 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMT 03.29.2017 SIGNED												30. Rcv'd for NUCC Use 55 .00			
32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043												33. BILLING PROVIDER INFO & PH# (716) 725-0264 GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: If a person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil pen. litig.

REFERS TO GOVERNMENT PROGRAMS ONLY

TRICARE/MD TRICARE PAYMENTS: A patient's physician requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 5 through 10 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information, and authorizes his/her employer, entity or insurance company, to file a liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services in this claim. Medicare claim is made. See 42 CFR 411.504. Item 9 is completed if the patient's signature authorizes release of the health plan or agency information to the health plan or agency office. In those cases where TRICARE does not administer the program it refers to the agency to accept the charge submission of the physician claim. TRICARE itself will make the final charge and the government responsible for "negligible, consequential and non-covered services." Compensation and the deductible are based upon the charge determination of the physician, carrier or TRICARE for inpatient liability. It also has the right to change submitted TRICARE is not a health insurance program but makes payment for health benefits provided through certain enrollment via the Uniform Services Insurance on the patient's signature should be provided in these items captioned as "insured", i.e., items 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The person whose service request the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (TRICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment, I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished my office with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) my claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and TRICARE regulations and program instructions for payment, including but not limited to the Federal anti-kickback statute and Physician Self-Referral Law (commonly known as Stark law); 5) the services on the form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision or as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license, etc.) or 85% of the primary individual rendering each service, is reported in the designated section for services to be considered "incident to" a physician's professional services; 7) they must be rendered under the physician's direct supervision by his/her employee; 8) they must be an integral, although incidental part of a covered physician's professional services; 9) they must be of funds commonly furnished in physician's offices, and 10) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black-Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OMB to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1626, 1627 and 1674 of the Social Security Act as amended, 42 CFR 411.34(p) and 424.5(a)(5), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1080, 6 USC 8101 et seq. and 30 USC 901 et seq. 38 USC 613, E.O. 13377.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer those programs. For example, it may be necessary to disclose information about the results you have had at a hospital or clinic, additional disclosures can made through multiple uses for information contained in system - of records.

FOR MEDICARE CLAIMS: See the notice modifying item No. 09-70-0701, titled, "Clarification Medicare Claims Report," published in the Federal Register, Vol. 65 No. 177, page 57943, Wed. Sept. 17, 2002, or its update if and reproduced.

FOR CHOP-CI (AMERICAN) PLAN OF LIFE, Privacy Act of 1974, "Restitution of Nutria of Systems of Records," Federal Register Vol. 56 No. 40, Wed Feb. 26, 1991, Sec. 136.5, PMA-5, CBA-12, DVA-12, FSA-12, or its update if and reproduced.

FOR TRICARE CLAIMS: PRINCIPLE: To evaluate eligibility for medical care provided by civilian sources and to issue payment upon evidence of liability and documentation that the care supplied is rendered and authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services, and/or the Dept. of Transportation consistent with their statutory authority and/or permission under TRICARE/RETIREMENT; to the Dept. of Justice for representation of the Secretary of Defense; in civil actions to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with repayment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosure may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on notices relating to enrollment, claim, adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation involved in the operation of TRICARE.

DISCLOSURE(S): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

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I further agree to certify, or pay medical bills, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, insurance co-payment or similar cost sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were properly furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statement, or documents, or noncompliance of a material fact, may be prosecuted under applicable Federal or State laws.

According to Title 44, Part 1, section 10, the system is 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 0938-0110. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, to gather relevant data, to complete and review the information collection. If you have any comments concerning the accuracy of the time expenditure or any suggestions for improving this form, please send an e-mail message to GSA, FECA Projects Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21204-1870. That address is for comments and inquiries only. DO NOT MAIL COMPLETED OR ALREADY FILLED OUT FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14204
 Office: (716) 725-0834 Fax: (716) 725-0865

Client Name: Danielle Harwell Date: 3/24/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client feels better. Still sore/achy. Moderate pressure in above areas to give tissue a buzz.

Action/s Applied: (Check All that Apply) and heat.

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat/Zipper

Therapist:

Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14204
 Office: (716) 725-0834 Fax: (716) 725-0865

Client Name: Danielle Harwell Date: 3/27/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client feels better. It's sore w/ pain
 "Shooting" down legs. Cervical mm
 tightness into thoracic region.

Action/s Applied: (Check All that Apply) B/P/q/t/c lightness w/

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage Q/pain
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat/Zipper

Therapist:

Danielle Harwell

04 03 17

04 03 17



FREDERICKSBURG VA 22403-9527

PO BOX 9507

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BLUFFSTADT

Great Lakes Therapeutic Massage
355 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Marx



0138739400101059

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE <input type="checkbox"/> (Medicare)		MEDICAID <input type="checkbox"/> (Medicaid)		TRICARE <input type="checkbox"/> (NMEDICA)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP <input type="checkbox"/> (ADM)		HEALTH PLAN <input type="checkbox"/> (ADM)		FECA BENEFIT <input type="checkbox"/> (ADM)		OTHER <input type="checkbox"/> (ADM)		1a. INSURED'S ID NUMBER 0138739400101059*		(For Program in Item 1)									
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08291980												SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5 PATIENT'S ADDRESS (No. Street) 1131 CLEVELAND DRIVE												6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>												7. INSURED'S ADDRESS (No. Street) 56 BEREHAVEN DR, LEFT			
CITY CHEEKETOWAGA		STATE NY		CITY AMHERST		STATE NY																					
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951																					
8 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
b. RESERVED FOR NUCC USE												a. INSURED'S DATE OF BIRTH MM DD YY 08291980															
c. RESERVED FOR NUCC USE												b. OTHER CLAIM ID (Designated by NUCC)															
d. INSURANCE PLAN NAME OR PROGRAM NAME												c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												10d. CLAIM CODES (Designated by NUCC)															
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												14. SIGNATURE ON FILE															
15. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115												16. OTHER DATE MM DD YY 454 111215															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM <input type="checkbox"/> TO <input type="checkbox"/>															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to services listed below (24e))												22. RESUBMISSION CODE ORIGINAL REF NO															
A M50.222 B M51.26 C M51.27 D M54.12												E I823.3XXA F M99.01 G M99.03 H M99.02															
I M99.05 J M54.2 K M54.5 L M54.6												23. PRIOR AUTHORIZATION NUMBER															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR		C. PROCEDURES, SERVICES, OR SUPPLIES (List any unusual circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS CODE ICD-10		F. R. S CHARGES		G. DAYS ON DATE		H. OPEN ITEM PER		I. ID QUAL.		J. RENDERING PROVIDER ID #									
1 03162017 03162017 11				98941				ABCD		32 28		1						NPI 1710014188									
2 03162017 03162017 11				97124		59		ABCD		11 63		1						NPI 1710014188									
3 03232017 03232017 11				98941				ABCD		32 28		1						NPI 1710014188									
4 03232017 03232017 11				97010				ABCD		10 53		1						NPI 1710014188									
5																		NPI									
6																		NPI									
25. FEDERAL TAX ID. NUMBER 364500165		SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO 343881244		27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE 86.72		29. AMOUNT PAID 8		30. Reserved for NUCC Use															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to the bill and my signature on this PETER GOZINSKI DC		32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849																							
SIGNED 03312017 DATE "1235256546"																"1235256546"											

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
March 31, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday March 16, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 03/16/2017 at 12:04pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain and headaches. Patient saw neurologist who ordered a new cervical and head MRI. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last week.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->5/10. *Pain is occasional.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she has been experiencing daily headaches. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since onset.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that she has an injection scheduled for March 30, 2017 with Dr. Siddique. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 3->4/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Encounter dated 03/16/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/31/2017

Objective

Cervical: Range of motion: flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. Posture: rounded shoulders. Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. X-ray findings: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C1, C2, C5, C6, left occiput, left first rib. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Mild to Moderate. Trigger points: bilateral rhomboids. Orthopedic tests: Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: 40/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

Encounter dated 03/16/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/31/2017

mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* continue 1x/week for 2 weeks; 1x every 2 weeks for 2 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization); C1 left lateral flexion restriction (Instrument adjustment Arthrostim); C2 left lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to March 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Addendum: Under treatment and plan, physical modalities, heat and electric stimulation were not performed today. PJG. 03/16/2017. 12:07 PM

Thursday March 23, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 03/23/2017 at 8:23am

Encounter dated 03/23/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/31/2017

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain and headaches. Patient going for her cervical and head MRI on March 27, 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. since last week. *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->5/10. *Pain is occasional.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she has been experiencing daily headaches. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation with trigger point injections. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. since onset. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. She states that she has an injection scheduled for March 30, 2017 with Dr. Siddique. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 3->4/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C1, C2, C5, C6, left occiput, left first rib. *Subluxations detected by:* motion and static palpation.

Encounter dated 03/23/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/31/2017

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppelman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 40/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: continue 1x/week for 1 weeks; 1x every 2 weeks for 2 weeks; Re-examination for 3 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (anterior); T3 left rotation restriction (anterior); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4

Encounter dated 03/23/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 03/31/2017

extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization); C1 left lateral flexion restriction (Instrument adjustment Arthrostim); C2 left lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to April 30, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

- *Postscript* This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



Item# 43568
Patent Pending



04 05 17



Geico
P.O. Box 9507
Fredericksburg, VA 22403

Depew, NY 14043
345 Dick Rd.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

013873940.0101-059

PIKA

1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDERAL BUILDING	OTHER	1a INSURED'S I.D. NUMBER	(For Progress in Item 1)			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> Group Health Plan	<input type="checkbox"/> FED Bldg	<input type="checkbox"/> Other	013873940011059				
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE	SEX		4 INSURED'S NAME (Last Name, First Name, Middle Initial)				
				MM DD YY	<input type="checkbox"/> M	<input checked="" type="checkbox"/> F	HARWELL DANIELLE				
HARWELL DANIELLE				08291980							
5 PATIENT'S ADDRESS (No. Street)				6 PATIENT'S RELATIONSHIP TO INSURED		7 INSURED'S ADDRESS (No. Street)					
1131 CLEVELAND DRIVE				<input checked="" type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	56 BEREHAVEN DR., LEFT				
CITY	STATE	8 RESERVED FOR NUCC USE				CITY	STATE				
CHEEKERTOWAGA	NY					AMHERST	NY				
ZIP CODE	TELEPHONE (Include Area Code)					ZIP CODE	TELEPHONE (Include Area Code)				
14225	(716) 536 0951					14228	(716) 536 0951				
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10 IB PATIENT'S CONDITION RELATED TO							
				a. EMPLOYMENT? (Current or Previous)							
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	b. INSURED'S DATE OF BIRTH					
				MM DD YY	08291980	SEX					
				<input type="checkbox"/> YES	<input type="checkbox"/> NO	NY					
b. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?							
				PLACE (State)	d. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	e. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				f. GEICO							
				g. IS THERE ANOTHER HEALTH BENEFIT PLAN?							
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	If yes, complete items 8, 9a, and 9d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
SIGNED SIGNATURE ON FILE DATE SIGNATURE ON FILE											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
MM DD YY	QUAL	MM DD YY	QUAL	MM DD YY	QUAL	MM DD YY	FROM	MM DD YY	TO	MM DD YY	
103115	Q1A 431	454	111215								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
								MM DD YY	TO	MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									19. OUTSIDE LAB? \$ CHARGES		
									<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)									22. RESUBMISSION CODE ORIGINAL REF NO.		
A M50.222	B M51.26	C M51.27	D M54.12								
E S23.3XXA	F M99.01	G M99.03	H M99.02								
I M99.05	J M54.2	K M54.5	L M54.6								
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Universal Circumstances)	D. MODIFIER	E. DIAGNOSIS CODE	F. \$ CHARGES	G. QTY OR UNITS	H. DRG Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID #	
From MM DD YY	To MM DD YY	EMR	CPT/HCPCS	MODIFIER	CODE	20 29	1	NPI	1710014188		
04072017	04072017	11	99212	25	ABCD						
04072017	04072017	11	98941		ABCD	32 28	1	NPI	1710014188		
04072017	04072017	11	97010		ABCD	10 53	1	NPI	1710014188		
								NPI			
								NPI			
								NPI			
25. FEDERAL TAX I.D. NUMBER		SSN EN	26. PATIENT'S ACCOUNT NO		27. ACCEPTANCE AGREEMENT I accept assignment of benefits	28. TOTAL CHARGE		29. AMOUNT PAID	30. Reserved for NUCC Use		
364500165		<input type="checkbox"/>	343821246		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	\$ 63.10	\$ 6				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this form are true and correct.)									32. SERVICE FACILITY LOCATION INFORMATION		
PETER GOLINSKI DC									CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		
SIGNED 04132017 DATE * 1235256546 ^b									33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849		

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 13, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday April 7, 2017 Provider: Peter Guzinski DC RE-EXAM

Electronically signed by Peter Guzinski DC on 04/09/2017 at 12:24pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. She stated that she had a brain and cervical MRI performed on March 27, 2017. Due to the pain, she is unable to lift heavy weights, she has moderate headaches which come infrequently and she can do most of her usual work, but no more. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last re-examination on February 7, 2017. *Pain:* achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Cervical Disability Index:* 28%. *Recent medical treatment for this condition:* Head and cervical MRI; Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving.

Encounter dated 04/07/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2017

since last re-examination on February 7, 2017. **Pain:** achy, dull, sharp, shooting; level: 3/10. **Pain is frequent.** **Exacerbates symptoms:** movement; bending; lifting; activities of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Oswestry score:** 28%.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain has been better since her recent set of injection. She stated that she had lumbar injections performed on March 30, 2017 with Dr. Siddique. Due to the pain, she is unable to lift heavy weights, she is unable to sit greater than 30 minutes, she is unable to stand greater than 60 minutes and she is unable to travel on journeys greater than 60 minutes. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** improving, since last re-examination on February 7, 2017. **Pain:** achy, dull, sharp, shooting, numb. **Range:** 2->3/10. **Pain is frequent.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **OSWESTRY Disability Index:** 28%. **The Keele Start Back Screening Tool:** Low risk. **Recent medical treatment for this condition:** Pain management evaluation with injections. **Changes in past medical history:** None.

Activity of Daily Living Form Bending forward/backward: moderate impairment; Driving: mild impairment; Drying Hair: mild impairment; Household chores: moderate impairment; Laundry: moderate impairment; Lifting less than 10 lbs: mild impairment; Lifting more than 10 lbs: severe impairment; Kneeling: mild impairment; Making Meals: moderate impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: no impairment; Restful night's sleep: no impairment; Seated to standing position: mild impairment; Sexual activity: moderate impairment; Standing: mild impairment; Squatting: mild impairment; Tying shoes: mild impairment; Using lavatory: no impairment; Walking: no impairment.

Objective

Cervical: Her recent cervical and brain MRI were not available for review today. **Range of motion:** flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. **Posture:** rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Sensation:** all upper extremity sensory exams (C5-T1) were WNL to Pin prick. **Hypertonicity & Tenderness** Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Reflexes:** bilateral upper extremity reflexes (C5, C6, C7) 2+. **Orthopedic tests:** left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppelman's: Negative

Encounter dated 04/07/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2017

bilateral. *Spinal subluxation level(s)*: T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation*.

Lumbar/Sacral/Pelvis: *Range of motion*: flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Heel to toe walking*: WNL. *Gait pattern*: normal. *Strength*: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation*: all lower extremity sensory exams (L1-S1) were WNL to Pin prick. *Tenderness & Hypertonicity* lumbar paraspinal left mild to moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation*: left SI: mild to moderate. *Trigger points*: left gluteus maximus. *Reflexes*: bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests*: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative; Minor's sign: Negative; Slump Test: Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for lower back pain on a cough or sneeze. *Spinal subluxation level(s)*: L4, L5, Left SI. *Subluxations detected by*: motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-examination on February 7, 2017 her active cervical rotation improved from 60 to 70 degrees and she is now able to sleep without being limited by neck pain. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL. **Diagnosis**: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis**: Guarded. **Post-treatment analysis**: patient tolerated treatment without incident. **Set backs**: Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment**: unchanged.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last re-evaluation on February 7, 2017. Her active lumbar flexion improved from 20 to 60 degrees, extension from 10 to 15 degrees, bilateral rotation from 20 to 30 degrees and left lateral flexion from 15 to 25 degrees. In addition, her left SLR improved from 30 to 60 degrees. Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to sit, stand, bend, perform household chores and lift with less pain. **Post-treatment analysis**: patient tolerated treatment without incident. **Set backs**: Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion

Encounter dated 04/07/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2017

(herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 4 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 8 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

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04 17 1
UNCLERED - DEP.
CHIROPRACTIC

345 Dick Rd.
Depew, NY 14043



Geico
P.O. Box 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

01381394D-0101-059

PIKA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> TEL LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (TRICARE) (CHAMPVA) (Group Health Plan) (FECA) (TEL LUNG) (Other)												1a INSURED'S ID NUMBER 01387394001059			(For Program Item 1)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3. PATIENT'S BIRTH DATE 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT		
CITY CHEKTOWAGA		STATE NY		8. RESERVED FOR NUCC USE			CITY AMHERST		STATE NY		ZIP CODE 14228 TELEPHONE (Include Area Code) (716) 536 0951						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NY			b. OTHER CLAIM ID (Designated by NUCC)		
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO		
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below					
SIGNED SIGNATURE ON FILE												SIGNED SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115 GUM. 431												15. OTHER DATE QUAL 454 111215			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI												18. DIGITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-H to services line below (24e))												22. RESUBMISSION CODE ORIGINAL REF ID					
A IM50 222		B IM51 26		C IM51 27		D IM54 12		E IM99 05			F IM54 5						
E IS23 3XXA		F IM99 01		G IM99 03		H IM99 02		I IM54 2			J IM54 6						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE ENG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS POINTER			F. \$ CHARGES	G. BILLS OR UNITS	H. REBATE/FIN. PAY	I. ID #	J. RENDERING PROVIDER ID #		
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Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 13, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday March 28, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 03/28/2017 at 11:06am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain and headaches. Patient stated that she had her neck and head MRI last night. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since* last week. *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->5/10. *Pain is occasional.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she has been experiencing daily headaches. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation with trigger point injections. *Changes in past medical history:* None.

Thoracic: Patient stated that her middle back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since onset.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is occasional.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activites of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been more intense since last for her MRI yesterday. She stated that she was unable to get off the table due to the pain. She states that she has an injection scheduled for March 30, 2017 with Dr. Siddique. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since* last visit. *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 5->6/10. *Pain is occasional.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Encounter dated 03/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2017

Objective

Cervical: Range of motion: flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. Posture: rounded shoulders. Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. X-ray findings: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C1, C2, C5, C6, left occiput, left first rib. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Mild to Moderate. Trigger points: bilateral rhomboids. Orthopedic tests: Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: 40/60 with pain lower back; extension: 10/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: WNL 30/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild to moderate. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Patrick's/Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in

Encounter dated 03/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/13/2017

mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* continue 1x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (anterior); T3 left rotation restriction (anterior); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (flexion/distraction); L5 extension restriction (flexion/distraction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization); C1 left lateral flexion restriction (Instrument adjustment Arthrostim); C2 left lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left humbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes.

Additional instructions: Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain.

Disability status: Temporary partial starting on November 12, 2015 to April 30, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Abbreviations.

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

04 17 17

04 17 1
WICKETTE, DEPEW
CHIROPRACTIC

345 Dick Rd.
Depew, NY 14043



Geico
P.O. Box 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA												PICA							
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BUKING		OTHER		1a. INSURED'S ID NUMBER		(For Program Item 1)			
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input checked="" type="checkbox"/> DOD/DoD		<input type="checkbox"/> Member/DoD		<input type="checkbox"/> DOD		<input type="checkbox"/> DOD		<input type="checkbox"/> DOD		013873940-0101-059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARWELL, DANIELLE												MM DD YY		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		HARWELL, DANIELLE			
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)					
56 BEEBEAVER DR												Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>							
CITY		STATE		8. RESERVED FOR NUCC USE		CITY		STATE											
AMHERST		NY		X															
ZIP CODE		TELEPHONE (Include Area Code)				ZIP CODE		TELEPHONE (Include Area Code)											
14228		(716) 536-0951																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FEGA NUMBER					
												a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH					
												<input type="checkbox"/> YES <input type="checkbox"/> NO		MM DD YY					
												b. AUTO ACCIDENT?		SEX					
												<input type="checkbox"/> YES <input type="checkbox"/> NO <u>INJ</u>		<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/>					
												c. OTHER ACCIDENT?		d. INSURANCE PLAN NAME OR PROGRAM NAME					
												<input type="checkbox"/> YES <input type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
														<input type="checkbox"/> YES <input type="checkbox"/> NO					
														If yes, complete items 9, 9a, and 9d					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below					
SIGNED - ON FILE -												DATE 01-06-2016		SIGNED - ON FILE -					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		MM DD YY		15. OTHER DATE		MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
30 01 2015		QUAL		QUAL		MM DD YY		FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a		17b		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
SIDNEY GRABAU, PA												NPI		FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB?		\$ CHARGES					
												<input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A/L to service line below (24e))												10d. IND		22. RESUBMISSION CODE					
A LM79.1		B L		C L		D L		ORIGINAL REF. NO.											
E L		F L		G L		H L		23. PRIOR AUTHORIZATION NUMBER											
I L		J L		K L		L L													
24. A DATE(S) OF SERVICE		B PLACE OF SERVICE		C		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E DIAGNOSIS CODE/ICD-9 CM/ICD-10 CPT/HCPCS NDC/DRG		F \$ CHARGES		G DAYS ON BEDS		H SHOT PER DAY		I ID CUAL		J RENDERING PROVIDER ID. #	
From MM DD YY	To MM DD YY	PLACE OF SERVICE EMR	CODE CPT/HCPCS	ICD-9 CM/ICD-10 CPT/HCPCS NDC/DRG	DIAGNOSIS CODE/ICD-9 CM/ICD-10 CPT/HCPCS NDC/DRG	\$ CHARGES	DAYS ON BEDS	H SHOT PER DAY	I ID CUAL	J RENDERING PROVIDER ID. #									
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2 04 14 17	04 14 17	11	97140		h	55.00	3		NPI	1144462011									
3 04 17 17	04 17 17	11	97140		h	55.00	3		NPI	1144462011									
4 04 21 17	04 21 17	11	97140		h	55.00	3		NPI	1144462011									
5 									NPI										
6 									NPI										
25. FEDERAL TAX ID NUMBER		SSN SSN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? <small>(If you do not accept assignment, check here)</small>		28. TOTAL CHARGE		29. AMOUNT PAID		30. RAdv for NUCC Use							
47-0989449		<input checked="" type="checkbox"/>		HARWELL, D		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 220.00		\$ 0.00		220.00							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH#					
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043		(716) 725-0264					
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							
COLLEEN MARK, LMFT 04.22.2017 SIGNED DATE												#1144462011		#1144462011					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY / APPLICABLE PROGRAMS.
 NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

REG. 411.210 TRICARE PAYMENT: A patient's signature, where it is known that payment will be made and releases release of any information necessary to process the claim and certifies that the individual identified in Pacer 1 through 12 has, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information and identifies the person has a employer group health insurance, liability, no-fault, workers' compensation or other insurance which is responsible to pay for the services furnished the healthcare claim as follows. See 42 CFR 411.210(a), if item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency that, in the opinion of the physician, is responsible for the deductible, copayments and non-covered services. Consents and the deductible can be copied onto the charge documentation. See Medicare name of provider (Healthcare claim) if item 9 is not checked, then no charge. Tricare is not a health insurance program but makes payment for health benefits provided through contractor to the Uniformed Services. The information on the patient's sponsor should be provided in these boxes captioned "Inured", i.e., items 10 & 11, 12 & 13, 14 & 15.

BLACK LUNG AND FECA CLAIMS

The amount shown is the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedures and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, AND BLACK LUNG)

I acknowledge that I am filing a claim for payment from Federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed decision; and payment decision; 4) the claim number submitted by me or on my behalf, by my designee being completely consistent with an appropriate Medicare, FECA, and/or Black Lung claim number, and provides for payment according to law but not limited to the Federal rate-tables; 5) I am and Physician Bill Retainer law (commonly known as Stark law); 6) the services rendered are not medically necessary in nature, and personally furnished to my professional service by my employee under my direction, my direct, cap, or noncap, except as otherwise may be permitted by Medicare or TRICARE; 6) for each service rendered, I am not paid in part, in the discounted scenario. For services to be coded, not "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they may be rendered by a physician's non-physician, 3) they must be of good condition furnished by physician's employee, and 4) the services, or non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that: 1) my employee/veteran rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contractor or employee of the United States Government, other civilian or military (refer to 5 USC 3336). For Black Lung claims, I further certify that the services performed by you for a Black Lung medical provider.

For FECA and Black Lung claims, my signature below this form is received as required by existing law and regulations (42 CFR 424.2).

NOTICE: Any person who knowingly files inaccurate information to receive payment from Federal funds requested by the firm may upon conviction, be subject to fine and imprisonment under applicable criminal laws.

NOTICE TO PAYMENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, THICARE and CIVICP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in sections 205(h), 107, and 107c of the Social Security Act as amended, 42 CFR 411.24(p) and 421.5(a)(6), and 44 USC 3101, 1 CFR 101 et seq and 10 USC 1079 and 1079.5 USC 3101 et seq, and 30 USC 601 et seq 38 USC 610, E.O. 9897.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to detect if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, companies, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the objective administration of Federal programs that require other third parties pay to primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used in a hospital or doctor. Additional disclosures are made through routine uses for information retained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 00-70-0001, titled, "Gamer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37548, Wed. Sept. 12, 1990, as updated and republished.

FOR OIGCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See RSA-5, EGA-6, EGA-12, EGA-13, EGA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the service supplied received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense, in civil actions; to the Health Resources Service, private collecting agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the House or Senate in regard to record patterns. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, payor's business entities, and individual providers of care, on matters relating to enrollment, claims, nondisclosure, fraud, program abuse, utilization review, quality assurance, peer review, premium inquiry, third-party liability, continuation of benefits, and civil and/or criminal litigation related to the operation of TRICARE.

INSTRUCTIONS: Voluntarily or, if ever, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under the program for failing to supply information. However, failure to furnish information regarding the medical services rendered or the "amount charged would" prevent payment of claim, which then negates. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to furnish medical information under FECA, could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1198B of the Social Security Act and 31 USC 3401-3112 provide penalties for withholding the information.

You are advised to consult Title P.L. 102-393, the "Computer Matching and Privacy Protection Act of 1992," prior to the government to verify information by way of computer matching.

PHYSICAL PAYMENTS (PROPOSED CERTIFICATION)

I hereby agree to be bound by rules and regulations to disclose fully my cost of services provided to individuals under the State's Medicaid plan and to furnish information to the appropriate Medicaid contractor or agency on the State Agency or Dept. of Health and Human Services may request.

I further agree to submit, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under this program with the exception of deductible, coinsurance, co-payment or similar co-charging charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal decision.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claim, documents, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

ATTACHMENT: I, Robert J. Binkowski, # 415-51199, am required to respond to a collection of information unless I display a valid OMB control number. The valid OMB control number for this information is 0937-1190. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to answer the questions, search existing records, gather the required information, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or any suggestions for reducing this burden, please write to: CMS, PRA Reports Clearance Officer, Mail Stop C4-98-03, Baltimore, Maryland 21201. Thank you for your assistance in making our forms more user friendly and accurate. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

373 Dick Rd Dugew, NY 14048

Office: (716) 725-4004

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 4/10/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Newer block injects in dxe last wk slowly starting to work. See all over from being in bed w/

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massag~~e~~ Glute
 Deep Tissue Massage Myofascial Release Friction Trigger
 Manual Traction Stretching Range-of-Motion Nechigan
 Stripping Compression Lymph Drainage mmf (b)

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat more

Therapist: Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

373 Dick Rd Dugew, NY 14048

Office: (716) 725-0354

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 4/14/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client felt sudden / in (R) shoulder low. It feels better.

Saw Chiro on Tues. Feeling

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Message
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat more

Therapist: Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-034

Fax: (716) 725-0365

Client Name: Danielle Harrell Date: 4/17/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Area's of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliques ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client care from general
HDL's getting ready for Easter.

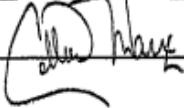
Shoulder/upper trap hypertonic w/ lom

Action's Applied: (Check All that Apply) Ice/Heat Stretch
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Cool Meds Ice / Heat myofascial

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-034

Fax: (716) 725-0365

Client Name: Danielle Harrell Date: 4/21/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Area's of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliques ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client had IMC Wednesday

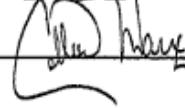
The things that they made client do aggravated discomfort. LB tightness

Action's Applied: (Check All that Apply) aggr. sacrum & glutes Heat Packs Cold Packs Sombra/Biofreeze Light Pressure Massage Moderate Pressure Massage Deep Tissue Massage Myofascial Release Friction Manual Traction Stretching Range-of-Motion Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Cool Meds Ice / Heat / Deep

Therapist:



04 25 17



04 25 17



FREDERICKSBURG VA 22403-9527

PO BOX 9507

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GEICO

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UNITED STATES



44-344
22-AUG-77
P&L 22

Great Lakes Therapeutic Massage
6 Bodily Health Practitioners
375 Dick Road, Suite #2
Delpark, NY 14043
Am. C. Marx



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/11

GEICO INSURANCE - NFT
NY FIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22

FREDERICKSBURG VA 22403

ENGLISH

例題 1

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP MEMBER	HEALTH PLAN MEMBER	FCA DOI	OTHER DOI	1a. INSURED'S I.D. NUMBER 0138739400101059	(For Program in Item 1)
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TRICARE)	<input type="checkbox"/> (CHAMPVA)	<input type="checkbox"/> (Member)	<input type="checkbox"/> (DOI)	<input checked="" type="checkbox"/> (DOI)	<input type="checkbox"/> (DOI)		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE	
HARWELL, DANIELLE				08 29 1980		M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Sister <input checked="" type="checkbox"/> Brother <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR	
CITY CHEEKTONWAGA		STATE NY		CITY CHEEKTONWAGA		STATE NY			
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()		ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()			
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				9. IS PATIENT'S CONDITION RELATED TO:					
				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
				b. AUTO ACCIDENT? (Place State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____					
				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10. CLAIM CODES (Designated by NUCC)					
				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO /year complete name & Ga. and id.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
SIGNED PETER J GUZINSKI				SIGNATURE ON FILE DATE 02 09 16					
SIGNED PETER J GUZINSKI SIGNATURE ON FILE DATE 02 09 16									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (IMP) MM DD YY QUAL				15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI	
				17a. 1G U62607		17b. 1710014188		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Please A-L to service line below (24E) ICD IND: 0									
A. M79.1	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>	J. <input type="checkbox"/>
22. PREMISSION CODE ORIGINAL REF. NO.									
23. PRIOR AUTHORIZATION NUMBER									
F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> \$ CHARGES DAYS CH UNITS H. AMT PER UNI I. REND PROV ID #									
04 25 17 04 25 17 11 20553 A 95 74 1 BI 161582336									
NPI 1154482859									
NPI									
NPI									
NPI									
NPI									
NPI									
NPI									
25. FEDERAL TAX I.D. NUMBER SSN EN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 161582336 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE 29. AMOUNT PAID 30. Revd for NUCC Use \$ 95 74 \$ 0 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made in part thereof.) LIXIN ZHANG, MD									
32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727									
33. BILLING PROVIDER INFO & IHP # (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002									
SIGNED LIXIN ZHANG 05 01 17 #1457850911 S #1457850911 Rev#161582336									

PATIENT AND INSURED INFORMATION — CARRIER —

PHYSICIAN OR SUPPLIER INFORMATION



DENT
NEUROLOGIC INSTITUTE

Vernon Bates, MD	Sunjay Gupta, MD	Mahdi Patel, MD
Bela Ajtoni, MD	Tomas Holmlund, MD	Mohammed M. Qasimy, MD
Alfred Belen III, MD	J. Maurice Ibarrangil, MD	Michelle M. Rainke, PharmD
Horacio Capote, MD	Anupama M. Kalu, MD	Lilia Rojas, MD
Ana N. Cervantes, MD	Xiuli Li, MD	Nikola Salikai, MD
Donald M. Czarski, PhD	Laszlo Mechler, MD	Lixin Zhang, MD, PhD
J. Alvarez Botella, PhD	Jennifer W. McVea, MD	Joseph V. Fritz, PhD, CPO
Mark S. Prost, MD	Kenneth R. Murray, MD	
Francis M. Gengo, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note Date: 04/25/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- Migraines, Trigger Point Injections, Headaches
- Neck pain

History of Present Illness

General:

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. The patient reports good results with her trigger point injection. She does still complain of dizziness. She has not yet started vestibular therapy. MRI results were reviewed with the patient which have remained unchanged since previous over one year ago.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C

(716) 250-2000
www.dentinstitute.com

Amherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Center • Batavia, NY 14220 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrogram	Positronigraphy
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infusion	

- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Ilicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 122/74, HR 76, RR 16, Ht 63, Wt 221.8, BMI 39.29, BSA 2.11.

ExaminationNeurological:

		DIAGNOSTICS & SERVICES
(716) 250-2000	www.dentinstitute.com	MRI/CT
		Arthrography
		Botax
		Doppler/TCD
		EEG
		EMG
		ImMCT
		Inflation
		Neuropsychology
		Positron
		Sleep Studies
		SPECT
		Ultrasound
		TMS
		VNG

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The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

. Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 8 cc was injected with a 25-gauge needle without complication into 8 areas in the back within the trapeziell and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 04/25/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 04/25/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 04/25/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 04/25/2017 at 09:48 AM EDT

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrography	Painscopy
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infusion	

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DIAGNOSTICS & SERVICES

MRI/MCT	Neuropsychology
Arthrograms	Pneurography
BioRx	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Influsion	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

<p>1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FEDA EXCLUND OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member ID# <input type="checkbox"/> (DOD) <input checked="" type="checkbox"/> (DOD) <input type="checkbox"/> (DOD) <input type="checkbox"/> (DOD) <input type="checkbox"/> (DOD)</p> <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE</p> <p>3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/></p> <p>4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE</p> <p>5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE</p> <p>6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other</p> <p>7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE</p> <p>CITY STATE CHEEKTONWAGA NY</p> <p>ZIP CODE TELEPHONE (Include Area Code) 14225 ()</p> <p>8. INSURED'S POLICY NUMBER (Last Name, First Name, Middle Initial) GEICO INSURANCE NY PIP</p> <p>9. INSURED'S POLICY GROUP OR PROGRAM NAME GEICO INSURANCE NY PIP</p> <p>10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY</p> <p>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>11. INSURED'S POLICY GROUP OR FICA NUMBER Y4 0138739400101059</p> <p>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature On File DATE 4/10/2017</p> <p>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED Signature On File</p> <p>14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 15 QUAL 431</p> <p>15. OTHER DATE (MM DD YY) QUAL 439 10 31 15</p> <p>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO MM DD YY MM DD YY</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN J PETER GUZINSKI</p> <p>17a. NPI 1710014188</p> <p>18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</p> <p>19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD 9-CM 0</p> <p>A. I M51.26 B. I M54.16 C. I D. I E. I F. I G. I H. I I. I J. I K. I L. I</p> <p>20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>21. RESUBMISSION CODE ORIGINAL REF. NO.</p> <p>22. PRIOR AUTHORIZATION NUMBER NOT REQUIRED</p> <p>23. F. G. H. I. J. \$ CHARGES DATE OF SERV OR USES HOSPITAL PAY I. ID. QUA J. RENDERING PROVIDER ID. #</p> <p>24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. PROCECDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS CODE 03 30 17 03 30 17 11 62311 AB 276 18 1 OB 248830 NPI 1023202355</p> <p>25. 03 30 17 03 30 17 11 00003029328 99070 AB 12 00 6 OB 248830 NPI 1023202355</p> <p>26. 03 30 17 03 30 17 11 77003 AB 116 08 1 OB 248830 NPI 1023202355</p> <p>27. FEDERAL TAX ID NUMBER SSN ENR 28. PATIENT'S ACCOUNT NO. 29. ACCEPT ASSIGNMENT 030445678 <input checked="" type="checkbox"/> X 102251 YES <input type="checkbox"/> NO 30. TOTAL CHARGE 31. AMOUNT PAID 32. Rev'd for NUCC Use \$ 404.26 \$ 0.00</p> <p>33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <i>I certify that the statements on the reverse apply to this bill and are made a part thereof.</i> Jafar Siddiqui</p> <p>34. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery, Inc 180 Park Club Lane, STE 250 PO Box 8000 DEPT 883</p> <p>35. BILLING PROVIDER INFO & PH# (716) 218-1030 UB Neurosurgery, Inc Williamsburg, NY 14221 Buffalo, NY 14267</p> <p>BILLED 4/10/2017 DATE 4/10/2017 1306896220 248830 1306896220 b</p>											
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UNIVERSITY AT BUFFALO
NEUROSURGERY

180 Park Club Lane, Suite 250, Williamsville, NY 14261
(716) 218-1050

Thu Mar 30, 2017 8:45 am Drf 126
102251 08/29/80
HARWELL, DANIELLE

OPERATIVE PROCEDURAL REPORT

Date of admission: 3/30/17

Physician: Jafar W. Siddiqui MD

Preop Dx/ICD-9:

M5.1.26/M50.16

Postop Dx/ICD-9:

- Procedure: Cervical transforaminal sacroiliac
 Thoracic facet stellate ganglion
 Lumbar Interlaminar sympathetic
 Lateral medial branch block other

Same as preop

Fluoroscopy Diagnostic # _____

Isovia M300 therapeutic # _____

Preop medications:

N/A

Anesthesia: Local IV moderate sedation

____ mg Midazolam - ____ mg Fentanyl

Complications: NCNE

LEVEL (circle)	NEEDLE (circle)	APPROACH	MEDICATION
Level <u>sacro / lumbus</u>	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/4" <input type="checkbox"/> spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" <input type="checkbox"/> touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/4" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6" <input type="checkbox"/> 26ga 3 1/4" Crawford	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> 10 ml saline <input type="checkbox"/> 60 mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol
Level _____	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/4" <input type="checkbox"/> spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" <input type="checkbox"/> touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/4" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6"	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol
Level _____	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/4" <input type="checkbox"/> spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" <input type="checkbox"/> touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/4" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6"	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol
Level _____	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/4" <input type="checkbox"/> spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" <input type="checkbox"/> touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/4" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6"	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol

After consenting to the procedure the patient was taken to the operating room and positioned on the fluoroscopy table. Sterile prep and drape was done and procedure started as stated above. Local anesthetic was administered. Screening fluoroscopy was utilized to identify the levels stated above. The needle was advanced under direct visualization. The patient's vital signs remained stable throughout the procedure and the patient was taken to the recovery room in stable condition.

Pre-procedure vital: CO stat: 66 BP: 117/80 Pain Score: 10

Post-procedure vital: CO stat: 66 BP: 114/77 Pain Score: 0/10

Physician signature: Jafar W. Siddiqui, MD Date: 3/30/17 Time: 9:15 AM
 Cctor: James Panzica, PA-C; Peter Ganzinski, DC
 (this must be sent out same day)

Op Proc Rept L_2016

Invoice

Page 2 of 2

Invoice Number 799967471	PO Number PEGGY RN	Invoice Date 06/08/16
--------------------------	--------------------	-----------------------

Item Number	Vendor / Vendor Cat #	Description	Ordered	Unit Shipped	Unit Price	Amount	Sales Tax
462514	Vendor: BMSPHM NDC Name: & 00003029328	KENALOG-40, VL 40MG/ML 10ML PO LN 9	50	EA	50	74.00	3,700.00

SUB TOTAL	TAX	TOTAL AMOUNT
\$4,541.02	\$0.00	\$4,541.02

The purchase listed on this invoice may be subject to a discount or other promotional consideration that may require you to report the value of such discount or promotional consideration, if any, as a discount. In addition, the prices on this invoice may include fees for services that may not be reimbursable under the Medicare/Medicaid statutes. You can receive an itemized list of any fees included in the prices upon request.

PRICING IS CONFIDENTIAL AND PROPRIETARY.



Organization Manifest

UB Neurosurgery, Inc(14)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01387394001010593		HARWELL, DANIELLE	03/30/2017	03/30/2017
04029720001010341		HUDECKI, MELISSA	03/22/2017	03/22/2017
04991315201010163		CHAN, DANIEL	04/13/2017	04/13/2017
02347570501010161		FIX, MELODY	04/13/2017	04/13/2017
04991315201010163		CHAN, DANIEL	04/10/2017	04/10/2017
02722382001010351		ECKERT, SHEILA	04/12/2017	04/12/2017
03918375101010271		FULLER, CHARLOTTE	04/11/2017	04/11/2017
05354554601010173		SCOTT, CAROL	04/11/2017	04/11/2017
04741711801010531		MCDUFFIE, BRITTANY	04/13/2017	04/13/2017
03808139301010151		PALADINO, ANNMARIE	04/10/2017	04/10/2017
01730813901010541		BROOKS, CATHERINE	04/12/2017	04/12/2017
02800034501010221		YOUNG, NANCY	04/13/2017	04/13/2017
05354554601010173		SCOTT, CAROL	04/13/2017	04/13/2017
03221360401010431		DABROWSKI, NICOLE	04/12/2017	04/12/2017

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APPLIES O



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

PATIENT AND INSURED INFORMATION

THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS. SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a federal civil and/or criminal offense.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENT: A complete signature signifies that payment for medical and other services is authorized by the patient. The signature is not necessary to process the claim and certifies that the information provided therein is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and related information which the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay or be liable for the Medicare claim. Under 42 CFR 414.51(a), if item 6 is completed, the patient's signature certifies the release of the information to the health plan or agency shown in item 6, unless otherwise designated. TRICARE beneficiaries, when they agree to accept TRICARE as their primary provider of the healthcare benefit, the liability and payment is responsibility only to the DoD health insurance and medical care and services. **CONTRACTOR** and the deductible (as base) upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary (less, after the charge submitted). TRICARE is not a health insurance program but makes payment for health benefits provided through certain authorities in the Uniform Services. Information on the claim's charges should be provided in there terms captured in "item 6," items 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 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1323, 1324, 1325, 1326, 1327, 1328, 1329, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400, 1401, 1402, 1403, 1404,

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office (716) 725-0324

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 4/24/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) L
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client stated "feel very achy today with discomfort going into my upper arms. Cerv. imm."Action's Applied: (Check All that Apply) Light esp @ side side Heat Packs Cold Packs Somiva/Biofreeze Light Pressure Massage Mod Pressure Massage to @ trap Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion CB better
 Stripping Compression Lymph Drainage w/ fmPlan/Recommendations: (check All that Apply) ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D. Highness
 Follow-up w/ PT Stretchies Can't Meds Ice / Heat inTherapist: Cheri Mayx

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Pain Level: (no pain) 0 2 3 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

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 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) L
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 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client waved Tension/
in cervical area. Light pressure
used here: @ glute light w/ @ QLAction's Applied: (Check All that Apply) hypothermically.

- Heat Packs Cold Packs Somiva/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply) ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat moreTherapist: Cheri Mayx

05 01 17

11 month - 2nd year old male

05 01 17

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

BUFFALO

NY 1420

28 APR 'T

FM 61

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 10110 WASHINGTON D.C.

POSTAGE WILL BE PAID BY ADDRESSEE

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FREDERICKSBURG VA 22403-9527

NO POSTAGE
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IN THE
UNITED STATES



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/2/12

GEICO
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FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE <input type="checkbox"/> (Medicare)	2 MEDICAID <input type="checkbox"/> (Medicaid)	3 TRICARE <input type="checkbox"/> (ComDoD)	4 CHAMPVA <input type="checkbox"/> (Member ID#)	5 GROUP HEALTH PLAN <input type="checkbox"/> (GHP) 6 FEPA <input type="checkbox"/> (FEPA) 7 OTHER <input type="checkbox"/> (Other)	1a. INSURED'S ID NUMBER 013873940011059 (For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			3. PATIENT'S BIRTH DATE MM DD YY 08291980		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT
CITY CHEEKETOWAGA	STATE NY	\$ RESERVED FOR NUCC USE		CITY AMHERST	STATE NY
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951			ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY		
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below					
SIGNED SIGNATURE ON FILE DATE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115 15. OTHER DATE (MM DD YY) 454 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM _____ TO _____ 111215					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____					
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM _____ TO _____					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 21. CHARGES					
22. RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/ICPCs E. MODIFIER F. G. DAYS OF CHARGE H. HOURS PER UNIT I. I.D. CODE J. RENDERING PROVIDER ID #					
1 04112017	04112017	11	98941	ABCD	32 28 1 NPI 1710014188
2 04112017	04112017	11	97010	ABCD	10 53 1 NPI 1710014188
3 04182017	04182017	11	98941	ABCD	32 28 1 NPI 1710014188
4 04182017	04182017	11	97010	ABCD	10 53 1 NPI 1710014188
5					NPI
6					NPI
25. FEDERAL TAX ID NUMBER 364500165	SSN/EIN 343821Z47	26. PATIENT'S ACCOUNT NO. 1235256546	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 85.62	29. AMOUNT PAID \$ 1
30. Reserved for NUCC Use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am making a statement of PETER GOZINSKI DC)					
32. SERVICE LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849					
33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849					
SIGNED 04282017 DATE 04282017 1235256546					

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 28, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday April 11, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 04/11/2017 at 9:52am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. She stated that she had a brain and cervical MRI performed on March 27, 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb. *Range:* 2->3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: Her recent cervical and brain MRI were not available for review today. *Range of motion:* flexion:

Encounter dated 04/11/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/28/2017

WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left mild to moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Post-treatment analysis: patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural

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foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 3 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 7 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 04/11/2017 at 9:52am

Tuesday April 18, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 04/18/2017 at 11:17am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Encounter dated 04/18/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/28/2017

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. She stated that she had a brain and cervical MRI performed on March 27, 2017 and she stated that she has not received any results. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior neck pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, sharp, shooting, numb; level: 3/10. **Pain is frequent.** **Pain radiates to:** right shoulder, left upper extremity. **Exacerbates symptoms:** movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** left upper extremity. **Recent infection or fever:** No. **Night sweats or pain:** No. **Headaches:** Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior thoracic pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, sharp, shooting; level: 3/10. **Pain is frequent.** **Exacerbates symptoms:** movement; bending; lifting; activites of daily living; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain remains the same. She stated that she still has been experiencing pain radiating down her left lateral thigh. Patient seeing Dr. Siddique on May 2, 2017. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** no change. **since last visit.** **Pain:** achy, dull, sharp, shooting, numb. **Range:** 2>3/10. **Pain is frequent.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Objective

Cervical: Her recent cervical and brain MRI were not available for review today. **Range of motion:** flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. **Posture:** rounded shoulders. **Strength:** left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative

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bilateral. *Spinal subluxation level(s)*: T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation*.

Lumbar/Sacral/Pelvis: *Range of motion*: flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Gait pattern*: normal. *Tenderness & Hypertonicity* lumbar paraspinal left mild to moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation*: left SI: mild to moderate. *Trigger points*: left gluteus maximus. *Orthopedic tests*: Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s)*: L4, L5, Left SI. *Subluxations detected by*: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Prognosis: Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 2 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 6 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). **Physical Modalities:** bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft

Encounter dated 04/18/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/28/2017

tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

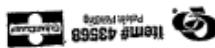
Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 04/18/2017 at 11:17am

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

5 03 17



05 03 17

MAILING DIVISION
CITY OF BUFFALO
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0812

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FECA) <input checked="" type="checkbox"/> (OTHER)												1a INSURED'S ID NUMBER 0138739400101059 (For Program in Item 1)					
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M F X			4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR		
CITY CHEERTOWAGA			STATE NY			CITY CHEERTOWAGA			STATE NY								
ZIP CODE 14225-1257			TELEPHONE (Include Area Code) ()			ZIP CODE 14225-1257			TELEPHONE (Include Area Code) ()								
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15					
b RESERVED FOR NUCC USE						b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) 						a INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M F X					
c RESERVED FOR NUCC USE						c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b OTHER CLAIM ID (Designated by NUCC) 					
d INSURANCE PLAN NAME OR PROGRAM NAME						10e CLAIM CODES (Designated by NUCC)						c INSURANCE PLAN NAME OR PROGRAM NAME 					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED _____ SIGNATURE ON FILE						DATE 02 09 16						SIGNED _____ SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE QUAL 439 MM DD YY 10 31 15			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI						17a U62607			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY								
17b NP 1710014188						19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES 								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Before A-L to service line below (24e)						22. RESUBMISSION CODE 			23. PRIOR AUTHORIZATION NUMBER 								
A M791	B L	C L	D L	E L	F L	G L	H L	I L	J L	K L	L L	ICD IND <input type="checkbox"/> 0	ORIGINAL REF. NO. 				
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY To MM DD YY						B PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E DIAGNOSIS CODING PENTER			F	G DAYS OR UNITS	H AMOUNT PER UNIT	I ID QUAL	J RENDERING PROVIDER ID. #	
1 04 25 17	04 25 17	11	20553					A	95	74 1		EI	161582336				
2												NPI	1154482859				
3												NPI	-----				
4												NPI	-----				
5												NPI	-----				
6												NPI	-----				
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 95 74 8	29. AMOUNT PAID 0 00	30. Rcv'd for NUCC Use NPI											
161582336	<input checked="" type="checkbox"/>	1604073															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING ADDRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LIXIN ZHANG, MD						32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727						33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002					
SIGNED 05 01 17						DATE *1497850911						*1497850911 EI161582336					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain utilizations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., Items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor, 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision, 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-locksback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (begin name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral although incidental part of a covered physician service, 3) they must be of value commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black-Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: I.C. 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21244-1650. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 0796
 DESTINATION ADDRESS 18562945154
 SURADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 05/01 08:37
 TX/RX TIME 01'11
 PGS. 5
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0512

PDX10A

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP	PECA	OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP	<input type="checkbox"/> PECA	<input checked="" type="checkbox"/> OTHER	0138739400101059	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

HARWELL, DANIELLE

08 29 1980 M F

HARWELL, DANIELLE

5. PATIENT'S ADDRESS (No., Street)

1131 CLEVELAND DR

CITY

CHEKTOWAGA

STATE

NY

26 ZIP CODE

14225-1257

()

TELEPHONE (Include Area Code)

14225-1257

()

6. RESERVED FOR NUCC USE

7. INSURED'S ADDRESS (No., Street)

1131 CLEVELAND DR

CITY

CHEKTOWAGA

STATE

NY

27 ZIP CODE

14225-1257

()

TELEPHONE (Include Area Code)

14225-1257

()

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. EMPLOYMENT (Current or Previous)

11. INSURED'S POLICY GROUP OR PECA NUMBER

12. OTHER INSURED'S POLICY OR GROUP NUMBER

13. INSURED'S DATE OF BIRTH

14. INSURED'S GENDER

15. AUTO ACCIDENT?

16. OTHER ACCIDENT?

17. INSURED'S PLAN NAME OR PROGRAM NAME

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM.YY)

20. OTHER DATE

21. NAME OF REFERRING PROVIDER OR OTHER SOURCE

22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

23. OUTSIDE LAB?

24. A. DATES OF SERVICE

25. B. PROBLEMS, DISORDERS, OR SURGICAL PROCEDURES, DISEASES, OR SURGERIES

26. C. ICD IND.

27. D. ICD CODE

28. E. ICD CODE

29. F. ICD CODE

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DENT
NEUROLOGIC INSTITUTE

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Marc S. Frost, MD	Kenneth R. Murray, MD	
Francis M. Gengo, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note
Date: 04/25/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- Migraines, Trigger Point Injections Headaches
- Neck pain

History of Present Illness

General.

Danielle is a 36-year-old patient with a history of migraine headaches, cervicalgia and associated trigger point. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. The patient reports good results with her trigger point injection. She does still complain of dizziness. She has not yet started vestibular therapy. MRI results were reviewed with the patient which have remained unchanged since previous over one year ago.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 intl units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking nizatidine 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C

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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-4315
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Posturegraphy
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infrared	

- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker.

Fall History:

Have you fallen: No Do you feel unsteady when: No

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies

Resides with:

Spouse: Husband, Children: Yes, x3 Self: Yes.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes

Driving:

Does Patient Drive: Yes

Exercise:

Daily: Yes, Walks

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 122/74, HR 76, RR 16, Ht 63, Wt 221 8, BMI 39 29, BSA 2.11

Examination

Neurological.

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DIAGNOSTICS & SERVICES	
<i>MRI/CT</i>	<i>Neuropsychology</i>
<i>Arthrograms</i>	<i>Pneumangiography</i>
<i>Botox</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>ImPACT</i>	<i>VNG</i>
<i>Inflmon</i>	

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 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

. Continue all previously prescribed medicines at the current doses

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures

Injections.

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 8 cc was injected with a 25-gauge needle without complication into 8 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 04/25/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 04/25/2017.

Exercise: Patient counseled on importance of moderate physical activity daily 04/25/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 04/25/2017 at 09:48 AM EDT

Sign off status: Completed

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Batavia Office | 35 Batavia City Centre • Batavia, NY 14220 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrography	Positronigraphy
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Influsion	

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DIAGNOSTICS & SERVICES

<i>MR/CT</i>	<i>Neuropsychology</i>
<i>Arthrography</i>	<i>Panurography</i>
<i>Botox</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>InPACT</i>	<i>VNG</i>
<i>Infusion</i>	

05 05 17

FIRST CLASS MAIL



5 05 17

DENT UROLOGIC GROUP, LLP
ADM. & OPERATIVE OFFICE
3980 S. WILSON E.R. SUITE B
BUFFALO, NY 14226



\$ 002.870

1500LR

FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

RICA

1 MEDICARE		MEDICARE		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA EXCLUDING (DOL)		OTHER (OTR)		1a. INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)			
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicare		<input type="checkbox"/> TRICARE		<input type="checkbox"/> CHAMPVA		<input type="checkbox"/> GROUP HEALTH PLAN		<input type="checkbox"/> FECA EXCLUDING (DOL)		<input type="checkbox"/> OTHER (OTR)		1a. INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)						3 PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE									
HARWELL DANIELLE						08291980		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		HARWELL DANIELLE									
5 PATIENT'S ADDRESS (No. Street)						6 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No. Street) 56 BEREHAVEN DR., LEFT							
CITY CHEEKTONWAGA			STATE NY			8 RESERVED FOR NUCC USE			CITY AMHERST			STATE NY							
ZIP CODE 14225			TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228			TELEPHONE (Include Area Code) (716) 536 0951							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980							
						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d. RESERVED FOR NUCC USE						e. RESERVED FOR NUCC USE						f. OTHER CLAIM ID (Designated by NUCC) GEICO							
g. RESERVED FOR NUCC USE						h. INSURANCE PLAN NAME OR PROGRAM NAME GEICO						i. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.														13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED SIGNATURE ON FILE														SIGNED SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 CML 431						15. OTHER DATE QUAL 454 111215						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 17a							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17b NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 17c NPI													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)														20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Select A-H to describe line below (24e)) A M50.222 B I51.26 C M51.27 D M54.12 E I92.3 XXXA F I99.01 G M99.03 H M99.02 I M99.05 J I54.2 K M54.5 L M54.6														22. RESUBMISSION CODE ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04282017 04282017						B. PLACE OF SERVICE ENG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS 98941		D. MODIFIER		E. DIAGNOSIS CODE PONDER		F. \$ CHARGES		G. QRS OR UNITS	H. FRT FEE PER UNIT	I. ID QUAL.	J. RENDERING PROVIDER ID #
												ABCD		32 28 1		NPI		1710014188	
												ABCD		10 53 1		NPI		1710014188	
												ABCD		32 28 1		NPI		1710014188	
												ABCD		10 53 1		NPI		1710014188	
																NPI			
																NPI			
25. FEDERAL TAX ID NUMBER 364500165						SSN ENR <input type="checkbox"/> *		26. PATIENT'S ACCOUNT NO 343821248		27. ASSERT ASSESSMENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE \$ 85.62		29. AMOUNT PAID \$ 85.62		30. Reserved for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse of this form are true and correct.) PETER GOZINSKI DC						32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849											
SIGNED 05112017 DATE 1235256546								34. Reserved for NUCC Use		35. Reserved for NUCC Use									

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
May 11, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday April 28, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 04/28/2017 at 10:10am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* slightly worse. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb. *Range:* 4->5/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, they can last a few hours but not all day anymore. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain remains the same. She stated that she still has been experiencing pain radiating down her left lateral thigh. Patient seeing Dr. Siddique on May 2, 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb. *Range:* 3->4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. **Bowel or bladder incontinence:** No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Encounter dated 04/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/11/2017

Cervical: Her recent cervical and brain MRI were available for review today. *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left mild to moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: slightly worse. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. Cervical MRI was performed at DENT on March 27, 2017. According to the radiologist, only some subtle anterior spondylitic spurring is seen at C4-C5 and C5-C6. There is evidence of dextroscoliosis of the upper cervical spine. MRI of the brain was performed at DENT on March 27, 2017. According to the radiologist, it was a normal MRI scan of the brain without contrast.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set*

Encounter dated 04/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/11/2017

backs: Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. **Treatment schedule:** 1x/week for 1 week; 1x every 2 weeks for 4 weeks; Re-examination for 5 weeks. **Subluxations found on assessment and adjusted:** C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). **Physical Modalities:** bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. **Patient given:** home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. **Home care:** ice: neck / lower back pm for 20 minutes. **Additional instructions:** Advised patient to monitor for any changes in their symptoms. **Short term goals:** decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. **Long term goals:** decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. **Disability status:** Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 04/28/2017 at 10:10am

Monday May 1, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 05/01/2017 at 9:02am

Encounter dated 05/01/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/11/2017

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she did not have any headaches since last visit. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation with a referral for vestibular therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. She states that the pain is more to the right shoulder blade. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* slightly worse, since last visit. *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain remains the same. She stated that she still has been experiencing pain radiating down her left lateral thigh. Patient seeing Dr. Siddique on May 2, 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: Her recent cervical and brain MRI were available for review today. *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:*

Encounter dated 05/01/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/11/2017

bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Gait pattern:* normal. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, less headaches since last visit. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. Cervical MRI was performed at DENT on March 27, 2017. According to the radiologist, only some subtle anterior spondylitic spurring is seen at C4-C5 and C5-C6. There is evidence of dextroscoliosis of the upper cervical spine. MRI of the brain was performed at DENT on March 27, 2017. According to the radiologist, it was a normal MRI scan of the brain without contrast.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* mild increase in symptoms.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8

Encounter dated 05/01/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/11/2017

extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 05/01/2017 at 9:02am

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



05 15 17



100%
PRINTED
IN U.S.A.
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA

<input type="checkbox"/> PICA 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <small>(Medicare) (Medicaid) (AMVA/DM) (Member/DP) (DVA)</small> <input type="checkbox"/> OTHER 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BARWELL, DANIELLE 5. PATIENT'S ADDRESS (No. Street) 56 BERBIAUER DR										1a. INSURED'S ID NUMBER <input type="checkbox"/> (For Program in Item 1) 013873940-0101-059 4. INSURED'S NAME (Last Name, First Name, Middle Initial) - - - 7. INSURED'S ADDRESS (No. Street) - - -																									
CITY AMHERST ZIP CODE 14228					STATE NY					CITY - - -					STATE - - -																				
ZIP CODE (716) 536-0951					TELEPHONE (Include Area Code) ()					ZIP CODE - - -					TELEPHONE (Include Area Code) ()																				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																									
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY										b. OTHER CLAIM ID (Designated by NUCC) M <input type="checkbox"/> F <input checked="" type="checkbox"/>																									
c. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>If yes, complete items 9, 8a, and 8d.</small>																									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																									
SIGNED - ON FILE -										DATED 01-06-2016																									
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 2015 QUAL										15. OTHER DATE (MM DD YY) QUAL																									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM MM DD YY TO MM DD YY																									
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM MM DD YY TO MM DD YY																									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))										22. RESUBMISSION CODE <input type="checkbox"/> ORIGINAL REF. NO.																									
A <u>M79.1</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>	23. PRIOR AUTHORIZATION NUMBER																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PROCEDURES, SERVICES, OR SUPPLIES <small>(Explain Unusual Circumstances)</small>																									
C. PLAC OF SERVICE EMT										D. MODIFIER OPT/HDPOS																									
E. ICD IND										F. G. DATES CH UNITS \$ CHARGES																									
G. H. PAYOR/ <small>Rate/</small> I. ID <small>Qual</small>										J. RENDERING PROVIDER ID #																									
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2	05	09	17	05	09	17	11	97140					55	100	3		NPI	144462011																	
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6	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		NPI	-																	
25	FEDERAL TAX I.D. NUMBER 47-098449					SSN/EIN <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. BARWELL, D					27. ACCEPT ASSIGNMENT <small>(For Govt. Cases, See Below)</small> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					28. TOTAL CHARGE \$ 165 100					29. AMOUNT PAID \$ 0 00					30. Rcv'd for NUCC Use 165 100				
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043										33. BILLING PROVIDER INFO & PH# 116 725-0264														
COLLEEN MARX, LMFT 05.12.2017 SIGNED DATE										144462011										144462011															

NOTE: Any person who has made false or fictitious claims concerning new misclassification or any false, incomplete or misleading information sent by mail or

HEDIMCONE AND LIFEART TRICARE® A patient's signature signifies that payment has made and authorizes release of any information necessary to process the claim and/or indicates that the information contained in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes and entitles to release to Medicare medical information contained in the claim form. A statement and signature by the carrier, plan or employer group health insurance, liability, auto, workers' compensation or other insurance which is responsible for payment for the claim is also required. See 42 CFR 430.141(d)(4). Item 9 is completed. The patient's signature authorizes release of the information to the life insurance plan or agency plan or to the life insurance company for the group health insurance coverage and life-covered services. Consistently and the deductible(s) based upon the charge information of the Medicare carrier or TRICARE for medical services if the U.S. has the claim filed. TRICARE is not a health insurance program but makes payment for health care provided through certain military health care facilities, medical clinics, hospitals, dentists, optometrists, orthodontists, audiology, laboratories, pharmacists, physical therapists, speech pathologists, dietitians, social workers, nurses, and home health aides.

BLACKLINE AND READING

-This proposal is subject to approval by the Government as payment in full. See Black Lung and FECA Instructions regarding required pre-claim and claimant coding systems.

156 WOODRINGE PHYSICIAN 28 SUPPLEMENT TO 2009 CAMPUS TRICARE, FECA AND D-4 ACTIVITIES

In establishing the claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow this government to rule on my claim(s); 4) I am entitled to payment under this claim; 5) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare vendor rules; 6) I understand that if, at any time, it is determined that my claim(s) are not payable, I may be liable for repayment of any payment made to me, plus interest, and that I may be subject to a civil fine or criminal prosecution; 7) I have been advised, by my attorney or personally informed by me or were furnished to me in writing by my professional service, the identity (legal name and NPI, license #, or RSN) of the entity or individual rendering the services as reported in the dispensing service; for services to be considered "incident to" a physician's professional services, 8) they must be performed under the direction and direct supervision by her/his physician; 9) they must be an integral, although incidental part of a covered physician service; 10) they will be of benefit, commonly furnished in the dispensing service; and 11) no services for non-physician must be included on the physician's bills.

For TRICARE claims, I attest to the fact that I (or my employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government (other civilian or military), other than Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part II election, benefits may be used unless this form is received as required by existing law and regulations (42 CFR 136.32).

NOTICE: Any one who misrepresents or fails to furnish information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

WARNING TO CONSUMERS ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, HCPCS, and GHPIC to ask you for information needed in the administration of the Medicare, HCPCS, and Black Lung programs. Authority to collect information is in section 1105(a) (1)(B) and 1877 of the Social Security Act as amended, 42 CFR 411.84(a) and 494(a)(6), and 45 USC 3101(a)(1) CFR '91 as seq and 10 USC 101(a)

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations if Federal agencies for the effective administration of Federal programs require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to give this information about the benefit you have entitled to a hospital or doctor. Additional disclosures are made through routine uses for information on claims in systems of records.

POR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0901, titled, 'Carrier Medicare Claims Record,' published in the Federal Register Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or an update and republished.

FOR CMCF CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, Ser E8A-5, E8A-6, E8A-12, E8B-13, E8A-10, or as undated and reprinted.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and confirmation that the services/claims received are authorized by law.

HIGHLIGHTS: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services, and/or the Dept. of Transportation.

Other TRICARE administrative responsibilities of the TRICARE Office include the development of regulations for the delivery of medical care, enrollment, claims processing, and payment by the Defense Health Service, private collection agencies, and consumer reporting agencies in connection with recipient claims; and to Congressional Offices in response to inquiries made at the request of the public to whom a service provides. Appropriate disclosure may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care or services related to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, recuperation of benefits, and civil and criminal litigation related to the operation of TRICARE.

INTEGRAL GROUP < You shall, however, failure to provide information will result in delay in payment or may result in denial of claim. With 90th day exception discussed below, there are no extensions granted for filing of claims for medical expenses. However, failure to furnish Information regarding the medical services rendered or the amount charge I would request payment of before and/or the program. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information via FSCA, will be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 109-503, i.e. 'Computer Matching and Privacy Protection Act of 1988', permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

1. The City agrees to keep such records as are necessary to document the costs of services provided to individuals under the State's Title XX plan and to furnish information regarding payments claimed for providing such services to the State Agency or Dept. of Health and Human Services as may be requested.

I further agree to do my best payment plan, the current plan of the Medicaid program in these same substances for payment under this program, with the exception of animal care, insurance, co-payment or similar cost sharing charge.

NOTICE: The employee shall keep the documents referred to in Article 10 of the present contract in his/her possession, furnished by me or my employee under my personal direction.

According to the Paperwork Reduction Act of 1995, you are not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for the Information Collection Request is 1125-0001. This request is estimated to average 10 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 any comments concerning the accuracy of the time estimate or suggestions for improving the form, please contact: CMS, 2000 Revere Boulevard, Attn: PRA Response Clearance Officer, Mail Stop 04-26-03, Baltimore, Maryland 21236.

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14204
 Office: (716) 725-0634 Fax: (716) 725-0365

Great Lakes Therapeutic Massage & Bodywork Practitioners
 375 Dick Rd Depew, NY 14204
 Office: (716) 725-0634 Fax: (716) 725-0365

Client Name: Danielle Harrell Date: 5/12/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliges ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R) (L)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB sore at sacrum. Shooting leg (R) is gone. (R) glute tightness esp around sacrum. Back

Action's Applied: (Check All that Apply) Soreness

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat Mc

Therapist:

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 (Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliges ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R) (L)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist:

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0394

Fax: (716) 725-0395

Client Name: Danielle Howell Date: 5/3/17Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: (R) glute & hamstring to baby
(L) hurts too but doesn't go
leg. & glutes hyperextended w/ (R) glute

Action's Applied: (Check All that Apply) IT Band Tightness
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage Cervical
 Deep Tissue Massage Myofascial Release Friction cervix
 Manual Traction Stretching Range-of-Motion kettle
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat myof

Therapist: M. Mary

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0394

Fax: (716) 725-0395

Client Name: Danielle Howell Date: 5/9/17Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Felt bruised after last message
but feels better esp. (R) glute &
hamstrings. (R) neck & shoulders tight.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat myof

Therapist: M. Mary

05 16 17

1 0 1 1 0 0 0 0 0 0 0 0 0 0 0 0

05 16 17

Great Lakes Therapeutic Massage

Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14204

NY 14204
13 MAY '17
FNU 2 1

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 10110 WASHINGTON DC

POSTAGE WILL BE PAID BY ADDRESSEE

GEICO.

NY PPP
PO BOX 9507
FREDERICKSBURG VA 22403-9527





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

FICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> BOX LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (NOM) <input type="checkbox"/> (ADM) <input type="checkbox"/> (NM)												1a. INSURED'S ID NUMBER <small>(For Program in Item 1)</small> 013873940-0101-059									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE						3. PATIENT'S BIRTH DATE <small>MM DD YY</small> 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial) - 5000 -									
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)									
CITY AMBERT			STATE NY			8. RESERVED FOR NUCC USE			CITY			STATE									
ZIP CODE 14228			TELEPHONE (Include Area Code) (716) 536-0951			X			ZIP CODE			TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. INSURED'S DATE OF BIRTH <small>MM DD YY</small> SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>									
b. RESERVED FOR NUCC USE						b. AUTO ACCIDENT? <small>PLACE (State)</small> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY						b. OTHER CLAIM ID (Designated by NUCC)									
c. RESERVED FOR NUCC USE						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						c. INSURANCE PLAN NAME OR PROGRAM NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME						12. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to either to myself or to the party who accepts assignment below									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 31 2015 GUAL												15. OTHER DATE GUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA												17a. MM DD YY 17b. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO									
A <u>379.1</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>	23. PRIOR AUTHORIZATION NUMBER									
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY				B REASON FOR SERVICE EMR				C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				D DIAGNOSIS MODIFIER E DRG/DBIS POWERTR									
1	05 15	17	05 15	17	11	97140							F \$ CHARGES	G DRGS OR UNITS	H DRG/PWR RATE	I ID QUAL	J RENDERING PROVIDER ID #				
2													NPI								
3													NPI								
4													NPI								
5													NPI								
6													NPI								
25. FEDERAL TAX ID NUMBER 47-0989449				SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. BARWELL, D				27. ACCEPT ASSIGNMENT? <small>(For gov't claim see back)</small> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 55 00		29. AMOUNT PAID \$ 0 00		30. Rev'd for NUCC Use 55 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMFT 05.16.2017 SIGNED DATE												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPBM, NY 14043				33. BILLING PROVIDER INFO & PH# (716) 725-0264 GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPBM, NY 14043					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

LIFETIME AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible for pay for the services for which the Medicare claim is made. See 42 CFR 411.2(a)(4). Item 9 is completed. The patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assignable or TRICARE participation cases, the physician agrees to accept the charge determined by the Medicare carrier or TRICARE fiscal intermediary as the full charge and the physician is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if 2% to less than 10% charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations.

BLACKLINES AND RECALL CLAIMS

The previous entries to record the amount used by the Contractor as comment in J11. See Black Luma and RECA instructions re-garding required procedure re: distributor coding systems.

REGISTRATION OF PHYSICIAN OR STAFF FOR MEDICARE, TRICARE, FECA AND BLAIS LUNCHEON

In requesting that claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished my self with all applicable instructions, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on the line(s) are medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise stated or permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identifier (legal name and NPI, license#, or EBN) of the primary individual rendering such service is printed in the designated section for services to be considered "incident to" a physician's professional services; 7) they may be rendered under the direction and/or supervision by my lesser employee; 8) they may be an integral (though incidental part of a covered physician service, 9) they must be of items currently furnished in reasonable office, and 10) the location of rendered, as must be included on the physician's bills.

For TRICARE claims, I further certify that, for any individual(s) who rendered services or not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to USC 5398). For Black Lung claims, I further certify that the services performed were for a BIA-Listed Lavor related employer.

No Part II Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.37).

MDIGIC: A person who misappropriates or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

VA and authorized in 43 U.S.C. TRICARE, the CWA, is set by you for maximum benefit in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to do this under section 1301 of the CWA, 1982, 1972 and 1971 of the Social Security Act as amended, 42 CFR 411.26(a) and 42 CFR 515.16, and 44 USC 3101 et seq. and 10 USC 1070 et seq., 1980 5 USC 8101 et seq., and 99 USC 801 et seq; 38 USC 813, E.O. 9597.

The information we obtain to complete claim forms in these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you receive are covered by these programs and to insure that proper payment is made.

The information may often be given in other forms of services, grants, intermediaries, financial review boards, and other organizations or Federal agencies. In the administration of Federal provisions that require other third parties to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have had to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FCC PRACTICALLY CLIMBED. See the notice, including system No. 69-70-0501, titled, "Carrier Medium Claims Record," published in the Federal Register, Vol. 55 No. 177, page 375-19, Mar. 19, 1980, or as updated/republished.

FOR OIGCP CLAIMS: Department of Labor, Privacy Act of 1974, "Registration of Notice of Systems of Records," Federal Register Vol. 53 No. 40, Wrd Feb 28, 1989; See ESA-4, ESA-6, ESB-12, CSM-13, ESA-9C, or as updated and retitle by d.

automated list of services applies normally or is authorised by law.

entitlement "as if it statutorily administered." Report Agencies under TRICARE/REICH/AMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Inspector General, service collection regions; and consumer reporting agencies in connection with recompensation claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private health entities, and educational providers of care, or entities relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability coordination of benefit, and civil and criminal litigation related to the operation of TRICARE.

DISCLAIMER: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no "penalties" under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FICA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 112RB of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, at payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction

NOTICE: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of my claim will be from Federal and State funds, and that any false statement, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14204

Office: (716) 725-6024

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 5/2/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy
- Anxiety
- Burning
- Depressed
- Fatigued
- Low Energy
- Pain
- Restlessness
- Restricted
- Sore
- Numbness
- Tingling
- ↓ Strength
- Inability to Sleep
- Headaches/Migraines
- Spasms
- Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head
- Jaw
- Sinus/Eye Pressure
- Cervical (Posterior)
- Cervical (Anterior)
- Upper Thoracic (Anterior)
- Upper Thoracic (Posterior)
- Mid/Thoracic
- Ribs
- Scapula (R)
- Scapula (L)
- Abdomen/Obliges
- ASIS
- PSIS
- Lumber
- Sacrum
- Coccyx
- Hips
- Glutes (R)
- Glutes (L)
- IT Band
- Quads
- Hamstrings
- Knee (R)
- Knee (L)
- Calf Muscles (R)
- Calf Muscles (L)
- Ankle (R)
- Ankle (L)
- Foot (R)
- Foot (L)
- Shoulder (R)
- Shoulder (L)
- Upper Arm (R)
- Upper Arm (L)
- Forearm (R)
- Forearm (L)
- Hand (R)
- Hand (L)

Specific: LB sore at sacrum. Shaking leg (R) is gone. (R) glute tightness esp around sacrum. Check

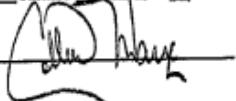
Action's Applied: (Check All that Apply) **Soreness**

- Heat Packs
- Cold Packs
- Sombra/Biofreeze
- Light Pressure Massage
- Mod Pressure Massage
- Deep Tissue Massage
- Myofascial Release
- Friction
- Manual Traction
- Stretching
- Range-of-Motion
- Stripping
- Compression
- Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O
- Follow-Up w/ Chiro
- Follow-up w/ M.D.
- Follow-up w/ PT
- Stretches
- Cont.Meds
- Ice / Heat
- Neck

Therapist:



Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0264

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 5/15/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy
- Anxiety
- Burning
- Depressed
- Fatigued
- Low Energy
- Pain
- Restlessness
- Restricted
- Sore
- Numbness
- Tingling
- ↓ Strength
- Inability to Sleep
- Headaches/Migraines
- Spasms
- Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head
- Jaw
- Sinus/Eye Pressure
- Cervical (Posterior)
- Cervical (Anterior)
- Upper Thoracic (Anterior)
- Upper Thoracic (Posterior)
- Mid/Thoracic
- Ribs
- Scapula (R)
- Scapula (L)
- Abdomen/Obliges
- ASIS
- PSIS
- Lumber
- Sacrum
- Coccyx
- Hips
- Glutes (R/L)
- IT Band
- Quads
- Hamstrings
- Knee (R)
- Knee (L)
- Calf Muscles (R)
- Calf Muscles (L)
- Ankle (R)
- Ankle (L)
- Foot (R)
- Foot (L)
- Shoulder (R)
- Shoulder (L)
- Upper Arm (R)
- Upper Arm (L)
- Forearm (R)
- Forearm (L)
- Hand (R)
- Hand (L)

Specific: Spasms (L) leg to outside of (L) gastroc. LB tight c sacrum

Neckline & (L) shoulder. Occipital

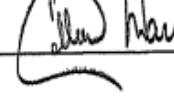
Action's Applied: (Check All that Apply) **Upper trap tight**

- Heat Packs
- Cold Packs
- Sombra/Biofreeze
- Light Pressure Massage
- Moderate Pressure Massage
- Deep Tissue Massage
- Myofascial Release
- Friction
- Manual Traction
- Stretching
- Range-of-Motion
- Stripping
- Compression
- Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- H2O
- Follow-Up w/ Chiro
- Follow-up w/ M.D.
- Follow-up w/ PT
- Stretches
- Cont.Meds
- Ice / Heat
- Neck

Therapist:



05 22 17

1991-05-22 17:00:00

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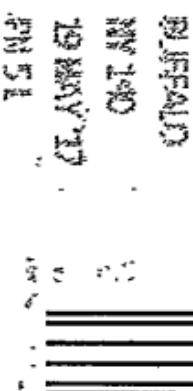
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05 22 17

Great Lakes Therapeutic Massage

Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BILING OTHER												1a. INSURED'S I.D. NUMBER (For Programs Item 1)			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> DOD/DoD	<input type="checkbox"/> Member/Off. (X)	<input type="checkbox"/> NM	<input checked="" type="checkbox"/> X (DOD)							0138739400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
HARWELL, DANIELLE				MM DD YY	SEX			HARWELL, DANIELLE							
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)							
1131 CLEVELAND DRIVE				Self <input checked="" type="checkbox"/>	Spouse <input type="checkbox"/>	Cbd <input type="checkbox"/>	Other <input type="checkbox"/>	1131 CLEVELAND DRIVE							
CITY CHEERTONAGA		STATE NY		8. RESERVED FOR NUCC USE				CITY CHEERTONAGA		STATE NY					
ZIP CODE 14225		TELEPHONE (Include Area Code) ()						ZIP CODE 14225		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous)			
b. RESERVED FOR NUCC USE												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
c. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? PLACE (State)			
d. INSURANCE PLAN NAME OR PROGRAM NAME												c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
11. INSURED'S POLICY GROUP OR FECA NUMBER												d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
Signature On File												DATE 5/15/2017	SIGNED Signature On File		
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)				15. OTHER DATE (MM/DD/YY)				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/DD/YY)							
10 31 15 QUAL. 431				16. OTHER DATE 439 10 31 15				FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE												17a. MM DD YY	17b. NR 1710014188	16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY)	
DN J PETER GUZINSKI												FROM MM DD YY TO MM DD YY			
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												19. OUTSIDE LAB? \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate A-L to service line below (S4E))												22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. M54.16	B. M51.26	C. M53.3	D. L	E. L	F. L	G. L	H. L	I. L	J. L	K. L	L. L	22. PRIOR AUTHORIZATION NUMBER NOT REQUIRED			
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. MODIFIER F. \$ CHARGES G. DURG ON UMTS H. REBATE PER UNIT I. L ID J. RENDERING PROVIDER ID #															
05 02 17	05 02 17 11		99214				ABC	74 79 1	OB 248830 NPI 1023202355						
25. FEDERAL TAX ID NUMBER 030445678				SSN EN <input checked="" type="checkbox"/> X				26. PATIENT'S ACCOUNT NO. 102251				27. ADJUSTMENT AMOUNT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 74 79 6	29. AMOUNT PAID \$ 0 00	30. Paid for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereto.) Jafar Siddiqui												32. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery, Inc 180 Park Club Lane, STE 250 Williamsburg, NY 14221	33. BILLING PROVIDER INFO & PH# (716) 218-1030 UB Neurosurgery, Inc PO Box 8000 DEPT 883 Buffalo, NY 14267		
SIGNED 5/15/2017 DATE												a. 1306896220 b. 248830	a. 1306896220 b.		

PHYSICIAN OR SUPPLIER INFORMATION

PATIENT AND INSURED INFORMATION



UNIVERSITY AT BUFFALO
NEUROSURGERY
UBNS.COM

Brett L. Levy, MD, MBA, FACS, FAAPM
Gregory J. Castiglia, MD, FACS
Kiran M. Davies, MD, FIB
William G. Giannakos, MD
John G. Habermann, MD, FACS, FRAMS
Kevin J. Gibson, MD, FACS, FRAMS
Robert E. Hsu, MD
Douglas B. Hershman, MD, FACS
Robert J. Pascual, MD
John Phillips, MD, FACS
James Rappoport, MD
Adrian H. Siddiqui, MD, PhD, FACS, FAAPM
John W. Siddiqui, MD, FAAPM, SBEPM
Bennett V. Snyder, MD, PhD
Michael R. Stoffman, MD, FACS, FRAMS

Jonathan P. Block, DC
Warren Narinska, DC
Stanley Payne, DC

Laura Grubisic-Milner, MS, RPT-C
Susan Wegrynski, RPT-C
Sara Reiter, MS, Chiro
Keith Cuddeback, PT, RPT-C
Thomas Tafolla, RPT-C
Kishan Chipli, RPT-C
Danielle Harwell, PA-C
Emily Horwitz, PA-C
Greg L. Oszczek, PA-C
Sarah O'Bryan, PA-C
Trisha L. Sperry, PA-C
Candy Grimes, PA-C
Sandhya Guha, PA-C
Nicole DiAngelo, PA-C
Kendra Compton, PA-C
Patrick Roan, RPT-C

3960-A Shoulder Suite
Amherst, NY 14226
716/219-1666
LWR Fax: 716/219-3991

Buffalo General Medical Center
100 High Street • Section B4
Buffalo, NY 14203
716/829-1666
FBB Fax: 716/829-7341

5939 Old Tree Road • Suite 203
Orchard Park, NY 14227
716/679-1666
EMR Fax: 716/679-4886
EPR Fax: 716/679-1577

180 Park Club Lane
Williamsville, NY 14221
716/639-9402
CMH Fax: 716/639-3570

6995 Wilson Road • Suite 3000
Mayfield Falls, NY 14204
716/233-1076
EMR Fax: 716/233-1186

May 2, 2017

Peter Guzinski, DC
345 Dick Road
Depew, NY 14043

Patient Name: Danielle Harwell
Date of Birth: 08/29/1980
No-Fault Carrier: NF Geico
CL#: 0138739400101059
Date of Injury: 10/31/15

Physiatry Re-evaluation: May 2, 2017

Chief Complaint(s): Tailbone pain, left leg pain

Dear Dr. Guzinski:

I had the pleasure of seeing Danielle in our Park Club Lane office for a physiatry re-evaluation on May 2, 2017.

HISTORY OF PRESENT ILLNESS

This is a 36-year-old female presenting today for an evaluation. She is status post a caudal epidural steroid injection with Dr. Siddiqui on 3/30/17. This worked very well at controlling her right leg pain, but unfortunately it has not helped her left side pain which seems to be somewhat worse. She reports pain that radiates down the left buttock and thigh in the posterolateral aspect of the left calf into the fifth digit of the left foot. She is utilizing Naproxen but finding this ineffective. She is also having some issues with pain at the injection site. She reports no fevers or chills associated with this. She continues to follow with her chiropractic and Dent Neurologic Institute for chronic headaches. She reports her pain today at a 4/10 on the visual analog scale. Coughing, standing, lifting, and walking aggravate her pain. Lying down helps alleviate it. She notes unsteadiness when she walks at times due to her left leg discomfort.

Review of systems is notable for headache and joint pain, otherwise noncontributory.

PHYSICAL EXAMINATION

BP Sitting: 127/86 **Pulse:** 76 **Resp:** 16 **Ht:** 63" **Wt:** 200lb **BMI:** 35.4

General: 36-year-old female in no acute distress. She is awake, alert and appropriate. Speech is fluent and coherent.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are pink and moist.

Cardiovascular: Normal S1, S2.

Abdomen: Soft, non-distended, nontender.

Neuromusculoskeletal: The patient demonstrates well preserved strength. Sensory examination is intact to light touch. She demonstrates symmetric muscle bulk and tone without spasticity or rigidity. Straight leg raise sign is positive on the left, negative on the right. Patrick's testing is negative bilaterally. She has tenderness to the left buttock and left lumbar paraspinal muscles. She ambulates with a mildly antalgic gait. The caudal injection site was inspected today. There is no swelling or erythema. The coccyx is tender.

Psychiatric: Judgement and cognition appear to be within normal limits.

ASSESSMENT

M54.16 - Radiculopathy, lumbar region, M51.26 - Other intervertebral disc displacement, lumbar region, MS53.3 - Sacrococcygeal disorders, not elsewhere classified

IMPRESSION/RECOMMENDATIONS

This is a 36-year-old female with dominant complaints today of low back and left leg pain in the setting of multi-level lumbar degenerative disc disease and facet arthropathy with lumbar disc bulges/hemiations at L4-L5 and L5-S1. She also has clinical evidence of coccygodynia today. At this time, we will initiate a Methylprednisolone Dosepak. She will hold Naprosyn while utilizing this. I also will forward the patient for a left L5-S1 transforaminal epidural steroid injection. She will continue with her other medical providers who are treating her for symptoms causally related to her motor vehicle accident on 10/31/15. The patient expressed understanding and agreement to today's plan of care.

The material risks, benefits, side effects and alternatives with the above named procedure were discussed with the patient today. These include, but are not limited to, injection site pain, bleeding, bruising, infections, damage to targeted or non-targeted tissue, increased pain, nerve injury or other reaction. In rare cases potentially serious reactions such as a CVA, arrhythmia, or death may occur. The patient was given procedure instructions and educational materials for this specific purpose at the time of the visit.

The patient was advised today regarding treatment with the above named medication(s). The risks, benefits, common side effects and alternative treatments were discussed with the patient. The patient verbalized understanding and was told to call with any concerns.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

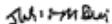
Sincerely,



Electronically signed by Sarah O'mara, PA-C on 05/05/2017 at 1:17 pm
Sarah O'mara, PA-C

Danielle Harwell DD 05/02/2017

Page #3



Electronically signed by Jafar Siddiqui, M.D. on 05/08/2017
Jafar Siddiqui, M.D.

cc:James Panzarella DO

05 24 17



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

I HCA

PIKA

<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> TRICARE	CHAMPVA	GROUP HEALTH PLAN	FICA BUKLING	OTHER (RM)	Ia INSURED'S ID NUMBER 01387394001-1059 o 1059	(For Program in Item 1)		
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TRICARE)	<input type="checkbox"/> (CHAMPVA)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (RM#)	<input type="checkbox"/> (RM#)				
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
HARWELL DANIELLE			08291980							
5 PATIENT'S ADDRESS (No., Street)			6 PATIENT RELATIONSHIP TO INSURED		Set <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
1131 CLEVELAND DRIVE										
CITY CHEEKETOWAGA	STATE NY	8 RESERVED FOR NUCC USE		CITY AMHERST		STATE NY				
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951			ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951					
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO		11. INSURED'S POLICY GROUP OR FICA NUMBER					
a OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY		SEX 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X			
b RESERVED FOR NUCC USE			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		PLACE (State) NY		b. OTHER CLAIM ID (Designated by NUCC)			
c RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
d INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, complete items 9, 9a, and 9d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										
SIGNED SIGNATURE ON FILE			DATE							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 103115			15. OTHER DATE 454		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. QUL 431 17b. 111215			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. QUL 431			17b. 111215		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24))			22. RESUBMISSION CODE		23. PRIOR AUTHORIZATION NUMBER					
A M50 222	B M51 26	C M51 27	D M54 12	ORIGINAL REF. NO.						
E I523 3XXA	F M99 01	G M99 03	H M99 02							
I M99 05	J M54 2	K M54 5	L M54 6							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTERS F. CHARGES G. DAYS ON H. EXPEND I. ID L. QMEL J. RENDERING PROVIDER ID #					
1 05082017 05082017 11 98941 ABCD 32 28 1 NPI 1710014188	2 05082017 05082017 11 97010 ABCD 10 53 1 NPI 1710014188	3 05162017 05162017 11 98941 ABCD 32 28 1 NPI 1710014188	4 05162017 05162017 11 97010 ABCD 10 53 1 NPI 1710014188	5 NPI	6 NPI	7 NPI	8 NPI			
25. FEDERAL TAX ID. NUMBER 364500165			26. PATIENT'S ACCOUNT NO 343821249		27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE 8 85 62 \$		29. AMOUNT PAID 8 85 62 \$	30. Rev'd for NUCC Use 8 85 62 \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in my behalf.) PETER GOZINSKI DC			32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849					
SIGNED 05262017 DATE 1235256546			34. SERVICE FACILITY LOCATION INFORMATION 1235256546		35. BILLING PROVIDER INFO & PH # 1235256546		APPROVED OMB-0938-1197 FORM 1500 (02-12)			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
May 26, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday May 8, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 05/08/2017 at 9:33am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she had 2 headaches since last visit. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation with a referral for vestibular therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving. *since last visit:* Pain: achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activites of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain remains the same. She stated that she still has been experiencing pain radiating down her left lateral thigh. Patient saw Dr. Siddique and he recommended another injection. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, shooting, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders.

Encounter dated 05/08/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/26/2017

Strength: left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. **Gait pattern:** normal. **Tenderness & Hypertonicity:** lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. Cervical MRI was performed at DENT on March 27, 2017. According to the radiologist, only some subtle anterior spondylitic spurring is seen at C4-C5 and C5-C6. There is evidence of dextroscoliosis of the upper cervical spine

MRI of the brain was performed at DENT on March 27, 2017. According to the radiologist, it was a normal MRI scan of the brain without contrast.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** improving, VAs score improved from a 5 to 3 out of 10.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation)

Encounter dated 05/08/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/26/2017

with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 3 weeks; Re-examination for 3 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 05/08/2017 at 9:33am

Tuesday May 16, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 05/16/2017 at 10:51am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Encounter dated 05/16/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/26/2017

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches continue at 2 a week. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation with a referral for vestibular therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain continues to remain the same. Patient going for an injection with Dr. Siddique on June 1, 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* slightly worse, since last visit. *Pain:* achy, dull, sharp, shooting, numb; level: 5/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature (C5-T1) were graded 5/5. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral

**Encounter dated 05/16/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/26/2017**

bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. Cervical MRI was performed at DENT on March 27, 2017.

According to the radiologist, only some subtle anterior spondylitic spurring is seen at C4-C5 and C5-C6. There is evidence of dextroscoliosis of the upper cervical spine

MRI of the brain was performed at DENT on March 27, 2017. According to the radiologist, it was a normal MRI scan of the brain without contrast.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (diversified side posture). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft

Encounter dated 05/16/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/26/2017

tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 05/16/2017 at 10:51am

Abbreviations.

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



Item# 43568
Polaris Products



06 02 17



345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA											
1. MEDICARE (Medicare)	2. MEDICAID (Medicaid)	3. TRICARE (DOD Only)	4. CHAMPAVA (Member ID#)	5. GROUP HEALTH PLAN (ID#)	6. FECA SEX/LEAVING (ID#)	7. OTHER (ID#)	8. INSURED'S ID NUMBER 013873940-0101-059 (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980			SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -				
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)					
CITY AMHERST		STATE NY	8. RESERVED FOR NUCC USE X			CITY		STATE			
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951					ZIP CODE	TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER b. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. OTHER INSURED'S POLICY OR GROUP NUMBER			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY			c. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10L CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 8a, and 9d					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED - ON FILE -			DATE 01-06-2016								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10-31-2015 QM			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SIDNEY GRABAU, PA			17a. NPI 17b. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below 24E)			22. RESUBMISSION CODE			ORIGINAL REF. NO.					
A <u>M79.1</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>	J <u> </u>		
L <u> </u>	K <u> </u>	L <u> </u>									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EXG C. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS			D. MODIFIER E. DIAGNOSIS PONTER			F. G. DAYS ON UNITS H. AMOUNT PER UNIT I. ID J. RENDERING PROVIDER ID #		
1 05 17 17	17 05 17 17	11 11	97140				55 5	00 0	3 3	NPI 1144662011	
2 05 23 17	17 05 23 17	11 11	97140				55 5	08 0	3 3	NPI 1144662011	
3 										NPI	
4 										NPI	
5 										NPI	
6 										NPI	
25. FEDERAL TAX I.D. NUMBER 47-0989449			26. PATIENT'S ACCOUNT NO. BARRELL, D			27. ACCEPT ASSIGNMENT TO PAYMENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			28. TOTAL CHARGE \$ 110.00	29. AMOUNT PAID \$ 0.00	30. Paid for NUCC Use 110.00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.) COLLEEN MARX, LMW SIGNED DATE 05.27.2017			32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			33. BILLING PROVIDER INFO & PH# (716) 725-0264					
*1144662011			*1144662011			*1144662011					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and verifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes my entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(d). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participating cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary; if this is less than the charge submitted, TRICARE is not a health insurance program but makes payment for health benefits provided through certain clinics such as the Uniformed Services. Information on the patient's spouse should be provided in those items captioned in "Insured" i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding system.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA, AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have knowledge myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment, including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 7) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by their employee, 2) they must be an integral, although incidental part of a covered physician's services, 3) they must be of such severity furnished in physician's office, and 4) the services of non-physicians must be indicated on the physician's bill.

For TRICARE claims, I further certify that 1) for a civilian employee(s) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government, either civilian or military (refer to 5 USC 5336). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part II Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 442.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to law and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to use your information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information in section 205(a), 1028, 1027, and 1071 of the Social Security Act as amended, 42 CFR 411.24(n) and 424.5(a) (8), and 44 USC 3101.41 CTR 101 of reg and 10 USC 1079 and 1080, 8 USC 8101 et seq and 30 USC 901 et seq 30 USC 912, E.O. 13397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of service, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties to pay to the Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 03-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed Sept. 12, 1990, as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Publication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See E&A-5, E&A-8, E&A-10, E&A-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the circumstance(s) applies to the individual authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with repayment claims; and to Congressional Offices in response to inquiries made at the request of individuals whom we record patients. Appropriate disclosure may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

PENALTIES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be disciplinary or obstructive.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3001-3012 provide penalties for withholding this information.

You should be aware that P.L. 100-693, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICARE PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such accounts as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of enhanced deductible, co-payment or similar cost sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claims, claims for, or document, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Information Report Act of 1974, a provider is 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 1905-0119. The time required to complete the information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improvement, please write to CMS, 4500 Security Boulevard, Rm. 2040, P.R. Reports Clearance Officer, Mail Stop C4-00-06, Baltimore, Maryland 21244-0006. The address is for comments only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14043
Office: (716) 725-0224 Fax: (716) 725-0265

Client Name: Danielle Howell Date: 5/17/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific side of body is sore today:
 trap & to mid thoracic right
 QL & hypertoncity along w/ glute med.

Action's Applied: (Check All that Apply) Glutes & QL slightly hyper tone.
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)
 H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: *Danielle Howell*

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043
Office: (716) 725-0224 Fax: (716) 725-0265

Client Name: Danielle Howell Date: 5/23/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Tingling Calf mm. glute hyper tone. QL tight. hamstring weak. lower on L8 shoulder

Action's Applied: (Check All that Apply)
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)
 H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Therapist: *Danielle Howell*

06.02.17

06 02 17

Great Lakes Therapeutic Massage

Colleen Marx, LMT

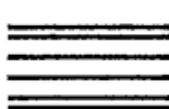
375 Dick Road, Suite #2

Buffalo, NY 14203

BUFFALO
NY 14203

30 MAY '17

PM 1 L



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GEICO.

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FREDERICKSBURG VA 22403-9527



NO POSTAGE
NECESSARY
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

NUCC PICA

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (SD/DoD) (Member ID) (DW) (NOM) (X) (DM)										1a. INSURED'S ID. NUMBER <input type="text"/> (For Progress in Item 1) 0138739400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE 3. PATIENT'S BIRTH DATE <input type="text"/> MM DD YY <input type="checkbox"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X 08 29 1980										4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY <input type="text"/> CHEEKTONWAGA STATE <input type="text"/> NY ZIP CODE <input type="text"/> 14225-1257 TELEPHONE (Include Area Code) <input type="text"/>										7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR			
8. RESERVED FOR NUCC USE										CITY <input type="text"/> CHEEKTONWAGA STATE <input type="text"/> NY ZIP CODE <input type="text"/> 14225-1257 TELEPHONE (Include Area Code) <input type="text"/>			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO _____ PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15										d. OTHER CLAIM ID (Designated by NUCC) 08 29 1980 <input type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X e. INSURANCE PLAN NAME OR PROGRAM NAME			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										f. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items 9, 9a, and 9d.			
SIGNED <input type="text"/> SIGNATURE ON FILE DATE 02 09 16										g. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.													
SIGNED <input type="text"/> SIGNATURE ON FILE													
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (I.M.P.) MM DD YY QUAL: <input type="text"/>										15. OTHER DATE MM DD YY QUAL: <input type="text"/> 4391 10 31 15			
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (S4E) ICD Ins. 0										22. REIMBRESSION CODE ORIGINAL REF. NO.			
A. M791		B. <input type="text"/>		C. <input type="text"/>		D. <input type="text"/>							
E. <input type="text"/>		F. <input type="text"/>		G. <input type="text"/>		H. <input type="text"/>							
I. <input type="text"/>		J. <input type="text"/>		K. <input type="text"/>		L. <input type="text"/>							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) GPT/HCPCS E. MODIFIER F. \$CHARGES G. \$/HR'S OR UNITS H. DENT. PER/PART I. ID. # J. RENDERING PROVIDER ID. #			
1 06 02 17 06 02 17 11 20553										EI 161582336 NPI 1649596495			
2													
3													
4													
5													
6													
25. FEDERAL TAX ID. NUMBER SSN EN <input type="checkbox"/> X										26. PATIENT'S ACCOUNT NO. <input type="text"/> 1629621 27. ACCEPT. ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28. TOTAL CHARGE <input type="text"/> \$ 95 74 6 29. AMOUNT PAID <input type="text"/> 0 00 30. Read for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JENNIFER W MCIVIGE, MD										32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727 33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002			
SIGNED <input type="text"/> DATE 06 06 17										E 1497850911 E 1497850911 EI 161582336			



DENT
NEUROLOGIC INSTITUTE

Vernice Bates, MD	Sanjay Gupta, MD	Malii Patel, MD
Bela Ajizi, MD	Tomas Helmich, MD	Mohammad M. Qasimyeh, MD
Alfred Balen III, MD	J. Maurice Houthase, MD	Michelle M. Rehka, PharmD
Hosacio Capote, MD	Anupama M. Kale, MD	Luis Rojas, MD
Ato N. Corvinca, MD	Xiuli Li, MD	Nicolas Saikali, MD
Dennis M. Czamiecki, PhD	Lasse Mechler, MD	Ulin Zhang, MD, PhD
J. Aubrey Boitano, PhD	Jennifer W. McVige, MD	Joseph V. Fritz, PhD, CSE
Marc S. Fron, MD	Kenneth R. Murray, MD	
Francis M. Gizzo, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note

Date: 06/02/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- NF- Requires Opinion
- headaches, trigger points. Patient presents for treatment of []

History of Present Illness

General:

The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. The patient reports good results with her trigger point injections.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 inti units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

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 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14220 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrograms	Positronigraphy
Betas	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNG
Inflators	

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen: No . Do you feel unsteady when: No

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using Illicit drugs: Denies.

Working:

Employed: Stay at home mom.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 118/72, HR 76, RR 16, Ht 63, Wt 229, BMI 40.56, BSA 2.15.

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

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 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14220 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrogram	Pornography
Beta	Sleep Studies
Doppler/TCD	SPECT
EEG	Unnaired
EMG	TMS
Im/RT	VNG
Infusion	

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site.

Procedures**Injections:**

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 8 cc was injected with a 25-gauge needle without complication into 8 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living. Patient counseled on the importance of healthy lifestyle. 06/02/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 06/02/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 06/02/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 06/02/2017 at 06:58 PM EDT

Sign off status: Completed

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Balvnia Office | 35 Balvnia City Centre • Balvnia, NY 14220 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrograms	Posturography
Batix	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
imPACT	VNG
Inflation	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA											
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BULKING OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> TRICARE <input type="checkbox"/> Member ID # <input type="checkbox"/> FECA <input type="checkbox"/> BULKING <input type="checkbox"/> Other											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE				6. PATIENT RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT			
CITY CHEKTOWAGA		STATE NY		CITY AMHERST		STATE NY					
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>NY</u> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
11. INSURED'S POLICY GROUP OR FECA NUMBER GEICO											
12. OTHER INSURED'S POLICY OR GROUP NUMBER											
13. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> 08291980											
14. RESERVED FOR NUCC USE											
15. RESERVED FOR NUCC USE											
16. INSURANCE PLAN NAME OR PROGRAM NAME GEICO											
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
18. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.											
19. SIGNATURE ON FILE DATE											
20. SIGNATURE ON FILE											
21. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 QUA 431											
22. OTHER DATE MM DD YY 454 111215											
23. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____											
24. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24c)) ICD Ind <input type="checkbox"/> 0 A M50.222 B M51.26 C M51.27 D M54.12 E I523.3XXA F M99.01 G M99.03 H M99.02 I M99.05 J M54.2 K M54.5 L M54.6											
26. DATE(S) OF SERVICE From MM DD YY To MM DD YY		27. PLACE OF SERVICE EMR		28. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		29. MODIFIER		30. DIAGNOSIS CODES		31. RENDERS CHARGES	
32. 05252017 05252017		33. 11		34. 98941		35. ABCD		36. 32 28 1		37. NPI 1710014188	
38. 05252017 05252017		39. 11		40. 97010		41. ABCD		42. 10 53 1		43. NPI 1710014188	
44. _____		45. _____		46. _____		47. _____		48. _____		49. _____	
50. _____		51. _____		52. _____		53. _____		54. _____		55. _____	
56. FEDERAL TAX ID NUMBER 364500165		57. SSN EMR <input checked="" type="checkbox"/>		58. PATIENT'S ACCOUNT NO 343821250		59. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		60. TOTAL CHARGE \$ 42 81 5		61. AMOUNT PAID \$ 1 1 1	
62. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849											
63. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse side of this form are true and correct. PETER GOLENSKI DC											
64. PATIENT FACILITY LOCATION INFORMATION											
65. SIGNED 06082017 DATE *1235256546* *1235256546*											

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
June 8, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday May 25, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 05/25/2017 at 9:47am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her left neck and shoulder area has been sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches have been daily for the past week. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain has been better. Patient going for an injection with Dr. Siddique on June 1, 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, sharp, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: Left neck extensors were weak and graded 4/5. *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 70/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Strength:* left deltoid: 4/5; all other upper extremity musculature

Encounter dated 05/25/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/08/2017

(C5-T1) were graded 5/5. **Hypertonicity & Tenderness** Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Mild to Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with no pain. **Gait pattern:** normal. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Positive left at 60 degrees for lower back pain; Well leg raise: Positive right at 60 degrees; Bechterew: Negative. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: unchanged. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. Cervical MRI was performed at DENT on March 27, 2017. According to the radiologist, only some subtle anterior spondylitic spurring is seen at C4-C5 and C5-C6. There is evidence of dextroscoliosis of the upper cervical spine

MRI of the brain was performed at DENT on March 27, 2017. According to the radiologist, it was a normal MRI scan of the brain without contrast.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: improving, VAS score improved from a 5 to 3 to out of 10. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac

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with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.
Treatment schedule: 1x/week for 1 week; Re-examination for 1 week. **Subluxations found on assessment and adjusted:** C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (diversified side posture). **Physical Modalities:** bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy.
Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. **Home care:** ice: neck / lower back prn for 20 minutes. **Additional instructions:** Advised patient to monitor for any changes in their symptoms. **Short term goals:** decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain. **Long term goals:** decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. **Disability status:** Temporary partial starting on November 12, 2015 to June 17, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 05/25/2017 at 9:47am

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits



Item# 43568
Presto Pakit





345 Dick Rd.
Depew, NY 14043

Geico
P.O. BOX 9507
Fredericksburg, VA 22408



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER →

PICA <input type="checkbox"/>												
1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA SEX/LINX	OTHER	1a. INSURED'S ID. NUMBER	(For Program In Item 1)				
<input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FECA Sex/Linx) <input type="checkbox"/> (Other)							013873940-0101-059					
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARWELL, DANIELLE				MM DD YY	SEX	- BARRY -						
5 PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)					
56 BERKELEY DR				Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>					
CITY AMHERST	STATE NY	8. RESERVED FOR NUCC USE			CITY		STATE					
ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536-0951	X			ZIP CODE	TELEPHONE (Include Area Code) ()						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR FECA NUMBER					
				a. EMPLOYMENT? (Current or Previous)	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		n. INSURED'S DATE OF BIRTH	SEX				
				b. AUTO ACCIDENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	PLACE (State) <input checked="" type="checkbox"/> NY	MM DD YY	M <input type="checkbox"/>	F <input type="checkbox"/>			
				c. OTHER ACCIDENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		d. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
							<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, complete items 9, 9a, and 10d.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												
SIGNED - ON FILE -				DATE 01-06-2016								
SIGNED - ON FILE -				DATE 01-06-2016								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)				15. OTHER DATE			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	MM DD YY	FROM MM DD YY	TO MM DD YY					
10 31 2015	QUAL											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. <input type="checkbox"/> NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
SIDNEY GRADAU, PA							FROM MM DD YY	TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB?			21. CHARGES					
				<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24e)				22. RESUBMISSION CODE			23. PRIOR AUTHORIZATION NUMBER					
A <input type="checkbox"/> LM79.1	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>				ORIGINAL REF NO					
E <input type="checkbox"/>	F <input type="checkbox"/>	G <input type="checkbox"/>	H <input type="checkbox"/>									
I <input type="checkbox"/>	J <input type="checkbox"/>	K <input type="checkbox"/>	L <input type="checkbox"/>									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS CODE NDC/ATC	F. \$ CHARGES	G. DAYS OR UNITS	H. FEE/UNIT	I. ID. #	J. RENDERING PROVIDER ID. #
1 05 31 17 05 31 17 11	97140						55 00 3			NPI	1144462011	
2 06 08 17 06 08 17 11	97140						55 00 3			NPI	1144462011	
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX ID. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE		29. AMOUNT PAID	30. Rev'd for NUCC Use	
47-0989449	<input type="checkbox"/> X							\$ 110 00	\$ 0 00	110 00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH#					
COLLEEN MARX, LMFT 06.10.2017 SIGNED				GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			(716) 725-0264					
DATE				S-1144462011			S-1144462011				S-1144462011	

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal and/or civil offense under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature accepts that payment is made and authorizes release of any information necessary to process the claim and settle the information provided in clause 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature entitles any entity to release to Medicare, either the individual or the program, any information which is necessary to pay for benefits under the Medicare program. In the case of a TRICARE claim, the patient's signature authorizes release of the items set forth in clause 1 through 8, except as otherwise prohibited by law. TRICARE payments are subject to the type of determination of the Medicare carrier or TRICARE local contractor and will change from the provider's perspective if and as the carrier, contractor and non-covered services. Contractors and the deductible are based upon the charge determinants of the Medicare carrier or TRICARE local contractor, not the actual amount paid. If any item is less than the charge submitted, TRICARE is not a health insurance program but makes payment for health benefits provided under the contract of coverage. Under clause 8, information in the provider's opinion should be provided in the space indicated in clauses 1 through 12, 4, 5, 7, 8 and 11.

BLACK LUNG AND FECA CLAIMS

For health claims in respect of the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding resuscitation procedure and diagnosis coding system.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In answer to your claim for payment from these funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have furnished myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have a private or will provide sufficient information to allow the government to make an audit of my records and payment of claims, either submitted by me on my behalf by my designated billing company, complete with all appropriate documentation for audit purposes; 4) I am entitled to receive payment for services or services furnished to me or to whom furnished incident to my professional services by my employer under my direct supervision, except as those expressly permitted by Medicare or TRICARE; 5) I, as each service rendered incident to my professional service, the item may (legal name and NPI 100-102-0000) or the primary care physician, if applicable, is referred to in paragraph 1 as "physician" or "practitioner"; 6) services rendered incident to a physician's consultation; I survived; 7) I file my claim under the laws of my state or the jurisdiction in which I practice; 8) they must be funds constantly kept at a physician's office; and 9) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) no longer serve as member of the Uniformed Services or a civilian employee of the U.S. State Department or a U.S. Government or a civilian employee of the United States Government, either civilian or military (refer to 3 USC 833e). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No more than one signature may be placed upon this form as required by existing law and regulations (42 CFR 442.32).

NOTICE: Any one who intentionally or falsely makes material information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTE: TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OMB to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is contained in 26 USC 1680, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.21(a) and 484.5(b)(6), and 14 USC 3101-3103, 40 CFR 101-102, and 1100-104 and 100-105, 9 CFR 8.01(c)(6) and 38 USC 613, E.O. 13377.

The information we obtain to compile our claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to make that proper payment is made.

This information may also be given to other providers of services, centers, intermediary sites, medical service benefit, health plans, and other organizations or Federal agencies, for the administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: So, the notice modifying system No. 09-70-0501, titled, "Comer Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, pg. 47349, Wed. Sep. 12, 1995, is as updated and republished.

FOR ONCP CL-113E: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990. See PS-1, CSA-6, CSA-12, CSA-13, CSA-14, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and confirmation that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation, as well as their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in legal actions, to the Internal Revenue Service, private collectors, ice agencies, and consumer reporting agencies in connection with recovery of claims, and to Congressional Offices in response to inquiries made in the request of or to whom a relevant program. Appropriate disclosures may be made to other Federal, state, local, foreign governmental agencies, private business entities, and individual providers of care on matters relating to enrollment, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and other relevant legislation relating to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3601-3812 provide penalties for failure to inform us.

You should be aware that P.L. 100-505, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to do my best to make it necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payment claim in accordance therewith such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to do my best, as payment is full, the amount paid by this Medicaid program for these claims submitted for payment under this program, with the exception of authorized deductible, consultation, or payments or similar consulting charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claim, false report, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Privacy Regulation, if OMB approves, we are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control numbers for the Medicare program are 1400-102 and 1400-115. The time interval to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or the "OMB number" for completing this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-05, Baltimore, Maryland 21204-1859. This address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0204

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 5/31/17Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific LB area/s achy: QL
 glute tightness.. iliotibial med. tight on Q side. Neck stiffness/Actions Applied: (Check All that Apply) discomfort to tip.
 Heat Packs Cold Packs Sombra/Biofreeze Fraxel
 Light Pressure Massage Mod Pressure Massage Curved
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion Isometrics
 Stripping Compression Lymph DrainagePlan/Recommendations: (check All that Apply)
 ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretch Con't Meds Ice / Heat MyofTherapist: Danielle Harwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0204

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 6/8/17Client Status: Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
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Observed Areas of Problem/Dysfunction: (Check All that Apply)

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 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client had LB injections done last week and it's starting to feel better. Neck & upper trap!Actions Applied: (Check All that Apply) hyper-tonicity causing
 Heat Packs Cold Packs Sombra/Biofreeze Curved
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph DrainagePlan/Recommendations: (check All that Apply)
 ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretch Con't Meds Ice / Heat MyofTherapist: Danielle Harwell

06 15 17

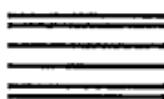
100% of total rainfall

06 15 17

Great Lakes Therapeutic Massage

Colleen Marr, LMT
375 Dick Road, Suite #2
Buffalo, NY 14243

BLUFFALO
NY 14243
12 JULY 17
PM 11



NO POSTAGE
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IF MAILED
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FREDERICKSBURG VA 22403-9527





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GBICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER —

PIRA

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FICA EXCLNG <input type="checkbox"/> OTHER <input type="checkbox"/> <input checked="" type="checkbox"/> (DME) <input type="checkbox"/> (DME)												1a INSURED'S ID. NUMBER (For Program in Item 1) 013873940-0101-059			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARNELL, DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
4 INSURED'S NAME (Last Name, First Name, Middle Initial) — SAME —												5 PATIENT'S ADDRESS (No., Street) 56 BEREHEAVEN DR			
6 PATIENT RELATIONSHIP TO INSURED Sister <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7 INSURED'S ADDRESS (No., Street)									
CITY AMERST		STATE NY		8 RESERVED FOR NUCC USE X		CITY		STATE							
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE ()		TELEPHONE (Include Area Code) ()							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO:			
a OTHER INSURED'S POLICY OR GROUP NUMBER												a EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b RESERVED FOR NUCC USE												b AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO NY			
c RESERVED FOR NUCC USE												c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d INSURANCE PLAN NAME OR PROGRAM NAME												10.5 CLAIM CODES (Designated by NUCC)			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO *Year, complete items 9, 9a, and 9d			
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below			
SIGNED - ON FILE - DATE 01-06-2016												SIGNED - ON FILE -			
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 2015 QMUL				15. OTHER DATE (MM DD YY) QUL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SIDNEY GRABAU, PA				17a NPI 17b				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A/L to service less below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.			
A M79.1				B C D				E G H							
E F				G H				I J K L							
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY				B PLAC OF SERVICE EMR C D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MCCHPER				E DIAGNOSIS POINTER F \$ CHARGES G DAYS OR UNITS H REIMB. PCT. I L ID QMUL J RENDERING PROVIDER ID #							
1	06 13 17	06 13 17	11	97140				55 00	3	NPI	1144462011				
2	06 16 17	06 16 17	11	97140				55 00	3	NPI	1144462011				
3										NPI					
4										NPI					
5										NPI					
6										NPI					
25 FEDERAL TAX ID NUMBER 47-0989449	SSN SIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. BARRELL, D				27 ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28 TOTAL CHARGE \$ 110 00	29 AMOUNT PAID \$ 0 00	30 Rcvd for NUCC Use 110 00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof)												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			
COLLEEN MARK, LMFT 06.16.2017 SIGNED DATE 1144462011												33. BILLING PROVIDER INFO & PH# (116) 725-0264 GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS PROVIDED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

167-02046-AZD (TRICARE PAYMENT) A patient's signature request that payment be made and authorizes release of any information needed to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary for the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in items 10-13 unless depicted in Item 1, i.e., items 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

It is my/her desire to file this claim paid by the Government as payment in full. See Black Lung and FECA insurance referring required procedure and diagnosis coding system.

STATE OF PLACE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an initial and complete payment claim; 4) this claim, whether submitted by me or on my behalf, by my direct or indirect billing company, complies with all applicable Medicare and/or Federal laws, regulations, and program instructions for payment rendering but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished to my professional service by my employee under my direct supervision, except as otherwise commonly paid for by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual or facility which rendered the specific service is reported to be correct; 7) medical records for services provided by a physician's professional services, 8) they must be referred under the physician's direct supervision by her/his employer, 9) they must be an integral, although incidental part of a certified physician service, 10) they must be referred under the physician's direct supervision by her/his employer, 11) they must be an integral, although incidental part of a certified physician service, 12) they must be of kinds commonly furnished at physician's offices, and 13) the services on this form, if any, must be indicated on the physician's bills.

For TRICARE claims, I further certify that (i) for any employee who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 8536) For Black Lung claims, I further certify that the service(s) performed were for a Black Lung entitled disease.

No Part B Medicare payments may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one-time arrangements or follow-on payments to receive payment from Federal funds requested by this form may upon conviction be subject to fine and incarceration under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)
This is maintained by CMS, TRICARE and OMB to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(c), 46 CFR, 1872 and 18% of the Social Security Act, as amended, 42 CFR 411.2(a) and 49 CFR 5(b) (8) and 44 USC 3101-11 CFR 101 et seq and 10 USC 107 and 108, 6 USC 8101 et seq, and 31 USC 901 et seq 31 USC 613, E.O. 8387.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered or free programs and to ensure that proper payment is made.

This information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system no. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, as updated and revised above.

FOR OMB CLU/ISS: Department of Labor, Privacy Act of 1974, "Reproduction of Notice of Systems of Records," Federal Register Vol. 53 No. 40, Wed Feb. 28, 1988. See CSA-6, EBA-6, CSA-12, EBA-13, EBA-9, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies rendered are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation, or to their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collective agencies, and consumer reporting agencies in connection with recipient claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosure may be made to other Federal, state, local, foreign government agencies, private benefit entities, and individual providers of care, on matters relating to enrollment, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, continuation of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary from me. Failure to provide information will result in delay in payment or may result in denial of claim. With the exception of the information discussed below, there are no penalties resulting from failure to furnish the type of information. However, failure to furnish information regarding the medical condition, route of or amount charged would prevent payment of claim, reduce those proceeds. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under this PA may result in disbarment.

If I stipulate that you will, if you know that another party is responsible for paying for your treatment, Section 1128B of the Social Security Act and 31 USC 9001-3812 prohibit me from furnishing this information.

You should be aware that P.L. 104-188, the "Computer Matching and Privacy Protection Act of 1996" permits the government to verify information by way of computer matching.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to render fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding my payment of claims for providing such services to the State Agency or Dept. of Health and Human Services as may be requested.

I further agree to accept payment in full the amount paid by the Medicaid program for those claims submitted for payment under this provision, with the exception of authorized deductibles, copayments or similar cost sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTING: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, false merits, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no person is 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 0948-0115. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, gather data, respond, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. The address is for comments and suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Deptw, NY 14043

Office: (716) 725-0824

Fax: (716) 725-0355

D.H.

Client Name: Danielle Harwell Date: 6/13/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) L7
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: DLB "popped" near injection site from steroid shots and really hurts today. DL and
Action/s Applied: (Check All that Apply) Glute very light.
 Heat Packs Cold Packs Sombra/Biofreeze Querci
 Light Pressure Massage Mod Pressure Message moving
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion very slow.
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ics / Heat ice

Therapist: Mary

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Deptw, NY 14043

Office: (716) 725-0824

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 6/16/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) L7
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: General cervical/mm stiffness esp. on D side. (2) LBP & SI joint ↓ into glute med. w/ tingling to outside of calf.
Action/s Applied: (Check All that Apply) Mod Deep pressure
 Heat Packs Cold Packs Sombra/Biofreeze break up.

- Light Pressure Massage Moderate Pressure Massage nerve block
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion in SB not
 Stripping Compression Lymph Drainage very effective.

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ics / Heat ice

Therapist: Mary

06 19 17



12



06 19 17



FREDERICKSBURG VA 22403-9527

PO BOX 9507

NY PTP

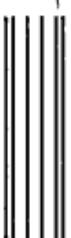
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BUFFALO
NY 14217
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18 JUN 17

Great Lakes Therapeutic Massage
Colleen Martz, LMT
375 Dixie Road, Suite #2
Buffalo, NY 14213

06 09 17

06/06/2017 TUE 07:55

FAX 716 250 2040

Dent Billing Dept.

001

*** FAX TX REPORT ***

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JOB NO. 2255
 DESTINATION ADDRESS 18562945154
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 TX/RX TIME 01' 03
 PGS. 4
 RESULT OK



GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

NUCC

PCN KEY

1. MEDICARE	MEDICAID	TRICARE	CRIMINAL	GROUP	EMERGENCY	OTHER	16. INSURED'S ID. NUMBER	(For Payment in Lieu of)		
<input type="checkbox"/> ANSWERED	<input type="checkbox"/> BURAWAY	<input type="checkbox"/> DIADEMO	<input type="checkbox"/> DIADEM	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> INDIVIDUAL	<input checked="" type="checkbox"/> SSI	0138729400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				6. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
HARRELL, DANIELLE				MM	DD	YY	HARRELL, DANIELLE			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)				
1131 CLEVELAND DR				Spouse	Spouse	Caregiver	1131 CLEVELAND DR			
CITY	STATE	6. RESERVED FOR NUCC USE		CITY	STATE	11. INSURED'S POLICY GROUP OR PCNA NUMBER				
CHEEKONWAGA	NY			CHEEKONWAGA	NY	DOI 10/31/15				
ZIP CODE	TELEPHONE (Include Area Code)			ZIP CODE	TELEPHONE (Include Area Code)	12. INSURED'S DATE OF BIRTH				
14225-1257	()			14225-1257	()	MM	DD	YY	BEX	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		13. OTHER CLAIMS (Designated by NUCC)				
				EMPLOYMENT (Current or Previous)	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	14. OTHER CLAIMS (Designated by NUCC)			
				b. AUTO ACCIDENT		15. OTHER ACCIDENTS				
				<input type="checkbox"/> Yes	<input type="checkbox"/> No	PLACE (State)				
				c. OTHER ACCIDENTS		16. INSURANCE PLAN NAME OR PROGRAM NAME				
				<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No					
8. INSURANCE PLAN NAME OR PROGRAM NAME				17. CLM CODES (Designated by NUCC)		18. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
						<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	19. HAS THIS FORM BEEN COMPLETED IN INK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM										
10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I Authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits otherwise myself or my family or my party who accepts assignment do so.										
11. SIGNATURE ON FILE					DATE 02-09-16					
12. SIGNATURE ON FILE					13. SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)		15. OTHER DATES (MM/YY)		16. DATES PATIENT ABLE TO WORK IN CURRENT OCCUPATION (MM/YY)		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. REFERRING PROVIDER'S BRANCH/CLINIC (Indicates payment of medical benefits to the undersigned physician or hospital for services described below)		
MM		DD		MM		MM		MM		
YY		YY		YY		YY		YY		
16. DATES PATIENT ABLE TO WORK IN CURRENT OCCUPATION (MM/YY)		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. REFERRING PROVIDER'S BRANCH/CLINIC (Indicates payment of medical benefits to the undersigned physician or hospital for services described below)		19. RECONSTITUTION DATES TO CURRENT SERVICES (MM/YY)		20. CHARGED LAB?		
FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		21. CHARGED		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. REFERRING PROVIDER'S BRANCH/CLINIC (Indicates payment of medical benefits to the undersigned physician or hospital for services described below)		19. RECONSTITUTION DATES TO CURRENT SERVICES (MM/YY)		20. CHARGED LAB?		21. CHARGED		
DN: PETER J GUSINSKI		17B: 1710014188		18. REFERRING PROVIDER'S BRANCH/CLINIC (Indicates payment of medical benefits to the undersigned physician or hospital for services described below)		19. RECONSTITUTION DATES TO CURRENT SERVICES (MM/YY)		20. CHARGED LAB?		
21. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
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		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
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		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
		22. HOSPITALISATION DATES		23. HOSPITALISATION DATES		24. HOSPITALISATION DATES		25. HOSPITALISATION DATES		
		FROM MM DD YY		TO MM DD YY		FROM MM DD YY		TO MM DD YY		
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06 09 17



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

PICA

PICA

1 MEDICARE MEDICARE TICARE CHAMPVA GROUP PLAN GROUP PLAN OTHER <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member ID# <input type="checkbox"/> (None) <input type="checkbox"/> (None) <input checked="" type="checkbox"/> (None)												1a INSURED'S ID NUMBER <small>(For Program in Item 1)</small> 0138739400101059			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M F <input checked="" type="checkbox"/>			
4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR			
6 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												7 INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR			
CITY CHEEKTONAGA		STATE NY		8 RESERVED FOR NUCC USE		CITY CHEEKTONAGA		STATE NY							
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()				ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Direct or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
												b AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
												c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d INSURANCE PLAN NAME OR PROGRAM NAME												11 INSURED'S POLICY GROUP OR FEA NUMBER DOI 10/31/15			
												a INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
												b OTHER CLAIM ID (Designated by NUCC)			
												c INSURANCE PLAN NAME OR PROGRAM NAME			
												d IS THERE ANOTHER HEALTH BENEFIT PLAN <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>if yes, complete items 9, 10, and 11</small>			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED SIGNATURE ON FILE												SIGNED SIGNATURE ON FILE			
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 08 09 17				15 OTHER DATE MM DD YY 04 13 99				16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. BETTER J GUZINSKI				17a LG U62607				18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (NE)) A M791 B _____ C _____ D _____ E _____ F _____ G _____ H _____ I _____ J _____ K _____ L _____												22 RESUBMISSION CODE ORIGINAL REF NO			
23 prior authorization number															
24 A DATE(S) OF SERVICE From MM DD YY 06 02 17		B PLAC OF SERVCE EMB 06 02 17		C EMB 11		D PROCEDURES, SERVICES, OR SUPPLIES (Specify Universal Categorization) CPT/HCPCS 20553		E DIAGNOSIS CODE/TER A		F 6 DAYS ON CHARGE 95 741		G REPORT PER UNIT 1 CUM 1		H PAYOR ID ET 161582336	
1 06 02 17												I NPI 1649596495			
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25 FEDERAL TAX ID NUMBER 161582336		SSN EN <input checked="" type="checkbox"/>		26 PATIENT'S ACCOUNT NO. 1629621		27 PATIENT ASSIGNMENTS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28 TOTAL CHARGE 8 95 74 0 00		29 AMOUNT PAID 0 00		30 Paid to NUCC Uni 0 00			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and we are under a joint plan.) JENNIFER W MCIVIGE, MD												32 SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE, 6TH FLOOR AMHERST NY 14226-1727			
												33 BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002			
												34 DATE 06 06 17			
												35 PAYOR BI 161582336			



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Hernando Capote, MD	Angeles M. Kalis, MD	Luisa Rajas, MD
Ass N. Corsetti, MD	Xiaoli Li, MD	Nicole Szkulik, MD
Donna M. Czarniak, PhD	Laszlo Mechler, MD	Liron Zhang, MD, PhD
J. Anthony Battaglia, PhD	Jennifer W. McVige, MD	Joseph V. Fritz, PhD, CEO
Mark S. Post, MD	Kenneth R. Murray, MD	
Frances M. Gengo, PharmD	Bennett Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note

Date: 06/02/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 36 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- NF- Requires Opinion
- headaches, trigger points Patient presents for treatment of []

History of Present Illness

General:

The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. The patient reports good results with her trigger point injections.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 intl units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

DIAGNOSTICS & SERVICES

MRI/CT	Neuropsychology
Arthrogram	Parotangiography
EEG	
Doppler/TCD	SPECT
EEG	
EMG	Ultrasound
InPACT	TAS
Inflatus	PNG

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Batavia Office | 35 Batavia City Centre • Batavia, NY 14220 | Fax: (716) 250-2045

Family History

Father alive, Stroke
 Mother alive, Asthma
 Siblings: alive
 1 brother(s) - healthy

Social HistoryTobacco Use:

Smoking Patient is a non-smoker.

Fall History:

Have you fallen No . Do you feel unsteady when. No .

Alcohol use:

Alcohol Consumption Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs. Denies.

Working:

Employed Stay at home mom.

Driving:

Does Patient Drive Yes.

Exercise:

Daily Yes, Walks

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 118/72, HR 76, RR 16, HT 63, WL 229, BMI 40.56, BSA 2.15

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

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DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Pastorography
Batex	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	ZMS
ImPACT	PNG
Injuries	

1 Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses
Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site

Procedures Injections

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 8 cc was injected with a 26-gauge needle without complication into 8 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 06/02/2017

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 06/02/2017

Exercise: Patient counseled on importance of moderate physical activity daily. 06/02/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 06/02/2017 at 06:58 PM EDT

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
MRI/CT	Neurophysiology
Arthroscopy	Pneumography
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Inflatus	



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Marc S. Forni, MD	Keanith R. Murray, MD	Joseph V. Putti, PhD, CEO

JUNE 6, 2017

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

DIAGNOSTICS & SERVICES	
MRI/CT	Neurophysiology
Angiogram	Pneurography
Sleep	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNF
Influsion	

(716) 250-2800
www.dentinstlinc.com

Anchorage Office | Dent Tower • 3888 Sheridan Drive • Anchorage, NY 14225 | Fax: (716) 250-2845
Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14227 | Fax: (716) 250-6015
Batavia Office | 25 Batavia City Center • Batavia, NY 14220 | Fax: (716) 250-2945



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDERAL EXEMPTION	OTHER	1a INSURED'S ID NUMBER	(For Program in Item 1)
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (N/A)	<input type="checkbox"/> (N/A)	<input type="checkbox"/> (N/A)	013873940011059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARWELL DANIELLE			MM <input type="text"/> DD <input type="text"/> YY	<input type="checkbox"/> M	<input checked="" type="checkbox"/> F	<input checked="" type="checkbox"/> X	HARWELL DANIELLE	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT'S RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)	
1131 CLEVELAND DRIVE			<input checked="" type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	56 BEREHAVEN DR., LEFT	
CITY CHEEKETOWAGA	STATE NY	ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		CITY AMHERST		STATE NY
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FICA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH		SEX	
			<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	MM <input type="text"/> DD <input type="text"/> YY	<input type="checkbox"/> M	<input type="checkbox"/> F	<input checked="" type="checkbox"/> X
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?		b. OTHER CLAIM ID (Designated by NUCC)			
			<input type="checkbox"/> YES	<input type="checkbox"/> NO	PLACE (State) NY			
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?		c. INSURANCE PLAN NAME OR PROGRAM NAME			
			<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	GEICO			
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
					<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	If yes, complete items 5, 9a, and 9d	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								
SIGNED SIGNATURE ON FILE DATE								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115 15. OTHER DATE (MM DD YY) 0411 454 111215								
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI								
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-H to service line below (SME)) ICD IND A. IM50-222 B. IM51-26 C. IM51-27 D. IM54-12 E. IS23-3XXA F. IM99-01 G. IM99-03 H. IM99-02 I. IM99-05 J. IM54-2 K. IM54-5 L. IM54-6								
22. RESUBMISSION CODE ORIGINAL REF. NO.								
23. PRIOR AUTHORIZATION NUMBER								
24. a. DATES OF SERVICE From <input type="text"/> To <input type="text"/> b. PLACE OF SERVICE <input type="text"/> c. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) d. CPT/HCPCS e. MODIFIER f. DIAGNOSIS POINTERS g. CHARGES h. DAYS OR UNITS i. HOURS PER DAY j. L. ID QMEL k. RENDERING PROVIDER ID #								
1 06122017	06122017	11	99212	25	ABCD	20 29	1	NPI 1710014188
2 06122017	06122017	11	98941		ABCD	32 28	1	NPI 1710014188
3 06122017	06122017	11	97010		ABCD	10 53	1	NPI 1710014188
4 								NPI
5 								NPI
6 								NPI
25. FEDERAL TAX ID NUMBER SSN EN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT 364500165 <input type="checkbox"/> <input checked="" type="checkbox"/> 343821251 <input type="checkbox"/> YES <input type="checkbox"/> NO								
28. TOTAL CHARGE 29. AMOUNT PAID 30. Rate for NUCC Use \$ 63.10 \$								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse side of this form are true and correct. PETER GOJINSKI DC 32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849								
33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849								
SIGNED 06232017 DATE * 1235256546^b * 1235256546^b								

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
June 23, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday June 12, 2017 Provider: Peter Guzinski DC RE-EXAM

Electronically signed by Peter Guzinski DC on 06/14/2017 at 1:24pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights, she has moderate headaches which come infrequently, she can do most of her usual work, but no more and her sleep has been moderately disturbed (1-2 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving since last re-examination on April 7, 2017. *Pain:* achy, dull, sharp, tingling, shooting; level: 4/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 2-3 x a week. She states that the duration varies, but they no longer last all day. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. Patient seeing Dr. McVige on Thursday. *Cervical Disability Index:* 36%. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving since last re-examination on April 7, 2017. *Pain:* achy, dull, sharp, shooting; level: 4/10. *Pain is frequent.*

**Encounter dated 06/12/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/23/2017**

Exacerbates symptoms: movement; bending; lifting; activities of daily living; reaching; activities of daily living.
Alleviates symptoms: nothing. *Numbness:* none. *Weakness:* none. *Oswestry score:* 36%.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain continues to slowly improve. Due to the pain, she is unable to lift heavy weights, she is unable to sit greater than 30 minutes, she is unable to stand greater than 60 minutes and she is unable to travel on journeys greater than 60 minutes. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last re-examination on April 7, 2017. *Pain:* achy, dull, sharp, shooting, tingling; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 36%. *The Keele STaRt Back Screening Tool:* Low risk. *Recent medical treatment for this condition:* Pain management evaluation with injections. *Changes in past medical history:* None.

Activity of Daily Living Form Bathing/Showering: no impairment; Bending forward/backward: moderate impairment; Brushing teeth: no impairment; Buttoning shirt: no impairment; Driving: mild impairment; Drying Hair: mild impairment; Household chores: moderate impairment; Laundry: severe impairment; Lifting less than 10 lbs: mild impairment; Lifting more than 10 lbs: severe impairment; Kneeling: mild impairment; Making Meals: moderate impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: no impairment; Restful night's sleep: no impairment; Seated to standing position: mild impairment; Sexual activity: no impairment; Standing: mild impairment; Squatting: mild impairment; Taking out the trash: not performed; Tying shoes: mild impairment; Using lavatory: mild impairment; Walking: mild impairment.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with no pain; left rotation: 60/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Negative; right lateral compression: Negative; maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Encounter dated 06/12/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/23/2017

Lumbar/Sacral/Pelvis: Range of motion: flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. Heel to toe walking: WNL. Gait pattern: normal. Strength: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. Sensation: all lower extremity sensory exams (L1-S1) were WNL to Pin prick. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. Tenderness on palpation: left SI: mild to moderate. Trigger points: left gluteus maximus. Reflexes: bilateral lower extremity reflexes (L4 and S1) 2+. Orthopedic tests: Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative; Minor's sign: Negative; Slump Test: Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for lower back pain on a cough or sneeze. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-examination on April 7, 2017 her neck condition has slightly regressed. Her Neck Disability Index score increased from 28% to 36%. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL and decrease the frequency and intensity of headaches.

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Prognosis: Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: Mrs. Harwell's lower back condition has slightly regressed since her last re-examination on April 7, 2017. Her Oswestry Disability Index score increased from 28% to 36% Further treatment is medically necessary to help improve her active lumbar ROM and improve her ability to sit, stand, bend, perform household chores and lift with less pain. **Post-treatment analysis:** patient tolerated treatment without incident.

Set backs: Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Encounter dated 06/12/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 06/23/2017

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.
Treatment schedule: 1x/week for 4 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 8 weeks.

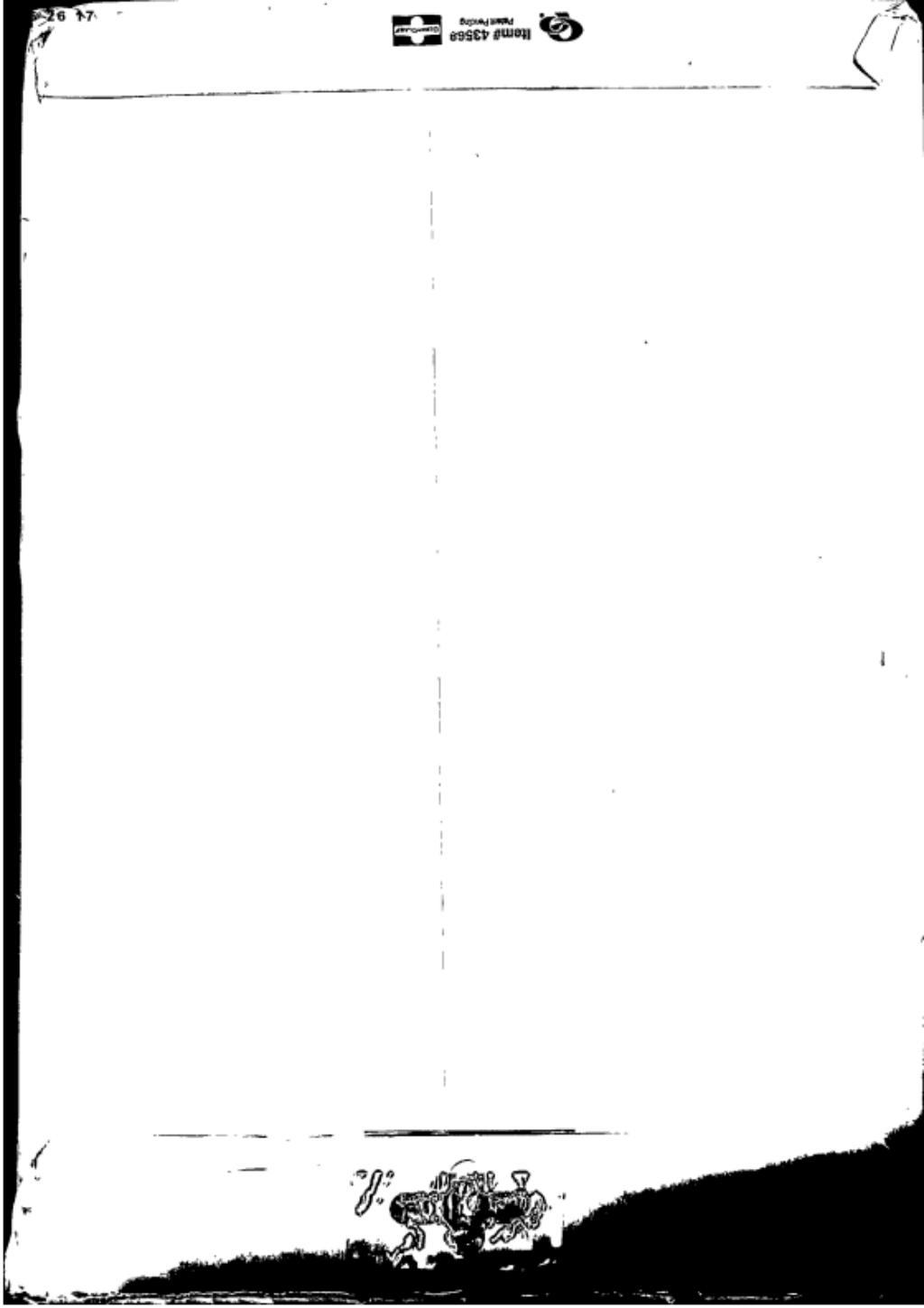
Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapulae trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and/or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 06/14/2017 at 1:24pm

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



06 26 17

INCUBATION PERIOD

Geico
P.O. Box 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NE

NY PIP CLAIMS

PO BOX 9507

FREDERICKSBURG VA 22403

NUCC PICA

PICA

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PATIENT AND INSURED INFORMATION																													
PHYSICIAN OR SUPPLIER INFORMATION																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FCA <input type="checkbox"/> OTHER <input type="checkbox"/> <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CHAMPVA <input type="checkbox"/> Member ID# <input type="checkbox"/> (None) <input type="checkbox"/> (None) <input type="checkbox"/> (None)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE																													
3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 <input type="checkbox"/> M <input checked="" type="checkbox"/> F																													
4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE																													
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR																													
6. PATIENT RELATIONSHIP TO INSURED Son <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																													
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8. CITY CITY CHEEKTONWAGA CHEEKTONWAGA STATE STATE NY NY																													
9. ZIP CODE ZIP CODE 14225-1257 ()																													
10. TELEPHONE (Include Area Code) 14225-1257 ()																													
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE																													
12. OTHER INSURED'S POLICY OR GROUP NUMBER DBD16761000																													
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25. FEDERAL TAX ID. NUMBER SSN/BN 26. PATIENT'S ACCOUNT NO. 27. ACCORD ASSIGNMENT? 161582336 <input type="checkbox"/> 1638265 <input type="checkbox"/> YES <input type="checkbox"/> NO												28. TOTAL CHARGE \$ 74.79		29. AMOUNT PAID \$ 0.00		30. Paid for NUCC USE 													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JENNIFER W MCIVIGE, MD 06 19 17												32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN SIXTH FLOOR 3980 AMHERST NY 14226-1727		33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002															
SIGNED DATE 1497850911												1497850911		1161582336															



DENT
NEUROLOGIC INSTITUTE

HEADACHE & NEURO-ONCOLOGY CENTER

Leslie Mechtler, MD, Director
Ajay Abud, MD

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Rachel Pienika, PA-C
Maria Ricco, RPA-C
Grace T. Schuster, FNP
Christopher Zdziarski, FNP-C

Jennifer W. McVige, MD

Re-Evaluation
Date: 06/15/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- Headaches/ Pain

History of Present Illness

General:

Dear Dr. Panzarella:
We had the pleasure of seeing Danielle today in neurologic reevaluation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a wonderful 36-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at the urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale. The headaches were worse than her baseline. She reported associated anosmia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes, but there are disk extrusions seen at C4-C5 and C5-C6. She did have an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 showed a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8. The remainder of the CBC was within normal limits. CMP, TSH, Vitamin D and Vitamin B12 were within normal limits.

Danielle has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and physical therapy. After initial evaluation, she was started on magnesium oxide, Naprosyn and Rizatriptan. Vestibular therapy and physical therapy have both proven helpful in symptom management. Massage therapy is also very helpful with decreasing her cervical myofascial spasm. Regular trigger point injections have proven to be very beneficial.

Danielle is struggling with episodes of dizziness and vertigo. These can be so severe she will have to pull over when she is driving. They seem to be triggered by certain neck movements. She will experience a sharp pain starting from the base of her head that will radiate up and over to the top of her head. These do tend to occur with a headache. Lamictal was started and is currently at 100mg, but there is no notable relief. Headaches are almost daily and tend to be located along the right occipital and temporal regions and will radiate into her right eye.

The patient did attend vestibular therapy and physical therapy until discharged from both. She

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Gregory Cook, Cleie Manager
Ashley Hemmer
Anasida McFayzie
Alles Trautskali

INFUSION CENTERS
Christie Mass, MBA, Director
Barbara Muthberg, RN, Manager

Patient: Marwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

Page 2 of 5

continues to do complete exercises at home. Unfortunately, the patient feels she has plateaued.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal.

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking: Patient is a: non smoker.

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Ilicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

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 Alice Trzaski

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 Barbara Mulvrig, RN, Manager

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Headaches, photophobia, sonophobia, osmophobia, fatigue, cervicalgia, anxiety, dizziness. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 120/78, HR 74, RR 16, Ht 63, Wt 227.2, BMI 40.24, BSA 2.14.

Examination

General Examination:

General Appearance: Well-nourished, well-developed, in no apparent distress, participated with the exam. Well groomed. Neck: Supple. Range of motion, restricted. Left shoulder greatly elevated over right. C1-2 is shifted to the right. Severely spasmed paraspinal muscles and trapezi bilaterally. Cardiovascular: S1, S2, no murmurs, regular rate. Extremities: Full range of motion of extremities x4. No edema.

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Plantar responses were downgoing bilaterally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Within normal limits. Tandem stance is unsteady. Romberg unsteady. Sensory: Sensation to touch and cold was intact in all 4 extremities bilaterally.

Cranial Nerves:

Cranial Nerve II: Visual fields full. Disc margins clear bilaterally. No vessel abnormalities. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Convergence insufficiency right eye. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

1. Vestibular dysfunction - H83.2X9 (Primary)
2. Concussion, without loss of consciousness, sequela - S06.0X0S
3. Posttraumatic headache - G44.309
4. Cervical radicular pain - M54.12
5. Left-sided low back pain with left-sided sciatica, unspecified chronicity - M54.42

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INFUSION CENTERS

Christie Muir, MBA, Director
Barbara Maltang, RN, Manager

Danielle is a 38-year-old female with a history of a car accident in October 2015. Headaches continue to be almost daily and located mostly along the right side of her head. The patient was discharged from both vestibular therapy and physical therapy due to improvement, however the patient feels she is almost regressing in regards to her myofascial spasm and dizziness. Since her accident, the patient continues to struggle with headaches, neck pain, muscle tension, dizziness, vertiginous events, decreased attention and concentration and overall feels cognitively impaired. When asked what percent she feels improved she was unable to answer due to persistent and almost worsening symptoms at today's appointment.

1. Wean off Lamictal. Decrease one tablet a day until completely off.
2. Nortriptyline to help with sleep and muscle relaxation. The patient is severely spasmed on exam. If symptoms are not improved or persist with nortriptyline, Topamax will be started. We will see how the patient does with nortriptyline and Topamax. Finally, if the patient continues to struggle Botox will be considered.
3. Compounded pain cream to apply BID. This should also help with her cervical myofascial spasm. Discussed increased efficacy with regular, daily use.
4. Restart vestibular and physical therapy due to worsening dizziness, imbalance and cervical myofascial spasm.

The patient should avoid headache triggers, exercise regularly and avoid skipping meals.

Thank you for allowing me to care for this patient. Any questions or concerns, please feel free to contact me at any point in time. This dictation was created by a medical scribe. Errors may be present. Efforts were made to ensure accuracy.

Treatment

1. Vestibular dysfunction

PHYSICAL THERAPY Vestibular nos1571218

2. Posttraumatic headache

Continue magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day

Continue Naprosyn tablet, 500 mg, 1 tab(s), orally, pm headache, up to BID

Continue Melatonin tablet, 3 mg, 1 tab(s), orally, once (at bedtime)

Continue Vitamin D3 capsule, 5000 intl units, 1 cap(s), orally, once a day

Decrease Lamictal tablet, 25 mg, 2 tab(s), orally, BID

Continue rizatriptan tablet, 10 mg, 1 tab(s), orally, pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3

Start nortriptyline capsule, 10 mg, 1 cap(s), orally, QHS, 30 day(s), 30, Refills 5

Notes: compounded pain cream.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 06/15/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 06/15/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 06/15/2017.

Follow Up

4 Weeks

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Patient: Harwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

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Electronically signed by Jennifer McVige , MD on 07/02/2017 at 12:05 AM EDT**Sign off status: Completed**

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Barbara Mulderig, RN, Manager



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

CARRIER

NUCC PICA

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member ID# <input type="checkbox"/> (DoD) <input type="checkbox"/> OTHER											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE											
3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M <input checked="" type="checkbox"/>											
4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE											
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR											
6. PATIENT RELATIONSHIP TO INSURED Sel <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR											
CITY CHEEKSTOWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY CHEEKSTOWAGA		STATE NY		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER DBD16761Q00		b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME INDEPENDENT HEALTH MEDISOURCE		10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER DOT 10/31/15	
b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment before		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below			
SIGNED SIGNATURE ON FILE DATE 02-09-16											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY Q3M		15. OTHER DATE MM DD YY Q3M 439 10 31 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI		17a U62607		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD IND O A HB32X9 B 1 S060X08 C G44309 D M5412 E M5442 F L G L H L I L J L											
22. RESUBMISSION CODE ORIGINAL REF NO NPI											
23. PRIOR AUTHORIZATION NUMBER NPI											
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B RUC/OF SERVICE EMR		C D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS POINTER		F G CHARGES H DAYS OR UNITS I H RENT PER DAY J ID QM		K RENDERING PROVIDER ID #	
1	06 15 17	06 15 17	11	99214		ABCD	74	79	1	BT	161582336
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX ID NUMBER 161582336		SSN/BIN K		26. PATIENT'S ACCOUNT NO. 1638265		27. ACCEPT ASSIGNMENTS (Check if you do not want to be assigned) K YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ 74 79 5		29. AMOUNT PAID 0 00	
30. Reserved for NUCC Use											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) JENNIFER W MCVIGE, MD 06 19 17											
32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN SIXTH FLOOR 3980 AMHERST NY 14226-1727											
33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002											

07 06 17

DENT NEUROLOGIC GROUP, LLP
ADMINISTRATIVE OFFICE
3880 SHERIDAN BLVD SUITE 200
WALSH CENTER



FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entry to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary upon the full charge and the patient is responsible only for one deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government in payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished to me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identify (legal name and NPI), license #, or SSN of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee; 2) they must be an integral, although incidental part of a covered physician service; 3) they must be of kinds commonly furnished in physician's office; and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who manipulates or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(b) (5), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 801 et seq, and 30 USC 801 et seq; 35 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying System No. 09-70-0501, Med, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37548, Wed Sept 12, 1990, as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See BSA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompensation claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-26-05, Baltimore, Maryland 21244-1630. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



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Ajay Abed, MD

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Maria Rizzo, RPA-C
Grace T. Schuster, FNP
Christopher Zalawski, FNP-C

Jennifer W. McVige, MD

Re-Evaluation
Date: 06/15/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 Age: 36 Y Sex: Female
PCP: James Panzarella, DO

Reason for Appointment

- Headaches/ Pain

History of Present Illness

General:

Dear Dr. Panzarella:

We had the pleasure of seeing Danielle today in neurologic reevaluation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a wonderful 36-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at the urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale. The headaches were worse than her baseline. She reported associated sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16 MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes, but there are disk extrusions seen at C4-C5 and C5-C6. She did have an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 showed a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8. The remainder of the CBC was within normal limits. CMP, TSH, Vitamin D and Vitamin B12 were within normal limits.

Danielle has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and physical therapy. After initial evaluation, she was started on magnesium oxide, Naprosyn and RizatRIPTAN. Vestibular therapy and physical therapy have both proven helpful in symptom management. Massage therapy is also very helpful with decreasing her cervical myofascial spasm. Regular trigger point injections have proven to be very beneficial.

Danielle is struggling with episodes of dizziness and vertigo. These can be so severe the she will have to pull over when she is driving. They seem to be triggered by certain neck movements. She will experience a sharp pain starting from the base of her head that will radiate up and over to the top of her head. These do tend to occur with a headache. Lamictal was started and is currently at 100mg, but there is no notable relief. Headaches are almost daily and tend to be located along the right occipital and temporal regions and will radiate into her right eye.

The patient did attend vestibular therapy and physical therapy until discharged from both. She

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Christina Mann, MBA, Director
Barbara Maderig, RN, Manager

continues to do complete exercises at home. Unfortunately, the patient feels she has plateaued.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal

Current Medications

- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 IU units capsule 1 cap(s) orally once a day
- Taking Lamictal 25 mg tablet 1 tab(s) orally 1 tab once daily x 2 weeks, then increase to 1 tab BID x 2 weeks, then increase to 2 tabs BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen No . Do you feel unsteady when No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies

Resides with:

Spouse: Husband. Children: Yes, x3 Self: Yes

Working:

Employed: Stay at home mom

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes

Exercise:

Daily. Yes, Walks.

Caffeine:

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ADMINISTRATIVE SUPPORT

Gregory Cole, Clinic Manager
 Ashley Henriven
 Amanda McFayden
 Alice Trzaski

INFUSION CENTERS

Christine Meen, MBA, Director
 Barbara Moléong, RN, Manager

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Other. Patient does not consume caffeine

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Headaches, photophobia, sonophobia, osmophobia, fatigue, cervicalgia, anxiety, dizziness. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 120/78, HR 74, RR 16, Ht 63, Wt 227 2, BMI 40.24, BSA 2.14.

Examination

General Examination:

General Appearance Well-nourished, well-developed, in no apparent distress, participated with the exam. Well groomed. Neck: Supple Range of motion, restricted. Left shoulder greatly elevated over right. C1-2 is shifted to the right. Severely spasmed paraspinal muscles and trapezi bilaterally. Cardiovascular: S1, S2, no murmurs, regular rate. Extremities Full range of motion of extremities x4. No edema.

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Plantar responses were downgoing bilaterally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Within normal limits. Tandem stance is unsteady. Romberg unsteady. Sensory: Sensation to touch and cold was intact in all 4 extremities bilaterally.

Cranial Nerves:

Cranial Nerve II: Visual fields full. Disc margins clear bilaterally. No vessel abnormalities. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Convergence insufficiency right eye. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetrical and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

1. Vestibular dysfunction - H83.2X9 (Primary)
2. Concussion, without loss of consciousness, sequela - S06.0X0S
3. Posttraumatic headache - G44.309
4. Cervical radicular pain - M54.12
5. Left-sided low back pain with left-sided sciatica, unspecified chronicity - M54.42

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 Barbara Mullings, RDN, Manager

Danielle is a 36-year-old female with a history of a car accident in October 2015. Headaches continue to be almost daily and located mostly along the right side of her head. The patient was discharged from both vestibular therapy and physical therapy due to improvement; however, the patient feels she is almost regressing in regards to her myofascial spasm and dizziness. Since her accident, the patient continues to struggle with headaches, neck pain, muscle tension, dizziness, vertiginous events, decreased attention and concentration and overall feels cognitively impaired. When asked what percent she feels improved she was unable to answer due to persistent and almost worsening symptoms at today's appointment.

1. Wean off Lamictal Decrease one tablet a day until completely off.
 2. Nortriptyline to help with sleep and muscle relaxation. The patient is severely spasmed on exam. If symptoms are not improved or persist with nortriptyline, Topamax will be started. We will see how the patient does with nortriptyline and Topamax. Finally, if the patient continues to struggle Botox will be considered.
 3. Compounded pain cream to apply BID. This should also help with her cervical myofascial spasm
- Discussed increased efficacy with regular, daily use
4. Restart vestibular and physical therapy due to worsening dizziness, imbalance and cervical myofascial spasm

The patient should avoid headache triggers, exercise regularly and avoid skipping meals

Thank you for allowing me to care for this patient. Any questions or concerns, please feel free to contact me at any point in time. This dictation was created by a medical scribe. Errors may be present. Efforts were made to ensure accuracy.

Treatment

1. Vestibular dysfunction

PHYSICAL THERAPY Vestibular nos1571218

2. Posttraumatic headache

Continue magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day

Continue Naprosyn tablet, 500 mg, 1 tab(s), orally, pm headache, up to BID

Continue Melatonin tablet, 3 mg, 1 tab(s), orally, once (at bedtime)

Continue Vitamin D3 capsule, 5000 int'l units, 1 cap(s), orally, once a day

Decrease Lamictal tablet, 25 mg, 2 tab(s), orally, BID

Continue rizatriptan tablet, 10 mg, 1 tab(s), orally, pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3

Start nortriptyline capsule, 10 mg, 1 cap(s), orally, QHS, 30 day(s), 30, Refills 5

Notes: compounded pain cream

Preventive Medicine

COUNSELING Healthy Living Patient counseled on the importance of healthy lifestyle 06/15/2017.

Diet Patient counseled on importance of lowering sugar intake, sodium and fats 06/15/2017.

Exercise Patient counseled on importance of moderate physical activity daily 06/15/2017

Follow Up

4 Weeks

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 Annette McFoyden
 Alex Traenki

INFUSION CENTERS

Christie Mann, MBA, Director
 Barbara Maliszewski, RN, Manager

Electronically signed by Jennifer McVige , MD on 07/02/2017 at 12:05 AM EDT

Sign off status: Completed

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Amanda McFayden
Alice Tracinski

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*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 3211
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 07/03 06:18
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 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

NCPA

PDA

CARRIER

b P&P
**GEICO INSURANCE - NF
 NY PIP CLAIMS
 POBOX 9507
 FREDERICKSBURG VA 22403**

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA EXCLUDED		OTHER		1a. INSURED'S ID. NUMBER		(For Programs in Item 1)	
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2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
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5. PATIENT'S ADDRESS (No. Street)												6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No. Street)			
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14225-1257		()		14225-1257		()											
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
HARWELL, DANIELLE												a. EMPLOYMENT (Cavant or Previous)	DOT 10/31/15				
b. RESERVED FOR NUCC USE												<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	6. INSURED'S DATE OF BIRTH			
c. RESERVED FOR NUCC USE												<input type="checkbox"/> YES	<input type="checkbox"/> NO	MM	DD	YY	SEX
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g. RESERVED FOR NUCC USE												<input type="checkbox"/> YES	<input type="checkbox"/> NO	9. IS THERE ANOTHER HEALTH BENEFIT PLAN			
h. RESERVED FOR NUCC USE												<input type="checkbox"/> YES	<input type="checkbox"/> NO	10. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
i. RESERVED FOR NUCC USE												11. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		12. SIGNATURE ON FILE			
j. RESERVED FOR NUCC USE												DATE 02-09-16		13. SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)		15. OTHER DATES		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES		17. PATIENT'S ADDRESS		18. PATIENT UNABLE TO WORK IN CURRENT OCCUPATION									
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25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES		25. DATE(S) OF SERVICE		26. PROCEDURES, USAGES, OR SUPPLIES		27. DIAGNOSIS		28. CHARGES			
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY			
25. DATE(S) OF																	

07 06 17



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

NUCC Instruction Manual available at: www.nucc.org

NUCC

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (Champva) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FECA)												OTHER <input type="checkbox"/> (Other)					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980				SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
HARWELL, DANIELLE												4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -					
5. PATIENT'S ADDRESS (No., Street)												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
56 BEEBEHAVEN DR				7. INSURED'S ADDRESS (No., Street)													
AMHERST				CITY													
NY				STATE													
ZIP CODE				CITY													
14228 (716) 536-0951				STATE													
X																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
												b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input checked="" type="checkbox"/> NY					
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME												11. INSURED'S POLICY GROUP OR PEOA NUMBER					
												a. INSURED'S DATE OF BIRTH MM DD YY					
												M <input type="checkbox"/> F <input checked="" type="checkbox"/>					
												b. OTHER CLAIM ID (Designated by NUCC)					
												c. INSURANCE PLAN NAME OR PROGRAM NAME					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to either me or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED - ON FILE -												DATE 01-06-2016					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10/31/2015 GUAL				15. OTHER DATE MM DD YY GUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SIDNEY GRABAU, PA				17a 17b NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))												22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. LM79-1				B. L				C. ICD IND									
D. L				E. L				F. L									
G. L				H. L				I. L									
J. L				K. L				L. L									
24. A. DATE(S) OF SERVICE MM DD YY				B. PLACE OF SERVICE EMR				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPTR/HCPCS				D. DIAGNOSIS CODE MODIFIER					
1. 06 19 17 06 19 17 11				2. 06 26 17 06 26 17 11				3. 06 26 17 06 26 17 11				4. 06 26 17 06 26 17 11					
47-0989449				47-0989449				47-0989449				47-0989449					
25. FEDERAL TAX ID NUMBER				26. PATIENT'S ACCOUNT NO. HARWELL, D				27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. TOTAL CHARGE \$ 110 00					
47-0989449				47-0989449				47-0989449				29. AMOUNT PAID \$ 0 00					
30. BILLING PROVIDER INFO & PH# GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043				31. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043				32. BILLING PROVIDER INFO & PH# (716) 725-0264									
33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMT SIGNED DATE				34. PATIENT'S SIGNATURE 1144462011				35. PAYMENT INFORMATION 1144462011									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal offense punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

ALL MEDICARE AND TRICARE PAYMENTS. A patient's signature authorizes final payment by me and authorizes disclosure of any information necessary to process the claim in I certifies that the information provided in Block 8 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical information and information and I understand the person has employer group health insurance, liability, no-fault, worker's compensation, auto or other insurance which is responsible to pay for the services for him/her. Medicare does not reimburse. See 42 CFR 411.24(a). In case it is complicated, the patient's signature authorizes release of the information to the insurance or agency shown in Medicare, private or TRICARE. In complicated cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the charge determined by the Medicare carrier or TRICARE fiscal intermediary if the physician is responsible only for the deductible, copayments and non-covered services. Copayments and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if the physician is less than the charge submitted. TRICARE is not a health insurance program but makes payment for the MTF benefits provided through outside providers via the Uniform Billing System. Information on the patient's insurance should be provided in those items captioned as "Insured"; i.e., Items 1a, 4, 6, 7, 8 and 11.

51. BLACK LUNG AND PECOA CLAIMS

The new date of service is indicated in a statement paid by the Government as payment in full. See Black Lung and PECOA instructions regarding required procedure for diagnosis and/or system.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, PECOA AND BLACK LUNG)

In returning this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from this Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed ability and payment decision; 4) this claim will be submitted by me or on my behalf by my designated physician or company, complete with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment, including but not limited to the Federal and/or Private state and Physician Self-Referral Law (commonly known as Stark Law); 5) the services for this claim were medically necessary and personally furnished by me or were furnished incident to my professional services by my employees under my direct supervision; 6) except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional services by me, my identity (legal name and NPI license), or NPI of my primary and initial rendering health care provider is reported in the designated column. For services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direct supervision by lesser employees; 8) I may be an employee, although incidental part of a covered physician service; 9) they must be or leads committee supervised in the rendering of care; and 10) the status of non-physician must be included on the physician's bill.

For TRICARE claims, I further certify that 1) any employee(s) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a civilian employee of the United States Government either civilian or military (refer to 3 USC 5336). For Black Lung claims, I further certify that the service performed is not for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 414.32).

NOTICE: Any person who knowingly or falsely certifies information to receive payment from Federal funds requested by this form may incur criminal liability for false statements under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, PECOA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OIGP to ask you for information needed in the administration of the Medicare, TRICARE, PECOA, and Black Lung programs. Authority to collect information is set forth in section 205(g), 1802, 1872, and 1877 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(e)(3), and 44 USC 301-41 CFR 101 et seq and 10 URC 1071 and 1076; 3 USC 6101 et seq., and 30 USC 991 et seq., 99 USC 613; E.O. 9397.

The column "An identifier to complete claims under Medicaid programs is used to identify you and to determine your eligibility. It is also used to identify if the service or supplier you received was provided by these programs and to insure proper payment is made."

The information may be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, to the effective administration of Federal programs that require other third parties to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice, mailing system No. 06-70-0001, titled "Carrier Medicare Claims Record," published in the Federal Register Vol. 55 No. 177, page 37484 on 17 Sep. 1990, 19, 20, 21, or as updated and republished.

FOR DOLCI CLAIMS: Department of Labor, Privacy Act of 1974, "Regulation of Use of Systems of Records," Federal Register Vol. 55 No. 40, W-14-P-36, 1990. See FSA-6, ER-6, ER-12, ER-14, FPA-70, or -14, -17, -18, -19, -20, -21 and -22, as updated and republished.

FOR TRICARE (TRICARE PRINCIPAL PURPOSES): To evaluate eligibility for medical care provided by civilian sources and to issue payment terms establishment of eligibility and claim status.

NOTICE TO TRICARE: Information of mine and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services, and the Dept. of Transportation contractors, the Dept. of Defense, audited in their responsibility under TRICARE/CHAMPVA. To the Dept. of Justice for representation of the Secretary of Defense, in civil actions, to the Postal Service, private collection agents, and consumer reporting agencies in connection with recompence claims, and to Congressional offices in connection with any legislative work at the request of the person to whom the claim pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, claims of non-payment, and other documents related to the operation of TRICARE.

INTERAGENCY: 2. Voluntary failure or failure to provide information will result in delay in payment or may result in denial of claim. With the one exception outlined below, no provider may deny payment under this program for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under TRICARE could lead to denial of payment.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-912 provide penalties for self-funding of the treatment.

You should be aware that P.L. 95-452, the "Computer Matching and Privacy Protection Act of 1998," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments made for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept all payments in full, the amount paid by the Medicaid program for the services submitted for payment under that program, with the exception of deductibles, coinsurance, co-payment or similar cost-sharing charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: There is a penalty for filing a false statement. The foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claim submission, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

An amendment to the Medicare Beneficiary Enrollment Form (M-160) is required to respond to a collection of information unless it displays a valid CMB control number. The valid CMB control number for this Medicare enrollment form is 19-00-1979. You are required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate or if you require further assistance, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C-28-06, Baltimore, Maryland 21207-2806. This address is for comments only. It is not for general correspondence. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Hanwell Date: 6/19/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunctions: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R)(L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Cervical Ramon Rotation to(R) & (L). Very stiff & sacrum
into glutes. (R) Cervical mm toAction's Applied: (Check All that Apply) Upper traps Hypertonicity

Heat Packs Cold Packs Sombra/Biofreeze Sports
 Light Pressure Massage Mod Pressure Massage Tension &
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Cool Meds Ice / Heat R.F.

Therapist: Danielle Hanwell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Hanwell Date: 6/26/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunctions: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R)(L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: (R) SI joint pinched w/ hyperflexion
around sacrum & glute on m.Neck feels better - Allow move itAction's Applied: (Check All that Apply) more

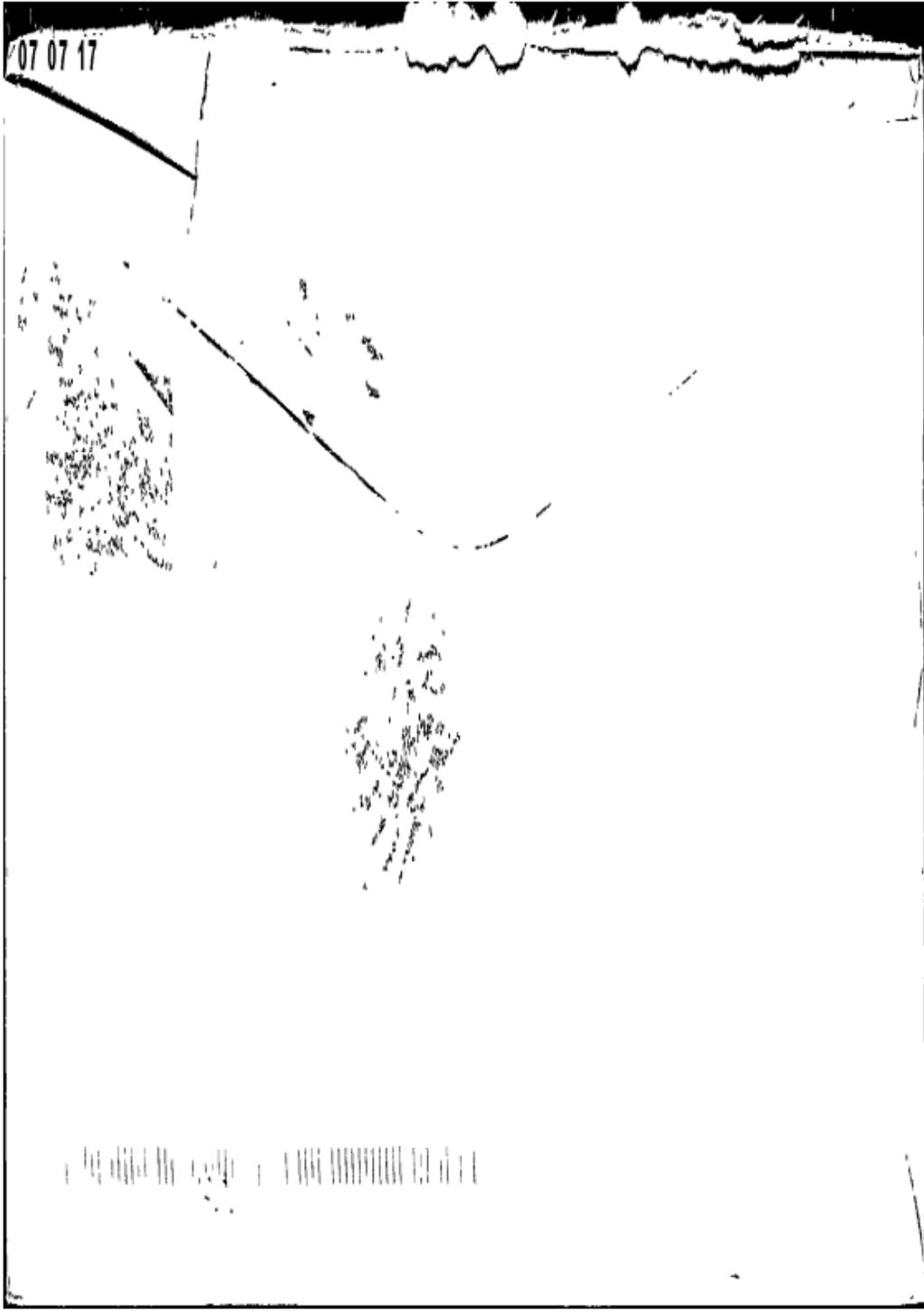
- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Cool Meds Ice / Heat R.F.

Therapist: Danielle Hanwell

07 07 17



07 07 17

Great Lakes Therapeutic Massage
& Bodywork Practitioners
375 Dick Road, Suite #2
Depew, NY 14043
Attn: C. Marx

BUFFALO

NY 140

03 JUL 17

2451

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 10110 WASHINGTON DC

POSTAGE WILL BE PAID BY ADDRESSEE

GEICO.

NY PIP

PO BOX 9507

FREDERICKSBURG VA 22403-9527





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA WORKERS COMP.		OTHER		1a INSURED'S ID NUMBER (For Program in Box 1)			
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> DOD/DIA		<input type="checkbox"/> Member ID#		<input type="checkbox"/> FECA WORKERS COMP.		<input type="checkbox"/> FECA WORKERS COMP.		<input type="checkbox"/> Other		01387394001-1059-01059			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)												3 PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		4 INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARWELL DANIELLE												08291980				HARWELL DANIELLE	
5 PATIENT'S ADDRESS (No., Street)												6 PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)	
1131 CLEVELAND DRIVE												<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				56 BEREHAVEN DR., LEFT	
CITY CHEEKTONWAGA		STATE NY		8 RESERVED FOR NUCC USE				CITY AMHERST		STATE NY							
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951							
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO		11 INSURED'S POLICY GROUP OR FECA NUMBER			
a OTHER INSURED'S POLICY OR GROUP NUMBER												a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a INSURED'S DATE OF BIRTH MM DD YY 08291980 <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X			
b. RESERVED FOR NUCC USE												b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY		b OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d CLAIM CODES (Designated by NUCC)		d IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.														13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below			
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below														13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below			
SIGNED SIGNATURE ON FILE												DATE		SIGNED SIGNATURE ON FILE			
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115		15 OTHER DATE QUAL 431		MM DD YY QUAL 454		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI				17 111215		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20 OUTSIDE LAB?		\$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))												21 IND <input type="checkbox"/> O		22 RESUBMISSION CODE ORIGINAL REF NO			
a M50 222		b M51 26		c M51 27		d M54 12		23 PRIOR AUTHORIZATION NUMBER									
e I523 3XXA		f M99 01		g M99 03		h M99 02											
i M99 05		j M54 2		k M54 5		l M54 6											
24 A DATES OF SERVICE From MM DD YY		B PLACE OF SERVICE To MM DD YY		C PROCECDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS		D MODIFIER		E DIAGNOSIS CODER		F \$ CHARGES	G DATES ON WHICH SERV. WERE PERFORMED	H DATES OF PAYMENT FOR THIS ITEM	I ID QUAN.	J RENDERING PROVIDER ID #			
1 06202017		11 06202017		98941				ABCD		32 28	1	NPI		1710014188			
2 06202017		11 06202017		97010				ABCD		10 53	1	NPI		1710014188			
3 06272017		11 06272017		98941				ABCD		32 28	1	NPI		1710014188			
4												NPI					
5												NPI					
6												NPI					
25 FEDERAL TAX ID NUMBER 364500165		SSN ER <input type="checkbox"/> X		343821252		36 PATIENT'S ACCOUNT NO 343821252		37 ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		38 TOTAL CHARGE \$ 75.00		39 AMOUNT PAID \$ 0		40 Rcv'd for NUCC Use			
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse of this form are true and correct.) PETER GOZINSKI DC				32 SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849				41 BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849									
SIGNED 07072017		DATE		1235256546 ^b				* 1235256546 ^b									

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
July 7, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday June 20, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 06/20/2017 at 12:13pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today stating that "I have been really sore since Sunday." Patient stated that saw Dr. McVige last Thursday for a neurological appointment. Driving and turning her head has been more difficult due to the pain. Some pain down her right arm today as well. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* worse. *since Sunday.* *Pain:* achy, dull, sharp, tingling, shooting; level: 5/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. **Headaches:** Patient stated that she did not have any headaches since last visit. *Recent medical treatment for this condition:* Massage therapy; Neurological evaluation. *Changes in past medical history:* None.

* **Thoracic:** Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* worse. *since last Sunday.* *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been more intense. She states that the pain is more in the center of her lower back. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* worse. *since last Sunday.* *Pain:* achy, dull, sharp, shooting, tingling; level: 5/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. **Bowel or bladder incontinence:** No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy; Neurology follow up. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left

**Encounter dated 06/20/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/07/2017**

rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: worse, patient has noticed increased pain while driving. In addition, active left rotation regressed from 60 to 30 degrees and right rotation regressed from 60 to 45 degrees. *Prognosis:* Guarded.

Post-treatment analysis: patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* worse, VAS score increased from a 4 to 5 out of 10.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated

**Encounter dated 06/20/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/07/2017**

disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x/week for 3 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 7 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization); Cervical (manual traction). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 06/20/2017 at 12:13pm

Tuesday June 27, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 06/27/2017 at 3:52pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Encounter dated 06/27/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/07/2017

Subjective

Cervical: Patient returned today stating that her neck pain has been a little better. Right shoulder and arm pain also has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 4/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she has had a headache since yesterday. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain continues to be painful. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting, tingling; level: 5/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal bilateral moderate; TFL / ITB left mild to

Encounter dated 06/27/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/07/2017

moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's/Fabre: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. *Spinal subluxation level(s):* L4, L5, Left SI, Right SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving. VAs score improved from a 5 to 4 out of 10. *Prognosis:* Guarded.

Post-treatment analysis: patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 2 weeks; 1x every 2 weeks for 4 weeks; Re-examination for 6 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left AS (prone mobilization); Cervical (manual traction); SI right PI (diversified side posture). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise

Encounter dated 06/27/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/07/2017

program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

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End of note. Electronically signed by Peter Guzinski DC on 06/27/2017 at 3:52pm

Abbreviations

ADL activities of daily living
MVA motor vehicle accident
ROM: range of motion
VAS- Visual Analog Scale
WNL within normal limits

07 10 17



Item# 43788



07 10 17

Lancaster Depew
345 Dick Road
Depew, NY 14043



Geico Insurance
P.O.Box 9507
Fredericksburg VA 22403-9507



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

XNUCC

PICA-XNUCC

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA EXCLUDING <input type="checkbox"/> (MASSACHUSETTS) <input type="checkbox"/> (MISSOURI) <input type="checkbox"/> (NORTH DAKOTA) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ND) <input type="checkbox"/> (NDW) <input checked="" type="checkbox"/> (NW) <input type="checkbox"/> (NW)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE SEX MM DD YY N F <input checked="" type="checkbox"/>					
HARWELL, DANIELLE						06 29 1980					
4. PATIENT'S ADDRESS (No., Street)						5. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
1131 CLEVELAND DR						HARWELL, DANIELLE					
CITY CHEEKTONWAGA						STATE NY					
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()									
6. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						7. INSURED'S ADDRESS (No., Street)					
HARWELL, DANIELLE						1131 CLEVELAND DR					
8. OTHER INSURED'S POLICY OR GROUP NUMBER						9. RESERVED FOR NUCC USE					
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15					
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____						12. INSURED'S DATE OF BIRTH MM DD YY N <input type="checkbox"/> F <input checked="" type="checkbox"/>					
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____						13. OTHER CLAIM ID (Designated by NUCC) 08 29 1980					
d. INSURANCE PLAN NAME OR PROGRAM NAME						14. INSURANCE PLAN NAME OR PROGRAM NAME					
10e. CLAIM CODES (Designated by NUCC)						15. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED SIGNATURE ON FILE						DATE 02 09 16					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) MM DD YY N QM <input type="checkbox"/> QD <input checked="" type="checkbox"/>						15. OTHER DATE QUAL 439 MM DD YY 10 31 15					
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
18. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI						19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES					
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to services line below (24e)) A M791 B L C L D L E L F L G L H L I L J L K L					
22. RESUBMISSION CODE ORIGINAL REF. NO.						23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 07 06 17 07 06 17						B. PLACE OF SERVICE BMS 20553					
C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 1654151						D. MODIFIER E. DIAGNOSIS POINTERS F. CHARGES G. DAYS ON UNITS H. AMOUNT PAID PER UNIT I. ID NUMBER J. RENDERING PROVIDER ID. # K. 161582336 L. NPI 1649596495					
25. FEDERAL TAX ID NUMBER 161582336						26. PATIENT'S ACCOUNT NO. 1654151					
27. BILLING ASSESSMENT X YES <input type="checkbox"/> NO						28. TOTAL CHARGE \$ 95 74 6					
29. AMOUNT PAID 0 00						30. RENDR'D BY NUCC USE X					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DOBESSES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JENNIFER W MCVIGE, MD 07 13 17 SIGNED											
32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN SIXTH FLOOR 3980 AMHERST NY 14226-1727						33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002					
*1497850911						*1497850911 B1161582336					



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Frances M. Gengo, PharmD	Brennan Myers, MD	

Abbey L. Burdick, PA-C

Procedure Note Date: 07/06/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- headaches, trigger points. Patient presents for treatment of headaches

History of Present Illness

General

The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. The patient states that trigger point injections are helpful in relieving myofascial symptoms.

Current Medications

- Taking Lamictal 25 mg tablet 2 tab(s) orally BID
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking nortriptyline 10 mg capsule 1 cap(s) orally QHS
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

(716) 250-2000
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 Orchard Park Office | Sterling Medical Park • 280 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
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DIAGNOSTICS & SERVICES	
MR/CT	Neurophysiology
Arthrogram	Positronigraphy
Breast	Sleep Studies
Doppler/TCD	SPECT
ERG	Ultrasound
EMG	TMS
InPACT	VNG
Inflator	

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a: non smoker.

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Radiates with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 110/72, HR 84, RR 16, Ht 63", Wt 231, BMI 40.92, BSA 2.18.

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

		DIAGNOSTICS & SERVICES
(716) 250-2000		MR/CT
www.dentinstitute.com		Neuropsychology
		Arthrograms
		Pneumography
		Breath
		Sleep Studies
		Doppler/TCD
		SPECT
		EEG
		Ultrasound
		EMG
		TMS
		ImPACT
		VNG
		Inflator

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site.

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with Isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 07/06/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 07/06/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 07/06/2017.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 07/06/2017 at 04:36 PM EDT

Sign off status: Completed

(716) 250-2000
www.dentlastitute.com

Amherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrograms	Panurography
Botux	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Influsion	

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Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES

MRI/CT	Neuropsychology
Arthrogram	Pastigraphy
Boxer	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infusion	

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

PIKA

PIKA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP SOUTH PLAN	FICA EXCLUDING (AM)	OTHER (AM)	1a. INSURED'S ID. NUMBER 0138739400101059	(For Program In Item 1)			
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TRICARE)	<input type="checkbox"/> (Member DV)	<input type="checkbox"/> (AM)	<input type="checkbox"/>	<input checked="" type="checkbox"/>					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
HARWELL, DANIELLE			08	29	80	<input type="checkbox"/> M <input checked="" type="checkbox"/> F	HARWELL, DANIELLE				
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)						
1131 CLEVELAND DRIVE			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			1131 CLEVELAND DRIVE					
CITY CHEKTOWAGA		STATE NY	8. RESERVED FOR NUCC USE		CITY CHEKTOWAGA		STATE NY				
ZIP CODE 14225		TELEPHONE (Include Area Code) ()			ZIP CODE 14225		TELEPHONE (Include Area Code) ()				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FICA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH						
			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	MM DD YY	08 29 80	SEX	<input type="checkbox"/> M <input checked="" type="checkbox"/> F				
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State) NY		b. OTHER CLAIM ID (Designated by NUCC) Y4 0138739400101059					
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO INSURANCE NY PIP						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, complete Items 9, 9a, and 9d.				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.						
SIGNED Signature On File			DATE 6/14/2017		SIGNED Signature On File						
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) 10 31 15			15. OTHER DATE QUAL 439		MM DD YY	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN J PETER GUZINSKI			17b. NPI 1710014188		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD IND. 0		22. RESUBMISSION CODE		ORIGINAL REF. NO				
A. <u>M54.16</u>	B. <u>M51.26</u>	C. <u>L</u>	D. <u>L</u>	E. <u>L</u>	F. <u>L</u>	G. <u>L</u>	H. <u>L</u>	I. <u>L</u>	J. <u>L</u>		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PERIOD OF SERVICE E/M	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	F. DIAGNOSIS CODE 5 CHARGES	G. DAYS OR UNITS	H. REBATE Per Unit Per Day	I. ID QUAL	J. RENDERING PROVIDER ID. #
06 01 17	06 01 17	11	11	64483	LT		AB	125	20	1	OB 248830
06 01 17	06 01 17	11		00003029328							NPI 1023202355
06 01 17	06 01 17	11		99070			AB	4	00	2	OB 248830
											NPI 1023202355
											NPI
											NPI
											NPI
											NPI
25. FEDERAL TAX ID. NUMBER 030445678			SSN EN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 102251	27. ADJUST ASSIGNMENT FEDERAL MEDICARE <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 129.20	29. AMOUNT PAID \$ 0.00	30. Rcvd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jafar Siddiqui			32. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery, Inc 180 Park Club Lane, STE 250 Williamsburg, NY 14221 e. 1306896220		33. BILLING PROVIDER INFO & PH# (716) 218-1030 UB Neurosurgery, Inc PO Box 8000 DEPT 883 Buffalo, NY 14267 e. 1306896220 b						
SIGNED 6/14/2017 DATE			PLEASE PRINT OR TYPE		APPROVED OMB-0938-1197 FORM 1500 (02-12)						

Invoice

Page 2 of 2

Invoice Number 79967471	PO Number PEGGY RN	Invoice Date 06/06/16
-------------------------	--------------------	-----------------------

Item Number	Vendor / Vendor Cat #	Description	Ordered	Unit Shipped	Unit Price	Amount	Sales Tax
462514	Vendor: BMSPHM. KENALOG-40, VL-40MG/ML 10ML NDC Num: & 00103029328	PO LN 9	50	EA	50	74.00	8,700.00

SUB TOTAL	TAX	TOTAL AMOUNT
\$4,541.02	\$0.00	\$4,541.02

The purchase listed on this invoice may be subject to a discount or other promotional consideration that may require you to report the value of such discount or promotional consideration, if any, as a discount. In addition, the prices on this invoice may include fees for services that may not be reimbursable under the Medicare/Medicaid statutes. You can receive an itemized list of any fees included in the prices upon request.

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UNIVERSITY AT BUFFALO
NEUROSURGERY

180 Park Club Lane, Suite 250, Williamsville, NY 14221
(716) 218-1050

Thu Jun 1, 2017 11:00 am Dr# 126
102251 08/29/80
HARWELL, DANIELLE

OPERATIVE PROCEDURAL REPORT

Date of admission: 6/1/17

Preop Dx/ICD-9:

Postop Dx/ICD-9:

Procedure: Cervical Transforaminal sacroiliac

Thoracic facet Fluoroscopy Diagnostic # _____

Lumbar Interlaminar stellate ganglion Kovac M300 therapeutic # _____

Caudal medial branch block other

Physician: Jafar W. Siddiqui MD

Preop medications:

Anesthesia: Local IV moderate sedation _____ mg Midazolam _____ mg Fentanyl

Complications: NONE

LEVEL	NEEDLE (dirig)	APPROACH	MEDICATION
Level <u>L5-S1</u>	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/2" spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" touchy <input checked="" type="checkbox"/> 22ga <input type="checkbox"/> 3 1/2" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6" <input type="checkbox"/> 20ga 3 1/2" Crawford	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input checked="" type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol
Level _____	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/2" spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/2" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6"	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol
Level _____	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/2" spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/2" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6"	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol
Level _____	<input type="checkbox"/> 17ga <input type="checkbox"/> 1 1/2" spinal <input type="checkbox"/> 20ga <input type="checkbox"/> 2 1/2" touchy <input type="checkbox"/> 22ga <input type="checkbox"/> 3 1/2" <input type="checkbox"/> 25ga <input type="checkbox"/> 5" <input type="checkbox"/> 7" <input type="checkbox"/> 6"	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Midline <input type="checkbox"/> Paramedian <input type="checkbox"/> Bilateral	<input type="checkbox"/> _____ ml saline <input type="checkbox"/> _____ mg Kenalog 40 <input type="checkbox"/> _____ mg Dexamethasone-10 <input type="checkbox"/> _____ ml 0.5% Bupivacaine <input type="checkbox"/> 1% Xylocaine mixed w/ NAHC03 infiltrated into skin <input type="checkbox"/> 2% Lidocaine <input type="checkbox"/> 80mg Depo Medrol

After consenting to the procedure, the patient was taken to the operating room and positioned on the fluoroscopy table. Sterile prep and drape was done and procedure started as stated above. Local anesthesia was administered. Screening fluoroscopy was utilized to identify the levels stated above. The needle was advanced under direct visualization. The patient's vital signs remained stable throughout the procedure and the patient was taken to the recovery room in stable condition.

Pre-procedure vital: O2 stat: 98 BP: 119/81 Pain Score: 4/10
 Post-procedure vital: O2 stat: 98 BP: 112/77 Pain Score: 3/10

Physician signature: JAMES PHILIP HARWELL, DO Date: 6/1/17 Time: 11:00 AM
 Ctox: Peter Gruenwald, DC Op Proc Rept: Op Proc Rept_6_2016
 (this must be sent out same day)

07 17 17

07/17/17



8 1/2

Organization Manifest

UB Neurosurgery, Inc(9)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
01742594001010531		SALADA-CONROY, JEANNE	06/02/2017	06/02/2017
01387394001010592		HARWELL, DANIELLE	06/01/2017	06/01/2017
03808139301010151		SANTAS, ANNMARIE	06/02/2017	06/02/2017
03139717701010571		BRYLINSKI, ROBERT	06/01/2017	06/01/2017
04320068801010221		CRAMPTON, CALEB	06/02/2017	06/02/2017
02010810901010121		HARRIS, JAMES	06/08/2017	06/08/2017
03099564501011012		SABUDA, NICOLE	06/05/2017	06/05/2017
02932630501010961		ADAMITIS, MARGARET	06/08/2017	06/08/2017
05428251501010171		KLYMKO, MARIYA	06/08/2017	06/08/2017



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

—CARRIER—

PATIENT AND INSURED INFORMATION

PHYSICIANS ARE DISINCENTIVIZED

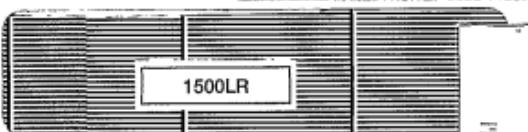
1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN (NOM)		FECA WORKERS COMP (NOM)		OTHER (NOM)		1a. INSURED'S I.D. NUMBER 013873940101059 (For Program in Item 1)							
<input type="checkbox"/> Medicare		<input type="checkbox"/> Medicaid		<input type="checkbox"/> DOD/DoD		<input type="checkbox"/> Member (DOD)		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980		SEX M F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE					
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR							
CITY CHEEKWTOWAGA		STATE NY		ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()		8. RESERVED FOR NUCC USE		CITY CHEEKWTOWAGA		STATE NY		ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980					
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. INSURE'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												SIGNED SIGNATURE ON FILE				DATE 02 09 16					
SIGNED SIGNATURE ON FILE												SIGNED SIGNATURE ON FILE				DATE 02 09 16					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 08 29 1980												15. OTHER DATE QUAL 04 39 10 31 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY MM DD YY MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI												17a. IC U62607		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY MM DD YY MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				\$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please A-L to service line below (24E))												22. RESUBMISSION CODE		ORIGINAL REF NO							
A. M791	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	ICD IND <input type="checkbox"/>		23. PRIOR AUTHORIZATION NUMBER															
E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	F. \$ CHARGES		G. DAYS OR UNITS	H. REPORT PER	I. ID CHNL	J. RENDERING PROVIDER ID #												
L. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	E. DIAGNOSIS POINTER		ETI 161582336 NPI 1649596495															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 07 06 17 07 06 17												B. PLACE OF SERVICE ENG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		D. MODIFIER		F. \$ CHARGES			
25. FEDERAL TAX I.D. NUMBER 161582336												26. PATIENT'S ACCOUNT NO 1654151		27. ACCEPT ASSIGNMENT? (For gov't clients see back)		28. TOTAL CHARGE \$ 95 74		29. AMOUNT PAID \$ 0 00		30. Paid for NUCC Use <input type="checkbox"/>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JENNIFER W MCVIGE, MD												32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN SIXTH FLOOR 3980 AMHERST NY 14226-1727		33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002							
34. DATE 07 13 17												35. SIGNED DATE 07 13 17		36. *1497850911		37. *1497850911		38. *1497850911		39. *1497850911	
40. PHYSICIAN OR SUPPLIER INFORMATION												41. PHYSICIAN OR SUPPLIER INFORMATION		42. PHYSICIAN OR SUPPLIER INFORMATION		43. PHYSICIAN OR SUPPLIER INFORMATION		44. PHYSICIAN OR SUPPLIER INFORMATION		45. PHYSICIAN OR SUPPLIER INFORMATION	

07 17 17

DENT NEUROLOGIC GROUP, LLP
ADMINISTRATIVE OFFICE
3980 SHERIDAN DR SUITE B
BUFFALO, NY 14226



002.45¢
02 1P
0003214482 JUL 13 2017
MAILED FROM ZIP CODE 14226



FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service; 3) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black-Lung-related disorder.

No Part B Medicare benefits may be paid unless the form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(e)(6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 8101 et seq, and 30 USC 901 et seq; 38 USC 613; E.O. 13397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No 08-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol 65 No. 177, page 37549, Wed. Sept 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol 65 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/principles received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recollection claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE(S): Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged could prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment and similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



DENT

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Vernice Bates, MD	Sanjay Gupta, MD	Malai Patel, MD
Bela Ajari, MD	Tomas Holmlund, MD	Mohammed M. Qasimzeh, MD
Alfred Belen III, MD	J. Maurice Houlihan, MD	Michelle M. Rauska, PharmD
Horacio Capote, MD	Anupama M. Kale, MD	Luisa Reyes, MD
Ana N. Cervantes, MD	Xinh Li, MD	Nicolas Sakkal, MD
Donna M. Czamecki, PhD	Laszlo Mechtler, MD	Lixia Zheng, MD, PhD
J. Autrey Bettens, PhD	Jennifer W. McVige, MD	Joseph V. Fritz, PhD, CEO
Marc S. Frost, MD	Kenneth R. Murray, MD	
Francis M. Gengo, PharmD	Francis M. Gengo, PharmD	

Abbey L. Burdick, PA-C

Procedure Note

Date: 07/06/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 36 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- headaches, trigger points. Patient presents for treatment of headaches

History of Present Illness

General

The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. The patient states that trigger point injections are helpful in relieving myofascial symptoms.

Current Medications

- Taking Lamictal 25 mg tablet 2 tab(s) orally BID
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 inti units capsule 1 cap(s) orally once a day
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking nortriptyline 10 mg capsule 1 cap(s) orally QHS
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

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DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Posturography
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	PNG
Infusion	

Family History

Father alive, Stroke
 Mother alive, Asthma
 Siblings alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a: non smoker

Fall History:

Have you fallen. No Do you feel unsteady when: No

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol

Illicit Drugs:

Using illicit drugs Denies

Resides with:

Spouse: Husband Children: Yes, x3. Self Yes

Working:

Employed: Stay at home mom

Marital Status:

Married: Yes

Driving:

Does Patient Drive: Yes.

Exercise:

Daily Yes, Walks

Caffeine:

Other: Patient does not consume caffeine

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy

Vital Signs

BP sitting 110/72, HR 84, RR 16, Ht 63", Wt 231, BMI 40.92, BSA 2.16.

ExaminationNeurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive

		DIAGNOSTICS & SERVICES	
(716) 250-2000	www.dentinstitute.com	MRI/CT	Neuropsychology
		Arthrograms	Pastigraphy
		Breast	Sleep Studies
		Doppler/TCD	SPECT
		EEG	Ultrasound
		EMG	TMS
		InPACT	VNG
		Inflator	

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Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site.

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING, Healthy Living. Patient counseled on the importance of healthy lifestyle 07/06/2017.

Diet. Patient counseled on importance of lowering sugar intake, sodium and fats. 07/06/2017.

Exercise Patient counseled on importance of moderate physical activity daily. 07/06/2017

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 07/06/2017 at 04:36 PM EDT

Sign off status: Completed

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Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
<i>MR/CT</i>	<i>Neurophysiology</i>
<i>Arthrograms</i>	<i>Pastigraphy</i>
<i>Breast</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>ImPACT</i>	<i>VNG</i>
<i>Inflations</i>	

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DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Angiogram	Pain/Anesthesia
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
Im/PC/CT	VNG
Infusion	

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 3513
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 07/13 06:59
 TX/RX TIME 01'12
 PGS. 5
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

NUCC/PIPC

1. MEDICARE MEDICARE TRICARE CHAMPVA GROUP HEALTH PLAN ECO OUTPATIENT OTHER (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare) (Medicare)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

HARMBELL, DANIELLE

MM DD YY

08 29 1980

M F X

HARMBELL, DANIELLE

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED

1131 CLEVELAND DR

SAW Spouse CNR Other

7. INSURED'S ADDRESS (No. Street)

1131 CLEVELAND DR

CITY STATE

CHEEKSTOWAGA NY

ZIP CODE TELEPHONE (Include Area Code)

14225-1257 ()

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO

9. OTHER INSURED'S POLICY OR GROUP NUMBER 11. INSURED'S POLICY GROUP OR FICA NUMBER

12. EMPLOYMENT? (Current or Previous) 13. DOB 10/31/15

14. AUTO ACCIDENT? PLACE (MM DD YY) SEX

15. OTHER ACCIDENT? MM DD YY M F X

16. INSURED'S SIGNATURE

17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary

to process this claim. I also request payment or government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE

DATE 02.09.16

SIGNED SIGNATURE ON FILE

18. OTHER DATE MM DD YY

19. HOSPITALIZATION DATES RELATED TO CURRENT DISABILITY MM DD YY

20. OUTSIDE LABS CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24L) ICD-9-CM

22. PREGNANCY/NON CREDIT ORIGINAL RGP. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE/BIN OF SERVICE B C D E F G H I J K L

MM DD YY MM DD YY DATE OF SERVICE EMB (Replace Universal Classification) MODIFIER

25. PROCEDURES, SERVICES, OR SUPPLIES (List up to 24 items) DIAGNOSIS

P H L I R REIMBURSED PROVIDER ID #

5 CHARGES D O S T D O Q

26. BII 161582336

API 1649596495

27. NR

28. NR

29. NR

CARRIER

PATIENT AND INSURED INFORMATION

SUPPLIER INFORMATION



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Verneca Bates, MD	Franco M. Geaga, PhD	Bessen Myers, MD
Bela Ayas, MD	Seray Gupta, MD	Mulu Patel, MD
Alfred Belen III, MD	Tomas Holmstedt, MD	Mohammad M. Qasimch, MD
Heracio Capois, MD	J. Maurice Houser, MD	Michelle M. Rzanka, PhD
Deena M. Czernicki, PhD	Xinh Lo, MD	Luis Rojas, MD
Steve Doffman, MD	Leslie Mechler, MD	Necela Sajali, MD
I. Anthony Duspar, PhD	Jennifer W. McVige, MD	Liun Zhang, MD, PhD
Marc S. Frost, MD	Kenneth R. Murray, MD	Joseph V. Pritz, PhD, CEO

JULY 13, 2017

Geico
PO Box 9507
Fredericksburg, VA 22403

Attn: Claims Dept

The attached claims have been faxed to Geico. Recently, there has been an issue with the clarity of the claims or they have not been scanned after they have been faxed. This is to verify that they were submitted both via fax and mail.

I hope this will help in getting the claims processed without any delay.

Sincerely,

Kristen R.
Billing

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www.dentinstitute.com

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DIAGNOSTICS & SERVICES	
MRI/CT	Neurophysiology
Angiogram	Pneurography
Basis	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	TMG
Infrared	

FIRST CLASS MAIL





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Frederickburg, VA 22403

CARRIER

PICA												
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA R&L LUNG	OTHER	1a. INSURED'S I.D. NUMBER			(For Program in Item 1)		
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TRICARE)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (Gov)	<input type="checkbox"/> (DOD)	<input checked="" type="checkbox"/> (JOM)	013873940-0101-059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARWELL, DANIELLE			08 29 1980			M <input type="checkbox"/> F <input checked="" type="checkbox"/>	- BANDO -					
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT'S RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)						
56 BERBREAVEN DR			Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY		STATE		8. RESERVED FOR NUCC USE			CITY		STATE			
AMHERST		NY		X								
ZIP CODE		TELEPHONE (Include Area Code)					ZIP CODE		TELEPHONE (Include Area Code)			
14228		(716) 536-0951		X								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT (Current or Previous)						
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. AUTO ACCIDENT?						
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY						c. PLACE (State)						
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						d. OTHER ACCIDENT?						
e. INSURANCE PLAN NAME OR PROGRAM NAME						f. CLAIM CODES (Designated by NUCC)						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.						g. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the physician who accepts assignment below.												
SIGNED - ON FILE -						DATE 01-06-2016						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL 10 31 2015 QUA						15. OTHER DATE QUAL MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17a. <input type="checkbox"/> NPI						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. M79.1 B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/> G. <input type="checkbox"/> H. <input type="checkbox"/> I. <input type="checkbox"/> J. <input type="checkbox"/> K. <input type="checkbox"/> L. <input type="checkbox"/>						22. RESUBMISSION CODE ORIGINAL REF. NO.						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PRICE OF SERVICE EMG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS CODE F. \$ CHARGES G. DAYS OR UNITS H. RPT/STY/TIM/PEN I. I.D. # J. RENDERING PROVIDER ID. #						23. PRIOR AUTHORIZATION NUMBER						
1	07 05 17	07 05 17	11	97140	A	55 .00	3	NPI	1144462011			
2	07 05 17	07 05 17	11	97140	A	55 .00	3	NPI	1144462011			
3	07 14 17	07 14 17	11	97140	A	55 .00	3	NPI	1144462011			
4								NPI				
5								NPI				
6								NPI				
25. FEDERAL TAX ID. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. cert. see back)			28. TOTAL CHARGE	29. AMOUNT PAID	30. Paid for NUCC Use		
47-0989449	<input type="checkbox"/> X	HARWELL, D			<input type="checkbox"/> YES <input type="checkbox"/> NO			\$ 165 .00	\$ 0 .00	165 .00		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043												
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043												
32. SERVICE FACILITY LOCATION INFORMATION												
33. BILLING PROVIDER INFO & PH # 716 725-0264												
COLLEEN MARK, LMT 07.14.2017 SIGNED DATE 1144462011												

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 5, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whenever submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare, senior Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE, i) for each service rendered incident to my professional service, the identity (legal name and NPI), license #, or SSN of the primary individual rendering each service is reported in the designated section for services to be considered; ii) a physician's professional services, i) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, iii) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 10 USC 5336). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or omits essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 at seq; 38 USC 613; E.O. 13037.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1995, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Reputation of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1157. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Step C4-25-25, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0165

Client Name: Daniel Harms Date: 7/14/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: B very tight esp. @ SI joint on(L) side. B glute tightness & to
hamstrings. Client moving veryAction's Applied: (Check All that Apply) Slowly today.

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction None.
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Mix

Therapist: DH

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0165

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Therapist: _____

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0265

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Harrel Date: 7/15/17Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Nick feels okay today."Lower back stuff & sore. Chiro not able to adjust SI in sideAction/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage Ongelie
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Laser

Therapist:*Danielle Harrel*Client Name: Danielle Harrel Date: 7/10/17Client Status: (Circle) Better Progressing Worse Same/No ChangePain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: TI injections Thursday caused neck/mn to tighten up again. Was feeling better before injections. LB veryAction/s Applied: (Check All that Apply) I n today. Client moving slowly

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Laser

Therapist:*Danielle Harrel*

07 17 17

270

07 17 17

Great Lakes Therapeutic Massage

& Bodywork Practitioners

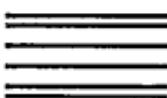
375 Dick Road, Suite #2

Derby, NY 14043

Attn: C. Marx

BUFFALO
NY 14203

14 JUL 17
PM 54



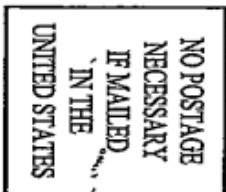
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NY PIP
PO BOX 9507
FREDERICKSBURG VA 22403-9527





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

01387394D-D1D1-D59

BCA

1 MEDICARE	MEDICARE	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDC BILKING (NIV)	OTHER	1a INSURED'S ID NUMBER 013879940011053	(For Program in Item 1)		
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/> (ADM)	<input type="checkbox"/> (NIV)	<input type="checkbox"/> (NIV)				
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			
HARWELL DANIELLE			08291980							
5 PATIENT'S ADDRESS (No., Street)			6 PATIENT RELATIONSHIP TO INSURED		Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7 INSURED'S ADDRESS (No., Street) 56 BREHABEN DR, LEFT			
1131 CLEVELAND DRIVE		CITY CHEEKWTOWAGA		STATE NY		CITY AMHERST		STATE NY		
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		8 RESERVED FOR NUCC USE		9 RESERVED FOR NUCC USE		10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
b RESERVED FOR NUCC USE		c RESERVED FOR NUCC USE		d INSURANCE PLAN NAME OR PROGRAM NAME		e OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		a. INSURED'S DATE OF BIRTH MM DD YY 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>		
e OTHER INSURED'S POLICY OR GROUP NUMBER 14228		f AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> NY		g OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		f OTHER CLAIM ID (Designated by NUCC)		b OTHER CLAIM ID (Designated by NUCC)		
g RESERVED FOR NUCC USE		h INSURANCE PLAN NAME OR PROGRAM NAME GEICO		i IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 10, and 11.		i INSURED'S POLICY GROUP OR FEDC NUMBER 14228		j INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below		13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below					
SIGNED SIGNATURE ON FILE			DATE		14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 QMUL 431		15 OTHER DATE MM DD YY 454 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI 17b NPI			18 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to A-L to service line below (24E)			22 RESUBMISSION CODE ORIGINAL REF NO.		20. OUTSIDE LABS F CHARGES					
A IM50 222 B IM51 26 C IM51 27 D IM54 12			E IS23 3XXA F M99 01 G M99 03 H M99 02		I IM99 05 J IM54 2 K IM54 5 L IM54 6		23. PRIOR AUTHORIZATION NUMBER NPI			
24. DATE(S) OF SERVICE From MM DD YY To MM DD YY Service EMR			E PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS MODIFIER		F CHARGES G DRAWS OR UNITS H DRAFT PEN I PEN L QMUL		J RENDERING PROVIDER ID # NPI			
07032017 07032017 11			98941		ABCD 32 28 1		1710014188			
07032017 07032017 11			97010		ABCD 10 53 1		1710014188			
07112017 07112017 11			98941		ABCD 32 28 1		1710014188			
07112017 07112017 11			97010		ABCD 10 53 1		1710014188			
							NPI			
							NPI			
							NPI			
							NPI			
25 FEDERAL TAX ID NUMBER 364500165			26 PATIENT'S ACCOUNT NO 343821753		27 ACCEPT ASSIGNMENT? From gov't Dept see box <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28 TOTAL CHARGE \$ 851.62		29 AMOUNT PAID \$ 0	
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and we are media to our themes.) PETER GOZINSKI DC			32 SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33 BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849					
SIGNED 07202017 DATE			1235256546		1235256546					

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
July 20, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday July 3, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 07/03/2017 at 10:30am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain continues to feel better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches have been "O.K. only a couple last week". *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been better since last visit. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting, tingling; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature

Encounter dated 07/03/2017 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 07/20/2017

Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal bilateral mild to moderate; TFL / ITB left mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. *Spinal subluxation level(s):* L4, L5, Left SI, Right SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* improving, VAS score improved from a 4 to 3 out of 10. *Prognosis:* Guarded.

Post-treatment analysis: patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** improving, VAS score improved from a 5 to 3 out of 10.

Lumbar assessment: improving, VAS score improved from a 5 to 3 out of 10. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Encounter dated 07/03/2017 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 07/20/2017

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 1 week; 1x every 2 weeks for 4 weeks; Re-examination for 5 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left AS (prone mobilization); Cervical (manual traction); SI right PI (diversified side posture). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 07/03/2017 at 10:30am

Tuesday July 11, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 07/11/2017 at 8:41am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain remains the same. She stated that she had a

**Encounter dated 07/11/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/20/2017**

injections last Thursday which initially increased her pain, but after her massage yesterday she has felt better. Right shoulder pain has been better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches were more intense last week. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting, tingling; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C1, C2, C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal bilateral mild to moderate; TFL / ITB left mild to moderate. *Tenderness on palpation:* left SI: mild to moderate. *Trigger points:* left gluteus maximus.

Encounter dated 07/11/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/20/2017

Orthopedic tests: Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. **Spinal subluxation level(s):** L4, L5, Left SI, Right SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine).

Cervical assessment: improving, less right shoulder pain. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x/week for 1 week; 1x every 2 weeks for 4 weeks; Re-examination for 5 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left AS (prone mobilization); Cervical (manual traction); SI right PI (diversified side posture); C1 right lateral flexion restriction (Instrument adjustment Arthrostim); C2 right lateral flexion restriction (Instrument adjustment Arthrostim). **Physical Modalities:** bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. **Patient given:** home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10

Encounter dated 07/11/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 07/20/2017

daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to July 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

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End of note. Electronically signed by Peter Guzinski DC on 07/11/2017 at 8:41am

- « Abbreviations
- » ADL: activities of daily living
- » MVA: motor vehicle accident
- » ROM: range of motion
- » VAS: Visual Analog Scale
- » WNL: within normal limits

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Fredericksburg VA 22403

A US Postage First-Class stamp with a value of \$3.29. The stamp features the text "US POSTAGE" and "FIRST-CLASS" along with a barcode and a unique identification number.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO INSURANCE - NF

MY PIP CLAIMS

PO BOX 9507

FREDERICKSBURG VA 22403

PIGA

PICA 5

1. MEDICARE	2. MEDICAID	3. TRICARE	4. CHAMPVA	5. GROUP HEALTH PLAN (DOD)	6. FEDERAL BULK PURCHASE (GPO)	7. OTHER (Other)	8. INSURED'S I.D. NUMBER 0138739400101059	(For Program in Item 1)
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> DoD Off	<input type="checkbox"/> Member/Dep	<input type="checkbox"/> DOD	<input type="checkbox"/> GPO	<input type="checkbox"/> Other		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
HARWELL, DANIELLE			08 29 1980 M <input checked="" type="checkbox"/>			HARWELL, DANIELLE		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR		
CITY CHEEKETOWAGA		STATE NY	8. RESERVED FOR NUCC USE		CITY CHEEKETOWAGA		STATE NY	
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()			ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15		
			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			c. OTHER CLAIM ID (Designated by NUCC) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
d. RESERVED FOR NUCC USE			e. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			f. INSURANCE PLAN NAME OR PROGRAM NAME		
g. RESERVED FOR NUCC USE			h. INSURANCE PLAN CODES (Designated by NUCC)			i. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 10, and 11.		
d. INSURANCE PLAN NAME OR PROGRAM NAME			i. INSURANCE PLAN CODES (Designated by NUCC)			j. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								
SIGNED SIGNATURE ON FILE DATE 02 09 16								
SIGNED SIGNATURE ON FILE								
14. DATES OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL:			15. OTHER DATE MM DD YY QUAL: 43D 10 31 15			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 17a. NPI: 1710014188			19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES		
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD ID: O								
A. M5481	B. G44309	C. M791	D. 02832X9	E. G479	F. S060X0S	G. L	H. L	I. L
22. RESUBMISSION CODE ORIGINAL REF. NO.								
23. PRIOR AUTHORIZATION NUMBER								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMB. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS E. MODIFIER DIAGNOSIS F. POINTER \$ CHARGES G. DAYS OR H. AMOUNT I. ID L. ID J. RENDERING PROVIDER ID # K. DATE L. ID M. ID N. ID O. ID P. ID Q. ID R. ID S. ID T. ID U. ID V. ID W. ID X. ID Y. ID Z. ID								
25. 07 27 17 07 27 17 11 96372 59 ABCD 18 43 1								
26. TOTAL CHARGE \$ 18 43 1 27. AMOUNT PAID 0 00 28. Reserved for NUCC Use NP								
29. FEDERAL TAX I.D. NUMBER 161582336 30. SSN/EIN X 31. PATIENT'S ACCOUNT NO. 1667541 32. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002								
34. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) JENNIFER W MCVIGE, MD								
35. DATE 08 01 17 *1497850911 b *1497850911 b Xi161582336								

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Invoice

Page 2 of 2

Invoice Number	91548515	PO Number	12-27-2016 4:34PM	Invoice Date	12/27/16
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Item Number	Vendor / Vendor Cat #	Description	Ordered	Unit Shipped	Unit Price	Amount	Sales Tax
695008	Vendor: BAHECO NDC Num: & 00338854906	SOD CHL, IV80L 0.9 NACL VIAFL PO LN 8	5	EA	5	5.89	28.45 <i>0.00</i>
811977	Vendor: BD Vend Cat: 302830	SYRINGE, LI 20CC (48/BX) PO LN 9	1	BX	1	16.94	16.94 1.48
511808	Vendor: SPHERIS NDC Num: & 00923018202	KETOROLAC TRIMETHAMINE, SOV 80 PO LN 10	1	CT	1	29.54	29.54 <i>0.00</i>
310000	Vendor: BPF NDC Num: & 00008004722	SOLU-MEDROL, VL ADV 125MG/2ML PO LN 11	10	EA	10	8.38	83.80 <i>0.00</i>
178448	Vendor: BAXTIV NDC Num: & 00338804948	SODIUM CHLORIDE, SOL 0.9 PO LN 12	1	CA	1	149.77	149.77 <i>0.00</i>
528611	Vendor: MGMTB Vend Cat: 16-9707	COMPRESS, HOT INST 6"X9" LF (2 PO LN 13	1	CA	1	19.77	19.77 1.73
477583	Vendor: MGMTB Vend Cat: 16-16650	LUNDERPAD, 3PLY TISSUE BLU 17X2 PO LN 14	1	CA	1	35.07	35.07 3.07
881399	Vendor: MGMTB Vend Cat: 2262	CONTAINER, SHARPS COLL HORIZ R PO LN 15	3	EA	3	3.47	10.41 0.91
444283	Vendor: BD Vend Cat: 305648	SALINE, SYR 8ML (30/BX) PO LN 16	3	BX	3	14.38	43.08 <i>0.00</i>
345068	Vendor: BD Vend Cat: 381823	CATHETER, INSYTE WNGD 22GX1* PO LN 17	1	BX	1	105.75	105.75 9.25
636622	Vendor: BBRAUN Vend Cat: 352901	EXT SET, SAFEDAY NDLFREE SM BO PO LN 18	1	CA	1	148.06	148.06 12.98

SUB TOTAL	TAX	TOTAL AMOUNT
\$1,768.12	\$69.82	\$1,837.94

The purchase listed on this invoice may be subject to a discount or other promotional consideration that may require you to report the value of such discount or promotional consideration, if any, as a discount. In addition, the prices on this invoice may include fees for services that may not be reimbursable under the Medicare/Medicaid statutes. You can receive an itemized list of any fees included in the prices upon request.

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J 1885-99070X 4 units = \$8.00

PT Danielle Harwell

DDS 7/27/17

Claim # 0138739400101059



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Abbey L. Burdick, PA-C

Re-Evaluation
Date: 07/27/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- Migraines . Patient present for treatment of headache

History of Present Illness

General:

Dear Dr. Panzarella:

We had the pleasure of seeing Danielle today in neurologic reevaluation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a wonderful 36-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at the urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale. She reported associated sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes, but there are disk extrusions seen at C4-C5 and C5-C6. She did have an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 were normal aside from a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8.

Danielle has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and physical therapy. After initial evaluation, she was started on magnesium oxide, Naprosyn and Rizatriptan. Vestibular therapy and physical therapy have both proven helpful in symptom management. Massage therapy and regular trigger point injections have been very helpful with decreasing her cervical myofascial spasm.

Danielle had been struggling with episodes of dizziness and vertigo which can be so severe she will have to pull over when she is driving. They seem to be triggered by certain neck movements. She will experience a sharp pain starting from the base of her head that will radiate up and over to the top of her head. These do tend to occur with a headache. Lamictal was started and is currently at 100mg, but there is no notable relief. Headaches are almost daily and tend to be located along the right occipital and temporal regions and will radiate into her right eye.

The patient found vestibular and physical therapies helpful, however she was discharged from both. She continues to do complete exercises at home. Unfortunately, the patient feels she has plateaued.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal.

At her last reevaluation, the patient was weaned off Lamictal. She was started on Nortriptyline.

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 Batavia Office | 35 Batavia City Center • Batavia, NY 14220 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Posturography
BioRx	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infrared	

Topamax was planned to start after Lamictal was weaned. Botox was also discussed if medication continued to be ineffective. She was also sent to restart vestibular and physical therapies.

The patient returns today with no improvement of her symptoms. Unfortunately, the patient has been suffering from a constant headache over the past week. She has been taking Nortriptyline at bedtime and tolerating well. She does feel that it has improved her sleep somewhat. She has not yet been able to obtain a vestibular therapy appointment due to availability. Due to her constant headache, she has been taking Naproxen at least 1-2 times a day over the past week. Since her last appointment she did wean off Lamictal.

Current Medications

- Taking Lamictal 25 mg tablet 2 tab(s) orally BID
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally pm headache, up to BID
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking rizatriptan 10 mg tablet 1 tab(s) orally pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking nortriptyline 10 mg capsule 1 cap(s) orally QHS
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker .

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Angiogram	Posturography
Breas	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infrared	

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Review of Systems

Positive for headache, falls, dizziness, sleep outcome blurry vision, ringing in ears, earache, vertigo, joint pain, stiffness, neck and lower back pain, muscle aches, easy bruising. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy. Positive for headaches. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit.

Vital Signs

BP sitting 122/82, HR 88, RR 16, Ht 63", Wt 234.2, BMI 0.29, HC 0, BSA 7.52.

Examination**General Examination:**

General Appearance: Well-nourished, well-developed, in moderate distress, participated with the exam. Well groomed. **Eyes:** Disc margins clear, no vessel abnormalities, no papilledema. **Neck:** Supple. Range of motion limited with lateral flexion. Trigger points palpated within cervical musculature bilaterally. **Cardiovascular:** peripheral pulses within normal limits. **Extremities:** Full range of motion of extremities x4. No edema.

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. **Speech:** Speech content and production was normal. **Memory:** Memory for remote and recent events was intact. **Fund of Knowledge:** Appropriate for events and past history. **Cognition:** was intact. **Motor:** 5/5 upper and lower extremities bilaterally. **Tone:** Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. **Reflexes:** DTRs were +2 globally. **Coordination:** Test of coordination and fine motor skills were within normal limits. **Gait and Station:** Gait within normal limits. Romberg positive.. **Sensory:** Sensation to touch and cold was intact in all 4 extremities bilaterally.

Cranial Nerves:

Cranial Nerve II: Visual fields are full. **Cranial Nerves III, IV, VI:** Extraocular movements intact. **PERRLA.** **Cranial Nerve V:** Facial sensation and muscles of mastication were normal bilaterally. **Cranial Nerve VII:** Face was symmetric and strength was equal bilaterally. **Cranial Nerve VIII:** Hearing was intact to finger rub bilaterally. **Cranial Nerves IX, X:** Swallowing and palate elevation was within normal limits. **Cranial Nerve XI:** Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. **Cranial Nerve XII:** Tongue was midline.

Assessments

1. Bilateral occipital neuralgia - M54.81 (Primary)
2. Posttraumatic headache - G44.309
3. Myofascial pain - M79.1
4. Vestibular dysfunction - H83.2X9
5. Sleep difficulties - G47.9
6. Concussion, without loss of consciousness, sequela - S06.0X0S

Danielle is a very sweet 36-year-old female who presents today for reevaluation regarding headaches and postconcussive symptoms. Unfortunately, the patient has had a severe headache that has persisted over the past week. We will provide her with a Toradol injection in the office. I would also like her to take a Medrol Dosepak as there is likely component of medication overuse. In addition, due to the severity of the patient's symptoms, I do feel as medically necessary to provide the patient with an occipital nerve block at today's appointment. This will be the patient's first nerve block. Regarding preventative agents, we will increase her Nortriptyline to 20 mg at bedtime to further aid with sleep. We will also start her on Topamax now that she is weaned off of Lamictal, which was ineffective for her. She does plan to start vestibular therapy once she is able to obtain an appointment. We will also continue regular trigger point injections,

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Bebbia Office | 35 Bebia City Centre • Bebia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
Arthrography	Painimetry
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infusion	

Patient: Harwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

Page 4 of 5

chiropractic therapy, and massage therapy. The patient is to return in 2 weeks for trigger point injections. We will see the patient again for reevaluation in 2-3 months, sooner if needed.

This dictation was created with Dragon voice recognition system. Although efforts were made to ensure accuracy, voice recognition errors may be present.

Dr. McVige is the supervising physician on site.

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Posttraumatic headache

Start Medrol Dosepak tablet, 4mg, as directed, orally, on package, 6 days, 21, Refills 0

Start Topamax tablet, 25 mg, 1 tab(s), orally, Take 1 QHS x 1 week; Increase to 1 tab in AM & 1 tab in PM x 1 week; Increase to 2 tabs AM & 2 tabs PM x 1 week, 30 day(s), 120, Refills 5

Stop Lamictal tablet, 25 mg, 2 tab(s), orally, BID

Increase nortriptyline capsule, 10 mg, 2 cap(s), orally, QHS

2. Myofascial pain

MASSAGE Therapy 1617284

Chiropractic therapy 1617283

3. Others

Notes: The patient is to continue with the current treatment plan.

Procedures

Toradol:

Assessment: Received patient signed informed consent. Patient was in the sitting position. Sterile prep utilizing an alcohol swab was performed. A total of 60 mg Toradol was injected into the Left deltoid, with a 27 gauge needle utilized. No complications occurred. Hemostasis was easily maintained. Post injection instructions given to patient. The patient was stable at discharge by Alesha Adams, LPN.

NERVE BLOCK: I positioned the patient in a sitting position within the exam room. The occipital area was prepped and cleansed with isopropyl alcohol in a sterile fashion. I provided the patient with a blockade using a 25-gauge needle Bilateral to the greater and lesser occipital nerves with equal volumes of 1% lidocaine and 0.5% bupivacaine. A total of 3 cc was injected on each side without complication. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was observed following treatment to assure the absence of complications and was discharged in good condition. The patient was instructed to apply ice and gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 07/27/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 07/27/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 07/27/2017.

Follow Up

RVAL 3 months

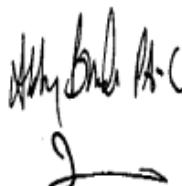
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 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-6315
 Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Posturography
Bone	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infusion	

Patient: Harwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

Page 5 of 5



Electronically signed by Abbey Burdick , PA-C on 07/27/2017 at 06:48 PM EDT

Sign off status: Completed

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www.dentinstitute.comAmherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045**DIAGNOSTICS & SERVICES**

MRI/CT	Neuropsychology
Arteriogram	Positronigraphy
Breast	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Inflation	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

*** RESUBMISSION OF corrected date of 07/10/2017 *** (07/28/2017)

NUCC

PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member ID# <input type="checkbox"/> (DOD) <input type="checkbox"/> OTHER												1a INSURED'S ID NUMBER (For Program in Item 1)							
												013873940-0101-059							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE SEX							
HARWELL, DANIELLE												MM <input type="text"/> DD <input type="text"/> YY	SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X						
5. PATIENT'S ADDRESS (No., Street)												4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -							
56 BEREBHAVEN DR												7. INSURED'S ADDRESS (No., Street)							
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE		CITY		STATE											
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X		ZIP CODE ()		TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO							
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>LINE</u>							
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												11. INSURED'S POLICY GROUP OR FECA NUMBER							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X							
SIGNED <u>ON DATE</u> _____ DATE 01-06-2016												b. OTHER CLAIM ID (Designated by NUCC)							
SIGNED <u>ON DATE</u> _____ DATE 01-06-2016												c. INSURANCE PLAN NAME OR PROGRAM NAME							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY) 10-31-2015 CUAL												15. OTHER DATE QUAL MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <u>SYDNEY GRABAU, PA</u>												16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17b. <u>NPI</u>												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to services line below (24e)) ICD Ind												22. RESUBMISSION CODE ORIGINAL REF. NO							
A. <u>L79.1</u>		B. <u> </u>		C. <u> </u>		D. <u> </u>		23. PRIOR AUTHORIZATION NUMBER											
E. <u> </u>		F. <u> </u>		G. <u> </u>		H. <u> </u>													
I. <u> </u>		J. <u> </u>		K. <u> </u>		L. <u> </u>													
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY												B. PROCEDURES, SERVICES, OR SUPPLIES PLACE OF SERVICE E/M (Explain Unusual Circumstances) CPT/HCPCS NDC/IFER				C. DIAGNOSIS CODE POINTER			
25. F. <u> </u>												G. DAYS OR UNITS				H. K CHARGE PER UNIT			
I. <u> </u>												J. L QUAL				K. I ID QUAL			
L. <u> </u>												M. <u> </u>				N. <u> </u>			
O. <u> </u>												P. <u> </u>				Q. <u> </u>			
R. <u> </u>												S. <u> </u>				T. <u> </u>			
U. <u> </u>												V. <u> </u>				W. <u> </u>			
X. <u> </u>												Y. <u> </u>				Z. <u> </u>			
26. FEDERAL TAX ID NUMBER <u>47-0989449</u>												28. PATIENT'S ACCOUNT NO <u>HARWELL, D</u>				29. ACCEPT ASSIGNMENT (Check one box, see back)			
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				30. TOTAL CHARGE <u>\$ 165.00</u>			
																31. AMOUNT PAID <u>\$ 0.00</u>			
																32. REV'D FOR NUCC USE <u>165.00</u>			
33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.)												34. SERVICE FACILITY LOCATION INFORMATION 716 725-0264							
COLLEEN MARK, IMT 07.14.2017 SIGNED DATE												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043							

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08 01 17



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4 Bodenwait Practitioners
375 Dixie Road, Suite #2
Dover, NH 03820
Attn: C. Martz

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a violation of law punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENT: A patient's signature requests that payment he made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information as to whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is to pay for the services for which the Medicare claim is made. § 18 CFR 411.2(a). Item 9 is completed by the patient's signature authorizes release of the information to the health plan or agency. In Medicare assigned or TRICARE preferred rates, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary if he fails to do so. In Medicare assigned or TRICARE preferred rates, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary if it is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain institutions with the United States Government. Information on the patient's sponsor should be provided in those items captioned in "insured", i.e., items 1a, 2, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have furnished myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed decision and pay my claim; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly removed by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, or SSN) of the primary individual rendering such service is noted on the claim, unless such service is a integral, although incidental part of a covered physician service; 7) they must be rendered under the physician's direct supervision by me or my employee; 8) they must be of kinds commonly furnished in physician's office; and 9) the services, if non-physician, must be included on the physician's bill.

For TRICARE claims, I further certify that, for any employee(s) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government, either civilian or military (refer to 10 USC 5336), for Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part H Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 442.82).

NOTICE: Any one of the requirements or failure to furnish essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PARTIES ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and DOL to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 703(a)(3), 1802 and 1874 of the Social Security Act, as amended, 42 CFR 411.24(a) and 426(g)(6), and 44 USC 3101; 41 CFR 101-11 sqq and 10 USC 1078 and 1079, 44 USC 6111 et seq and 30 USC 901 or seq; 38 USC 613, E.O. 13377.

The information you submit to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, insurance companies, medical review boards, health plans, and other organizations or Federal agencies, for the efficient administration of Federal programs. It may require other third parties to pay or remit to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying System No. 69-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 47549, Wed Sept 16, 1998, as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb. 26, 1990. See ESA-3, ESA-6, ESA-12, ESA-13, ESA-30, or as revised and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the care or supplies received are authorized by law.

ROUTINE USES: Information on claim and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services, and/or the Dept. of Transportation contractor and their statutory representatives under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Federal Bureau of Investigation for criminal investigations, and consumer reporting agencies in connection with recoupment claims, and to Congressional Offices in response to legitimate needs at the request of the person to whom it is a record holder. Appropriate disclosure may be made to other Federal, state, local, foreign governmental agencies, private business entities, and individual individuals or entities on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntarily, or when failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for failing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide timely information under TRICARE could be deemed an obstruction.

It is my duty and you shall find if you know that another party is responsible for paying for your treatment. Section 11206 of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-504, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to describe fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to stamp, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to notify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claim, statement, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Computer Matching Program Act of 1988, no person is 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 0960-1189. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review OMB's privacy impact statement, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of this time or believe OMB has overlooked any comments for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-28-05, Baltimore, Maryland 21244-2900. This address is for comments only. Do NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

NUCC

<input type="checkbox"/> PICA	<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP HEALTH PLAN	<input type="checkbox"/> FECA EXCLUDING (10M)	<input type="checkbox"/> OTHER (10M)	1a. INSURED'S ID-NUMBER (For Program Item 1)
-------------------------------	-----------------------------------	-----------------------------------	----------------------------------	----------------------------------	--	--	---	---

1b. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3 PATIENT'S BIRTH DATE SEX

HARWELL, DANIELLE MM DD YY M F

4 INSURED'S NAME (Last Name, First Name, Middle Initial) - - - - -

5 PATIENT'S ADDRESS (No., Street) 6 PATIENT RELATIONSHIP TO INSURED

56 BERBEAVER DR Spouse Child Other

7. INSURED'S ADDRESS (No., Street) CITY STATE

AMHERST NY CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ()

14228 (716) 536-0951 X

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT (Current or Previous) YES NOb. RESERVED FOR NUCC USE b. AUTO ACCIDENT? YES NO PLACE (State)c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? YES NO

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC) 11. INSURED'S POLICY GROUP OR FECA NUMBER

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary

to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below

SIGNED - ON P.T.R. - DATE 01-06-2016 SIGNED - ON P.T.R. -

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 15. OTHER DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

14-31-2015 QUAL FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

SYDNEY GRABAU, PA 17b. NPI FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below #4e) ICD IND. 22. RESUBMISSION CODE ORIGINAL REF. NO.

A. H79.1 B. C. D. E. F. G. H. I. J. K. L.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. RUC/EOR SERVICE EMG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) E. MODIFIER F. DIAGNOSIS POINTER G. DAYS ON UNITS H. DAILY AMT PAY I. ID QUAL J. RENDERING PROVIDER ID #

1 07-18-17 07-18-17 11 97340 1 55.00 3 NPI 1144462011

2 07-20-17 07-20-17 11 97340 1 55.00 3 NPI 1144462011

3 07-24-17 07-24-17 11 97340 1 55.00 3 NPI 1144462011

4 07-28-17 07-28-17 11 97140 1 55.00 3 NPI 1144462011

5 07-28-17 07-28-17 11 97140 1 55.00 3 NPI 1144462011

6 07-28-17 07-28-17 11 97140 1 55.00 3 NPI 1144462011

25. FEDERAL TAX ID NUMBER SSN BIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT FOR CO-PAY, DRG, ETC

47-0989449 33 HARWELL, D YES NO

28. TOTAL CHARGE 29. AMOUNT PAID 30. RWD FOR NUCC USE

\$ 220.00 \$ 0.00 220.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.)

GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPBM, NY 14043

COLLEEN MARK, LMFT 07.28.2017 R.1144462011 P.1144462011

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.
WARNING: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a civil or criminal penalty under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

STATEMENT OF PAYMENT AGREEMENT AND TRICARE PAYMENT: A physician signature requires that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Block 1 through 12 is true, accurate, and complete. In the case of a physician claim, the patient's signature authorizes him only to release to his/her medical provider the information on and that the person has employer group health insurance. In so doing, no fault provider compensation or other form of which is received is to be paid to the physician for which the Medicare claim is made. See 42 CFR 411.4(a). If item 8 is completed, the patient's signature authorizes release of the information to the hospital, in which case the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the billable amount and the amounts are responsible only for the deductible, coinsurance and non-covered services. Compensation and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes a payment to health benefits provided through uniform providers in Uniform Services. Information on the patient's sponsor should be provided in those items captioned in "Insured" i.e., items 1a, 4, 6, 7, 8 and 11.

BLACK LUNG AND FECA CLAIMS

A provider agrees to except fee payments by the Government as payment in full. See Black Lung and FECA instructions regarding required pronouncements against enrolling physicians.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on the form is true, accurate and complete; 2) I have furnished myself with all applicable laws, regulations and general instructions which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed decision and payment decision; 4) this claim, either submitted by me or on my behalf by my designee, is being correctly, completely and with all applicable documents and/or supporting forms, signatures and originals, submitted to my patient (but not to my employer, business or corporation); 5) the services on this form were not furnished directly and personally furnished by me or were furnished incident to my professional services as my employees under my direct supervision, except as otherwise agreed or authorized by Medicare or TRICARE; 6) for each service rendered incident to my professional services, the identity (first name and HICN) of the primary individual rendering such service is indicated in the designated section for services to be considered "incident to" a physician's professional services; 7) they must be listed under the physician's name as supervisor by his/her employee; 8) they must be an integral, although incidental, part of a physician's practice; 9) they must be of lands personally furnished by the physician's office; and 10) the services of non-physician, must be indicated on the physician's bills.

For TRICARE claim: 1) I further swear that I for any reason, or who render services are an employee, member of the Uniformed Services or civilian employee of the United States Government or a current employee of the United States Government, either civilian or military (just) is USC 554a. For Black Lung claims, I further certify that the services performed were for a Black Lung-related condition.

My signature is made herein in the belief the form is received as required by existing law and regulations (42 CFR 404.22).

WARNING: Any use of this form or its attachments except of information to receive payment from Federal funds is subject to law and regulations of the Department of Health and Human Services.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

I am authorized by CMS, TRICARE and OMB to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is set out in 208a(a), 1991, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101-4(f) CFR 101 et seq and 10 USC 1078 and 1079, 6 USC 141 et seq and 49 USC 501 et seq, 29 UCC 819, E.O. 12027.

The information is used to determine eligibility, to determine if your services are to be paid, to determine if you are eligible, and to determine if your services are to be paid.

This information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other Federal agencies to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the services you have used to a hospital or doctor. Additional disclosures are made through the uses of information contained in sections of this notice.

FOR MEDICARE CLAIMS: See the notice following section 1902-70-0501, titled "General Medicare Claims Record" published in the Federal Register, Vol. 55 No. 177, page 2518-2519, July 27, 1990, as updated and republished.

FOR OMB APPROVAL: OMB #13: Department of Labor, Privacy Act of 1974, "Reputation of Office of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, Supp 26A-6, EOB 6, 114-12, 12A-13 (E.O. 12057) as updated and republished.

FOR TRICARE AND FECA: PRINCIPAL PURPOSES: To exclude disability for medical care provided by civilian sources and to make payment upon establishment of disability and to determine if there is a conflict between medical care furnished by two.

FOR TRICARE (FECA): Information contained and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation and/or the Dept. of Justice, other Federal agencies under TRICARE/CHAMPVA, to the Dept. of Justice or representation of the Secretary of Defense in civil actions in the Federal Courts, private collectors, auditors, and consumers for rating agencies in connection with recuperation claims, and to Congressional Offices in response to inquiries made of the Office of the Inspector General about a medical program. Appropriate disclosure may be made to other Federal, state, local, or non-governmental agencies, private businesses and/or individuals and/or to other Federal, state, or local agencies relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, quality-of-care, compliance, and audit purposes, and for the operation of TRICARE.

DISCLOSURE: Voluntarily, however, failure to furnish information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties and/or other consequences in failing to supply information. However, failure to furnish information regarding the medical services, itemized or the amount charged would prevent payment of claims under Federal programs. Failure to furnish our other information, such as name or claim number, could delay payment of the claim. Failure to provide medical information that is FECA could be denied or deducted.

It is important to you to let us know if you know that another party is responsible for paying for your treatment. Section 11093 of the Social Security Act and 31 USC 3901-3912 provide penalties for false statements of information.

You should be aware that P.L. 102-593 (the Computer Matching and Privacy Protection Act of 1996), permits the government to verify information by way of computer matching.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services to the State Attorney or Dept. of Health and Human Services may request.

I further agree to submit to a review by the Medicaid program for those claims submitted for payment under that program, with the exception of any third party deductible, non-insurance, co-payment or similar third party charges.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

WARNING: It is illegal to certify that long-term care information is accurate and complete. I understand that payment and certification of this claim will be from Federal and State funds, and if a provider claim, statement or documents is found to be inaccurate, may be prosecuted under applicable Federal or State laws.

As required by the Patient Protection Act of 1996, no person is 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 OMB-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search for data resources, gather the data needed, and complete and review the information collected. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-25-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

08 01 17

DOS: on 10/20/07
was ~~in~~ correctly
submitted on 10/20/07
as "on 10/20/07"
This is resubmission
and corrected date.

Frank
Coldren
MLB-NAS-0004



Order Form for

Dent Tower 6th Flr

3980 Sheridan Drive 6th Floor,
Amherst, NY, 142261727
Tel: 716-250-2000 Fax: 716-250-2045

Abbey L. Burdick, PA-C (NPI:1164819363)
Provider Code:

Physician Assistant

Patient: Harwell, Danielle

Order Date: 07/27/2017 12:30 AM
Today: 07/27/2017 01:17 PM

DOB: 08/29/1980 **Sex:** Female **Phone:** 716-536-0951
Address: 1131 CLEVELAND DR, CHEEKTOWAGA, NY 14225-1257

Primary Insurance Name:**Insurance Address:****Subscriber Number:****Insured Name:** Address:**DIAGNOSTIC IMAGING:**

Code	Diagnostic Name	Assessment(s)	Notes	Instructions
	MASSAGE Therapy	M79.1, Myofascial pain		

Electronically Signed By: **Abbey L. Burdick, PA-C**

Signature of Patient/Guardian

Patient: Harwell, Danielle DOB: 08/29/1980

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0684

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 7/20/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Still sore & stiff but better.

Cerv-mm stiffness/tight to hyperst. LB tightness @ QL's

Actions Applied: (Check All that Apply) 8 Notes

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat mixer

Therapist: Deb May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0684

Fax: (716) 725-0355

Client Name: Danielle Harwell Date: 7/24/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calf Muscles (R) Calf Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Neck mm very tight from occiput ↓ to @ trap mm. ↓ rotation of head from stiffness. Lb mm ↓

Actions Applied: (Check All that Apply) 8 Notes

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Can't Meds Ice / Heat mixer

Therapist: Deb May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0034

Fax: (716) 725-0065

Client Name: Danielle Howell Date: 7/18/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: "LB better today." Neck & shoulder are. Up trap & cervical mm² hypertone w/ tightness into rhomboid & lev. spinesActions Applied: (Check All that Apply) Region LB mm still
 Heat Packs Cold Packs Sombra/Biofreeze Light Bed
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion better than last visit
 Stripping Compression Lymph DrainagePlan/Recommendations: (check All that Apply)
 Follow-up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Com'lt Meds Ice / Heat percTherapist: ellen Mary

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14205

Office: (716) 725-0034

Fax: (716) 725-0065

Client Name: Danielle Howell Date: 7/28/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has had a HT for over a wk. Had nerve block injections in knee and shot in L shoulder. Feels not and moving slowly. LB tight and sore around sacrum w/ swelling

Actions Applied: (Check All that Apply) Q/L WS
 Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph DrainagePlan/Recommendations: (check All that Apply)
 Follow-up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Com'lt Meds Ice / Heat percTherapist: ellen Mary



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

XNUCC

RCA-2000

1 MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TIPCare <input type="checkbox"/> (TIPCare)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (GHP)	FPCA BUKING <input type="checkbox"/> (FPCA)	OTHER <input checked="" type="checkbox"/> (Other)	1a. INSURED'S ID NUMBER 0138739400101059 (For Program in Item 1)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE							3 PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>	4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		
5 PATIENT'S ADDRESS (No. Street) 1131 CLEVELAND DR							6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7 INSURED'S ADDRESS (No. Street) 1131 CLEVELAND DR		
CITY CHEEKTONWAGA			STATE NY	8 RESERVED FOR NUCC USE			CITY CHEEKTONWAGA	STATE NY		
ZIP CODE 14225-1257			TELEPHONE (Include Area Code) ()				ZIP CODE 14225-1257	TELEPHONE (Include Area Code) ()		
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							10 IS PATIENT'S CONDITION RELATED TO a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
b RESERVED FOR NUCC USE							b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
c RESERVED FOR NUCC USE							c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
d INSURANCE PLAN NAME OR PROGRAM NAME							10d CLAIM CODES (Designated by NUCC) READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			
SIGNED SIGNATURE ON FILE							11 INSURED'S POLICY GROUP OR PEDA NUMBER DOI 10/31/15			
DATE 02 09 16							12a. INSURED'S DATE OF BIRTH MM DD YY 08 29 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY) MM DD YY QUAL							15 OTHER DATE MM DD YY QUAL 439 10 31 15			
16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI							17a. U62607			
17b. NPI 1710014188							18. OUTSIDE LABS S CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NDC 00409379501							20 RESUBMISSION CODE ORIGINAL REF. NO.			
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to services line below [24E]) A M5481 B L G44309 C M791 D H832X9							22 PRIOR AUTHORIZATION NUMBER			
E G479 F I SD60X08 G H L K L										
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE BMG							F. G. H. I. J. \$ CHARGES DAYS OR UNITS H. ID QUAL J. RENDERING PROVIDER ID #			
1 07 27 17	07 27 17	11	64405	RT			ABCD	117 84 1	EI 161582336 NPI 1649596495	
2 07 27 17	07 27 17	11	64405	LT			ABCD	117 84 1	EI 161582336 NPI 1649596495	
3 07 27 17	07 27 17	11	64450	RT	59		ABCD	64 44 1	EI 161582336 NPI 1649596495	
4 07 27 17	07 27 17	11	64450	LT	59		ABCD	64 44 1	EI 161582336 NPI 1649596495	
5 07 27 17	07 27 17	11	99215	25			AFDB	119 60 1	EI 161582336 NPI 1649596495	
6 07 27 17	07 27 17	11	J1885				ABCD	8 00 4	EI 161582336 NPI 1649596495	
25 FEDERAL TAX ID NUMBER 88KBN 161582336							26 PATIENT'S ACCOUNT NO 1667541	27 ACCEPT ASSIGNMENT For your claim, see section 8(b)(2) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28 TOTAL CHARGE 5 492 16 \$ 0 00	29 AMOUNT PAID 30 Reward for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) JENNIFER W MCVIGE, MD							32 SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727		33 BILLING PROVIDER INFO & P.H.# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002	
SIGNED 08 01 17							34 DATE 08 01 17		35 DATE 08 01 17	
36 SIGNED 08 01 17							37 DATE 08 01 17		38 DATE 08 01 17	

chiropractic therapy, and massage therapy. The patient is to return in 2 weeks for trigger point injections. We will see the patient again for reevaluation in 2-3 months, sooner if needed. This dictation was created with Dragon voice recognition system. Although efforts were made to ensure accuracy, voice recognition errors may be present.

Dr. McVige is the supervising physician on site.

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Posttraumatic headache

Start Medrol Dosepak tablet, 4mg, as directed, orally, on package, 6 days, 21, Refills 0

Start Topamax tablet, 25 mg, 1 tab(s), orally, Take 1 QHS x 1 week; Increase to 1 tab in AM & 1 tab in PM x 1 week, Increase to 2 tabs AM & 2 tabs PM x 1 week, 30 day(s), 120, Refills 5

Stop Lamictal tablet, 25 mg, 2 tab(s), orally, BID

Increase nortriptyline capsule, 10 mg, 2 cap(s), orally, QHS

2. Myofascial pain

MASSAGE Therapy 1617284

Chiropractic therapy 1617283

3. Others

Notes. The patient is to continue with the current treatment plan.

Procedures

Toradol:

Assessment. Received patient signed informed consent. Patient was in the sitting position. Sterile prep utilizing an alcohol swab was performed. A total of 60 mg Toradol was injected into the Left deltoid, with a 27 gauge needle utilized. No complications occurred. Hemostasis was easily maintained. Post injection instructions given to patient. The patient was stable at discharge by Alesha Adams, LPN.. NERVE BLOCK: I positioned the patient in a sitting position within the exam room. The occipital area was prepped and cleansed with isopropyl alcohol in a sterile fashion. I provided the patient with a blockade using a 25-gauge needle Bilateral to the greater and lesser occipital nerves with equal volumes of 1% lidocaine and 0.5% bupivacaine. A total of 3 cc was injected on each side without complication. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was observed following treatment to assure the absence of complications and was discharged in good condition. The patient was instructed to apply ice and gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living Patient counseled on the importance of healthy lifestyle 07/27/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats 07/27/2017

Exercise: Patient counseled on importance of moderate physical activity daily 07/27/2017

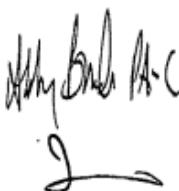
Follow Up

RVAL 3 months

(716) 250-2000
www.dentinstitute.com

Amherst Offices | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Posturography
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNG
Infusion	



Electronically signed by Abbey Burdick , PA-C on 07/27/2017 at 06:48 PM EDT

Sign off status: Completed

(716) 250-2000
www.dentinstitute.com

Amherst Office | Dent Tower • 3980 Sheridan Drive • Amherst, NY 14226 | Fax: (716) 250-2045
Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14277 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

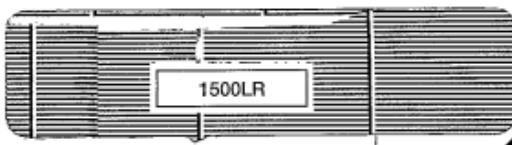
DIAGNOSTICS & SERVICES	
MRICCT	Neuropsychiatry
Arthrography	Pneumography
Bosox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infusion	

FIRST CLASS MAIL



08 04 17

DENT NEUROLOGIC GROUP, LLP
ADMINISTRATIVE OFFICE
3980 SHERIDAN DR SUITE B
BUFFALO, NY 14226



FIRST CLASS MAIL

PLEASE DO NOT BEND



**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 8 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 6536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(e), 1892, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101 et seq and 10 USC 1079 and 1085, 5 USC 801 et seq, and 30 USC 801 et seq, 38 USC 613; E.O. 12897

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying System No. 69-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompensation claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other Federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntarily, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment! Section 1120B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding the information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1690. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO INSURANCE - NF

NY PIP CLAIMS

POBOX 9507

FREDERICKSBURG VA 22403

RICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FECA) <input type="checkbox"/> (Other)												1a. INSURED'S ID. NUMBER (For Program Item 1) 0138739400101059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE						3. PATIENT'S BIRTH DATE MM 08 DD 29 YY 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE								
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR						6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR								
CITY CHEEKERTOWAGA			STATE NY			8. RESERVED FOR NUCC USE			CITY CHEEKERTOWAGA			STATE NY					
ZIP CODE 14225-1257			()						ZIP CODE 14225-1257			()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15								
						b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			a. INSURED'S DATE OF BIRTH MM 08 DD 29 YY 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>								
						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)								
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME								
									d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below					
SIGNED _____ SIGNATURE ON FILE						DATE 02 09 16						SIGNED _____ SIGNATURE ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 08/00/00			15. OTHER DATE (MM DD YY) QUAL 439 10 31 15			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI			17a. URGENT CARE NUMBER 1G U62607			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAST \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below [24e]) A M5481 B G44309 C M791 D #832X9 E G479 F S060X08 G L H L I J K L						22. RESUBMISSION CODE ORIGINAL REF NO											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 07 27 17 07 27 17						B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS 96372 59			D. MODIFIER ABCD			E. DIAGNOSIS PENTER pointer 18 43 1			F. \$ CHARGES 161582336	G. DAYS OR UNITS NPI 1649596495	H. PAYOR I. ID J. RENDERING PROVIDER ID #
1																	
2														NPI			
3														NPI			
4														MPI			
5														NPI			
6														NPI			
25. FEDERAL TAX ID NUMBER 161582336	SSN BIN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO 1667541			27. ACCEPT ASSIGNMENTS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE 5 18 43			29. AMOUNT PAID 0 00		30. Reqd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) JENNIFER W MCVIGE, MD						32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727			33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002								
OB 01 17						# 1497850911 b			# 1497850911			EI161582336					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if the fee is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured", i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service, by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI), license #, or SSN of the primary individual rendering each service is reported in the designated section For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employees, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bill.

For TRICARE claims: I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5538). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(e), 1892, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086, 5 USC 801 et seq; and 38 USC 801 et seq, 38 USC 613, E.O. 13397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties pay to primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, EBA-5, EBA-12, ESA-13, EBA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

BOUTLINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recipient claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1187. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: RA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 4112
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 08/01 08:59
 TX/RX TIME 03' 22
 PGS. 8
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/21/12

HCFA-1500

CARRIER

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FICA SOCSEC ADM	OTHER	10. INSURED'S ID. NUMBER [For Programs In Italic]
[Medicare] <input type="checkbox"/>	[Medicaid] <input type="checkbox"/>	[TRICARE] <input type="checkbox"/>	[CHAMPVA] <input type="checkbox"/>	[GROUP HEALTH PLAN] <input type="checkbox"/>	<input checked="" type="checkbox"/> X <input type="checkbox"/>	<input type="checkbox"/>	0138739400101059
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY	SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> X <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARWELL, DANIELLE				08 29 1980		HARWELL, DANIELLE	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
1131 CLEVELAND DR				Bf <input type="checkbox"/> Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		1131 CLEVELAND DR	
CITY CHEEKTONWAGA	STATE NY	8. RESERVED FOR NUCC USE		CITY CHEEKTONWAGA	STATE NY		
ZIP CODE 14225-1257	TELEPHONE (Include Area Code) ()	9. RESERVED FOR NUCC USE		ZIP CODE 14225-1257	TELEPHONE (Include Area Code) ()		
10. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FICA NUMBER DOI 10/31/15	
				12. EMPLOYMENT? (Current or Previous)		12. INSURED'S DATE OF BIRTH MM DD YY	
				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/> X	
13. RESERVED FOR NUCC USE				13. AUTO ACCIDENT?		13. OTHER CLAIM ID (Designated by NUCC)	
				<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	PLACE (State) PA		
14. RESERVED FOR NUCC USE				14. OTHER ACCIDENT?		14. INSURANCE PLAN NAME OR PROGRAM NAME	
				<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
15. INSURANCE PLAN NAME OR PROGRAM NAME				15. CLAM CODES (Designated by NUCC)		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> [If yes, complete items 6, 8a, and 1d.]	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of grievances benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE

DATE 02 09 16

16. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY)	16. OTHER DATE MM DD YY	16. DATED PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
QUAL QUAL	QUAL 439 10 01 15	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI	17a. LG U62607	16. HOSPITALIZATIONS RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
	17b. NPI 1710014188	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) NDC 00409379501	19. OUTSIDE LAB YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	19. CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-L to service line below (NDC) ICD-10 A. M5481 B. G44309 C. M791 D. 9832X9 E. G479 F. S060X08 G. H. I. J. K. L.	20. RESUBMISSION DATE ORIGINAL REF. NO.
22. PRIORITY NUMBER	
23. DATES OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE SMD CPT/HCPCS MODIFIER	F. DATES OF SERVICE MM DD YY G. DATES OF RENDERING PROVIDER MM DD YY H. DATES OF RENDERING PROVIDER MM DD YY I. DATES OF RENDERING PROVIDER MM DD YY J. DATES OF RENDERING PROVIDER MM DD YY
1 07 27 17 07 27 17 11 64405 R2 ABCD 117 84 1	E. DATES OF RENDERING PROVIDER MM DD YY
2 07 27 17 07 27 17 11 64405 R2 ABCD 117 84 1	E. DATES OF RENDERING PROVIDER MM DD YY
3 07 27 17 07 27 17 11 64450 R2 S9 ABCD 64 44 1	E. DATES OF RENDERING PROVIDER MM DD YY

SUPPLIER INFORMATION

08 04 17
4th FLOOR

Invoice

Page 2 of 2

Invoice Number 91548515		PO Number 12-27-2016 4:34PM			Invoice Date 12/27/16		
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Item Number	Vendor / Vendor Cat #	Description	'Ordered	Unit Shipped	99070		
					Unit Price	Amount	Sales Tax
885008	Vendor: BAHECO NDC Num: 8 00338064908	SOD CHL IV SOL 0.9 NACL VIAFL PO LN 6	5	EA	5	5.09	25.45 0.00
811977	Vendor: BD Vend Cat: 308830	SYRINGE, LL 20CC (48/BX) PO LN 9	1	BX	1	16.94	16.94 1.48
511808	Vendor: #FRK8 NDC Num: 8 03323016208	KETOROLAC TROMETHAMINE, SDV 60 J1885 PO LN 10	1	CT	1	29.54	29.54 0.00
310009	Vendor: #PFIZ NDC Num: 8 00009004722	SODIUM MEDROL, VIAL 125MG/2ML PO LN 11	10	EA	10	8.88	88.80 0.00
178448	Vendor: BAXTIN NDC Num: 8 003380404945	SODIUM CHLORIDE, SGL 0.9 PO LN 12	1	CA	1	149.77	149.77 0.00
526811	Vendor: MGM18 Vend Cat: 16-9707	COMPRESS, HOT INST 6"X9" LF (2 PO LN 13	1	CA	1	19.77	19.77 1.73
477563	Vendor: MGM18 Vend Cat: 18-16650	UNDERPAD, 3PLY TISSUE BLU 17X2 PO LN 14	1	CA	1	35.07	35.07 3.07
881399	Vendor: MGM128 Vend Cat: 2282	CONTAINER, SHARPS-COLL. HORIZ R PO LN 15	3	EA	3	3.47	10.41 0.91
444283	Vendor: BD Vend Cat: 306545	SALINE, SYR 5ML (30/BX) PO LN 16	3	BX	3	14.38	43.08 0.00
346966	Vendor: BD Vend Cat: 381523	CATHETER, INSYTE WINGD 22GX1" PO LN 17	1	BX	1	105.75	105.75 9.25
636622	Vendor: BBRAUN Vend Cat: 352901	EXT SET, SAPEDAY NDI-FREE SM BO PO LN 18	1	CA	1	148.08	148.08 12.96

SUB TOTAL	TAX	TOTAL AMOUNT
\$1,766.12	\$59.82	\$1,825.94

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J1885=99070X 4 units: \$8.00

PT Danielle Harwell

DDS 7/27/17

Claim # 0138739400101059



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NEUROLOGIC INSTITUTE

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Abbey L. Burdick, PA-C

Re-Evaluation
Date: 07/27/2017

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 36 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- Migraines . Patient present for treatment of headache

History of Present Illness

General:

Dear Dr. Panzarella:

We had the pleasure of seeing Danielle today in neurologic reevaluation regarding motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a wonderful 36-year-old young woman who had an unfortunate motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at the urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale. She reported associated sonophobia, osmophobia, spots before her eyes, fatigue, difficulty concentrating, neck stiffness, weakness in the arms and face.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16 MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes, but there are disk extrusions seen at C4-C5 and C5-C6. She did have an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 were normal aside from a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8.

Danielle has tried ibuprofen, Tylenol, Motrin, chiropractic care, massage therapy and physical therapy. After initial evaluation, she was started on magnesium oxide, Naprosyn and Rizatopran. Vestibular therapy and physical therapy have both proven helpful in symptom management. Massage therapy and regular trigger point injections have been very helpful with decreasing her cervical myofascial spasm.

Danielle had been struggling with episodes of dizziness and vertigo which can be so severe the she will have to pull over when she is driving. They seem to be triggered by certain neck movements. She will experience a sharp pain starting from the base of her head that will radiate up and over to the top of her head. These do tend to occur with a headache. Lamictal was started and is currently at 100mg, but there is no notable relief. Headaches are almost daily and tend to be located along the right occipital and temporal regions and will radiate into her right eye.

The patient found vestibular and physical therapies helpful, however she was discharged from both. She continues to do complete exercises at home. Unfortunately, the patient feels she has plateaued.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal.

At her last reevaluation, the patient was weaned off Lamictal. She was started on Nortriptiline.

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DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
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EMG	TMS
InPACT	VNG
Inflators	

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Topamax was planned to start after Lamictal was weaned. Botox was also discussed if medication continued to be ineffective. She was also sent to restart vestibular and physical therapies.

The patient returns today with no improvement of her symptoms. Unfortunately, the patient has been suffering from a constant headache over the past week. She has been taking Nortriptyline at bedtime and tolerating well. She does feel that it has improved her sleep somewhat. She has not yet been able to obtain a vestibular therapy appointment due to availability. Due to her constant headache, she has been taking Naproxen at least 1-2 times a day over the past week. Since her last appointment she did wean off Lamictal.

Current Medications

- Taking Lamictal 25 mg tablet 2 tab(s) orally BID
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking nizatidine 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking nortriptyline 10 mg capsule 1 cap(s) orally QHS
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father alive, Stroke
Mother, alive, Asthma
Siblings, alive
1 brother(s) - healthy

Social History

Tobacco Use

Smoking Patient is a non smoker

Caffeine

Other Patient does not consume caffeine

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

DIAGNOSTICS & SERVICES	
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	Arthrogram
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Review of Systems

Positive for headache, falls, dizziness, sleep outcome blurry vision, ringing in ears, earache, vertigo, joint pain, stiffness, neck and lower back pain, muscle aches, easy bruising. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy. Positive for headaches. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit.

Vital Signs

BP sitting 122/82, HR 88, RR 16, HT 63", Wt 234.2, BMI 0.29, HC 0, BSA 7.52.

Examination

General Examination.

General Appearance. Well-nourished, well-developed, in moderate distress, participated with the exam. Well groomed. Eyes: Disc margins clear, no vessel abnormalities, no papilledema. Neck: Supple. Range of motion limited with lateral flexion. Trigger points palpated within cervical musculature bilaterally. Cardiovascular: peripheral pulses within normal limits. Extremities: Full range of motion of extremities x4. No edema.

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper and lower extremities bilaterally. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Gait within normal limits Romberg positive. Sensory: Sensation to touch and cold was intact in all 4 extremities bilaterally.

Cranial Nerves:

Cranial Nerve II: Visual fields are full. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

- 1 Bilateral occipital neuralgia - M54.81 (Primary)
- 2 Posttraumatic headache - G44.309
- 3 Myofascial pain - M79.1
- 4 Vestibular dysfunction - H83.2X9
- 5 Sleep difficulties - G47.9
- 6 Concussion, without loss of consciousness, sequela - S06.0X0S

Danielle is a very sweet 36-year-old female who presents today for reevaluation regarding headaches and postconcussive symptoms. Unfortunately, the patient has had a severe headache that has persisted over the past week. We will provide her with a Toradol injection in the office. I would also like her to take a Medrol Dosepak as there is likely component of medication overuse. In addition, due to the severity of the patient's symptoms, I do feel as medically necessary to provide the patient with an occipital nerve block at today's appointment. This will be the patient's first nerve block. Regarding preventative agents, we will increase her Nortripptyline to 20 mg at bedtime to further aid with sleep. We will also start her on Topamax now that she is weaned off of Lamictal, which was ineffective for her. She does plan to start vestibular therapy once she is able to obtain an appointment. We will also continue regular trigger point injections,

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DIAGNOSTICS & SERVICES	
MR/CT	Neurophysiology
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EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infrared	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

013873940011059

PIKA

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FICA EXEMPTION (Box)	OTHER (Box)	1a. INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicaid	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> Member (DoD)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (DOD/DoD)						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)												3. PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
HARWELL DANIELLE												5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE		6. PATIENT'S RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT	
CITY CHEEKERTOWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY AMHERST		STATE NY		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FICA NUMBER 08291980			
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>NY</u> PLACE (State)		a. INSURED'S DATE OF BIRTH MM DD YY			
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)			
d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO												d. INSURANCE PLAN NAME OR PROGRAM NAME GEICO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		SIGNATURE ON FILE			
SIGNED SIGNATURE ON FILE												DATE		SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115		15. OTHER DATE QUAL 454		MM DD YY 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <u>NPI</u> 17b. <u>NPI</u>												18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to section 1a to service line below (ME)												22. RESUBMISSION CODE		ORIGINAL REF. NO.			
A <u>M50.222</u>	B <u>I51.26</u>	C <u>I51.27</u>	D <u>M54.12</u>	23. PRIOR AUTHORIZATION NUMBER													
E <u>S23.3XXA</u>	F <u>M99.01</u>	G <u>M99.03</u>	H <u>M99.02</u>														
I <u>M99.05</u>	J <u>I54.2</u>	K <u>M54.5</u>	L <u>M54.6</u>														
24. A. DATES OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE ENG.		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		E. MODIFIER	F. DIAGNOSIS CODE	G. DAYS OR UNITS	H. AMT PER UNIT	I. ID QUAL	J. RENDERING PROVIDER ID #						
1 07212017	07212017	11	98941				ABCD	32 28	1	NPI	1710014188						
2 07212017	07212017	11	97010				ABCD	10 53	1	NPI	1710014188						
3										NPI							
4										NPI							
5										NPI							
6										NPI							
25. FEDERAL TAX ID. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT. ASSESSMENT? (Check Box Before Billing) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE		29. AMOUNT PAID		30. Read for NUCC Use					
364500165		<input checked="" type="checkbox"/>		343821254				\$ 42181		\$							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDES DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this form are true and correct.) PETER GOZINSKI DC												32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849		33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			
SIGNED 08022017 DATE 1235256546^b												1235256546 ^b		APPROVED OMB-0838-1197 FORM 1500 (02-12)			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 14043-1849
716-681-3333
August 2, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday July 21, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 07/21/2017 at 9:12am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain continues to remain sore. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she noticed headaches "quite often this week". *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain remains the same, but her left posterior thigh pain "has not been as bad". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting, tingling; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature

Encounter dated 07/21/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 08/02/2017

Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C1, C2, C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Mild to Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal bilateral mild to moderate; TFL / ITB left mild to moderate. Tenderness on palpation: left SI: mild to moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. *Spinal subluxation level(s):* L4, L5, Left SI, Right SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: improving, less posterior thigh pain. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Encounter dated 07/21/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/02/2017

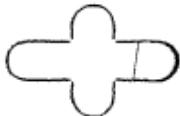
Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x every 2 weeks for 4 weeks; Re-examination for 4 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left AS (prone mobilization); Cervical (manual traction); SI right PI (diversified side posture); C1 right lateral flexion restriction (Instrument adjustment Arthrostim); C2 right lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 07/21/2017 at 9:12am

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



Item# 43568
Patent Pending



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111 R 02
345 Dick Rd
Depew, NY 14204

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Geico
P.D. BOX 9507
Fredericksburg, VA 22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BULKING OTHER (For Program Is Item 1)											
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> DOD/DODX	<input type="checkbox"/> Member ID#	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)	<input type="checkbox"/> (DOD)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)				3 PATIENT'S BIRTH DATE				4 INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARWELL, DANIELLE				MM	DD	YY	SEX	- NAME -			
OB 29 1980 M F											
5 PATIENT'S ADDRESS (No., Street)				6 PATIENT'S RELATIONSHIP TO INSURED				7 INSURED'S ADDRESS (No., Street)			
56 BEREBEAVEN DR.				<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other					
CITY AMBERT		STATE NY		8. RESERVED FOR NUCC USE X				CITY		STATE	
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951						ZIP CODE		TELEPHONE (Include Area Code) ()	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
a OTHER INSURED'S POLICY OR GROUP NUMBER											
b RESERVED FOR NUCC USE											
c RESERVED FOR NUCC USE											
d INSURANCE PLAN NAME OR PROGRAM NAME											
10. IS PATIENT'S CONDITION RELATED TO											
a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
b AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>LINE</u> PLACE (State)											
c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>											
b. OTHER CLAIM ID (Designated by NUCC)											
c. INSURANCE PLAN NAME OR PROGRAM NAME											
12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, b, and 9d											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED _____ ON FILE _____ DATE 01-06-2016											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 1-0-31-2015 QUA				15. OTHER DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a SYDNEY GRABAD, PA				17b NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD IND A L79.1 B L C L D L E L F G L G H L I K L J L											
22. RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. DIAGNOSIS POINTERS E. MODIFIER F. \$ CHARGES G. DAYS OF UFS H. HOURS & MIN I. ID # J. RENDERING PROVIDER ID #											
1	08 03 17	08 01	17 11	97140		55.00	3				NPI 31444662011
2	08 08 17	08 08	17 11	97140		55.00	3				NPI 31444662011
3	08 13 17	08 13	17 13	97140		55.00	3				NPI 31444662013
4											NPI
5											NPI
6											NPI
25	FEDERAL TAX ID NUMBER 47-0989449	SSN EIN <input type="checkbox"/> X	26. PATIENT'S ACCOUNT NO. HARWELL, D	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 165.00	29. AMOUNT PAID \$ 0.00	30. Revd for NUCC Use 165.00				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereto)											
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043											
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043											
COLLEEN MARX, LMFT 08.11.2017 SIGNED DATE 31444662011 31444662011											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VAHILU, CALENDAR AND PRIVATE HEALTH PLANS, DECISIONS MADE ON THIS FORM ARE SUBJECT TO APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly uses, or attempts to use, any computer system or any computer program or information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

תְּמִימָנָה וְעַמְמָנָה, כְּלֵבֶת בְּרִית

Test cases you can't predict from the day before are the ones that will make or break your application.

However, the main problem for most of the countries is that they have no clear policy on implants and no programmatic guidelines and policies for the use of implants. This is a major problem in India and less developed countries. The lack of a clear policy on implants has led to a lack of awareness among health workers and the public about the benefits and risks of implants. This is a serious concern for the future of the Indian population as more and more people are turning to implants for cosmetic purposes.

For TNCARE clients, I work directly with their insurance companies to coordinate care and services. This allows me to provide you with the best possible care while ensuring that the use of State Government's resources is kept to a minimum. If you have any questions or concerns, please do not hesitate to contact me. Thank you for your continued support.

No Part D "Medicare I enrollment begins no earlier than October 1, 2006, 120 days before the first day of the month in which the individual reaches age 65.

¹⁰ See, e.g., the discussion of the “right to privacy” in the Supreme Court’s decision in *Griswold v. Connecticut*, 381 U.S. 479 (1965), and the discussion of the “right to autonomy” in the Supreme Court’s decision in *Roe v. Wade*, 410 U.S. 113 (1973).

The following form is designed to help you determine whether your child has a learning disability. If you suspect your child has a learning disability, please consult with your physician or a professional who can help you determine what steps to take.

The information may be used for general purposes, such as the administration of Federal programs that benefit eligible persons. It may also be used for statistical purposes, such as to determine the number of people who have been affected by a particular program or to evaluate the effectiveness of a particular program.

POLYGRAPHIC CLIPPER: One of the polygraph manufacturers, located at 1000 N. 1st St., Phoenix, Arizona. The Polygraph is published in Phoenix, Arizona. Vol. V, No. 127, page 36540, Wed. Sept. 12, 1928. © Copyright 1928 by Polygraph Co.

FOR CIVIC CLAIMS: DRAFTERS OF LEVY, HARRIS AT & CO., LTD., 10 FEDERAL ST., BOSTON, MASS. 02110, ARE REQUESTED TO FILE A COPY OF THIS FORM IN THE CLERK'S OFFICE OF THE MASSACHUSETTS STATE HOUSE, BOSTON, MASS. 02114, ON OR BEFORE APRIL 1, 1970.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To provide medical care and services to eligible beneficiaries under TRICARE Prime, TRICARE Select, or TRICARE Standard.

1948/1949 von Paul Bösch sommertagsplatten, rechteckig, ohne Titel, 21 x 13 cm, Lp.

DISCLOSURES: We, however, believe it would be difficult to gain a true understanding of our financial condition without reference to our audited financial statements. Therefore, in addition to the information contained in this prospectus, you should refer to our audited financial statements for the fiscal years ended December 31, 2000, 2001 and 2002, which are incorporated by reference into this prospectus.

It is mandatory that you tell us if you know the another party's keep safe information to your position. A copy 1889 or the Social Security Act and 31 USC 741-18812 or may provide for withholding this information.

You should be aware that P.I. #30-303, the "Cannabis Health and Safety Project," which is run by the University of Mississippi, is one of the few groups that are attempting to verify information for any of these particular substances.

I hereby agree to keep secret, unless as and/or if stay or interim otherwise ordered by the court, all information contained in the Search Title 202 plan, and to return it when I am requested, any payment claimed for provision such returns at the rate of twenty-five dollars and one-half cents (\$25.50) per page.

I further agree to accept, no payment in aid, the amount paid by the third party providers for the medical services in the amount of my professional fee, which is the reason I authorized you to collect same, no payment or remittance copy being due.

NOTICE: This is a legally binding form prepared by a lawyer. It is not a "fill-in-the-blanks" form. Please read carefully, make any changes you need to, and then have it checked by a lawyer and notarized. See the "Legal Notices" section of this book for more information.

and, in the absence of the collision, the Higgs boson would have been produced at a lower energy than current, and it's difficult to imagine how the mass of the Higgs boson could be increased without changing the mass of the gluons.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Duxbury, NY 14048

Office: (716) 725-0304

Fax: (716) 725-0355

Client Name: Daniel Howell Date: 7/28/17

CM /

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Duxbury, NY 14048

Office: (716) 725-0304

Fax: (716) 725-0355

Client Name: Daniel Howell Date: 8/1/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client has had a H/H for over a week. Hard, nerve block sensations in head and shot in L shoulder. Feels very sore and moving slowly. LB tight and one arm's sacrum is pulling

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Core Meds Ice / Heat *M/R*

Therapist:

John May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Duxbury, NY 14048

Office: (716) 725-0304

Fax: (716) 725-0355

Client Name: Daniel Howell Date: 8/1/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Neck really sore today. Chiropractor couldn't adjust it yesterday due to shoulder stiffness. Lower back sore but not worse. Hypertonic cervical mm b-to upper rays. To the slight tightness down.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Core Meds Ice / Heat *M/R*

Therapist:

John May

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 8/8/17Client Status: Better Progressing Worse Same/No ChangePain Level: 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client stated "Very stiff today! barely see glute LB going for neck hyper tonic A.O. a little hamstring same for occiput + cervical mm down into upper traps. Cerv. ROM due to

Action's Applied: (Check All that Apply) Stiffness

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat MWF

Therapist: Allen Mary

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 8/11/17Client Status: Better Progressing Worse Same/No ChangeLB morePain Level: 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: "feels better, just stiff."
 a Upper back into neck very tight
 Cervical hyper tonicity leading deep into
Cerv. mm to shoulder. GLB not so

Action's Applied: (Check All that Apply) Hypertonic

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat MWF

Therapist: Allen Mary

08 15 17

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

08 15 17

Great Lakes Therapeutic Massage

& Bodywork Practitioners

375 Dick Road, Suite #2

Depew, NY 14043

Attn: C. Marx

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NY 144

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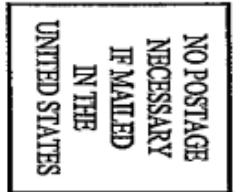
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IN THE
UNITED STATES





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

013873940011059

PICA

IPIA

1. MEDICARE <input type="checkbox"/> (Medicare)	MEDICAID <input type="checkbox"/> (Medicaid)	TBCARE <input type="checkbox"/> (TRICARE)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP <input type="checkbox"/> (ADP)	FECA <input type="checkbox"/> (SDD)	OTHER <input type="checkbox"/> (ADM)	1a INSURED'S ID NUMBER 013873940011059 (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		3. PATIENT'S BIRTH DATE MM DD YY 08291980		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY CHEKTOWAGA	STATE NY	8. RESERVED FOR NUCC USE		CITY AMHERST	STATE NY		
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951			ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY 08291980		b. OTHER CLAIM ID (Designated by NUCC) 08291980	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO	
c. RESERVED FOR NUCC USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 10, and 11	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d CLAIM CODES (Designated by NUCC)					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.							
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below							
14. SIGNED SIGNATURE ON FILE DATE							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (IMP) MM DD YY 103115		15. OTHER DATE MM DD YY 0454		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 111215		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD IND A. I50.222 B. I51.26 C. I51.27 D. I54.12 E. I82.3_XXXA F. I99.01 G. I99.03 H. I99.02 I. I99.05 J. I54.2 K. I54.5 L. I54.6							
22. RESUBMISSION CODE ORIGINAL REF NO							
23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE BLDG C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (English Universal Circumstances) E. MODIFIER F. CHARGES G. DAYS OF CARE H. AMOUNT PAID I. ID CODE J. RENDERING PROVIDER ID #							
1. 07312017	07312017	11	98941	ABCD	32.26	1	NPI 1710014188
2. 07312017	07312017	11	97010	ABCD	10.53	1	NPI 1710014188
3. 	 	 	 	 	 	 	NPI
4. 	 	 	 	 	 	 	NPI
5. 	 	 	 	 	 	 	NPI
6. 	 	 	 	 	 	 	NPI
25. FEDERAL TAX ID NUMBER 364500165		BBN <input type="checkbox"/> *	PATIENT'S ACCOUNT NO 343821255	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO In some cases, you can't choose to accept assignment.	28. TOTAL CHARGE \$ 42.81	29. AMOUNT PAID 5	30. Paid for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am ready and willing to sign it.) PETER GUZINSKI DC							
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849							
33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849							
SIGNED 08182017		DATE	a. 1235256546	b. 1235256546			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
August 18, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday July 31, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 07/31/2017 at 8:45am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck is "stiff." Patient stated that she had a nerve block last week at DENT which has helped with her headaches. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving regarding her headaches. *since* last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that her headaches have been more slight. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since* last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain has been "stiff. Left posterior thigh feels tight". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since* last visit. *Pain:* achy, dull, stiff, tight. *Range:* 3->4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders.

Encounter dated 07/31/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/18/2017

Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C1, C2, C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Mild to Moderate. **Trigger points:** bilateral rhomboids. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Tenderness & Hypertonicity** lumbar paraspinal bilateral mild to moderate; TFL / ITB left mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. **Spinal subluxation level(s):** L4, L5, Left SI, Right SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving, headaches have not been as intense. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Encounter dated 07/31/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/18/2017

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x every 2 weeks for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left AS (prone mobilization); Cervical (manual traction); SI right PI (prone mobilization); C1 right lateral flexion restriction (Instrument adjustment Arthrostim); C2 right lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

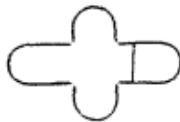
Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 07/31/2017 at 8:45am

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

08 24 17



Item# 43568
Patent Pending



08 24 17

INCORPORATED
345 Dick Rd.
Depew, NY 14204

Geico
P.O. BOX 9507
Fredericksburg, VA 22403





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE IN JUCI 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

— CARRIER —

PICA										PIGA								
<input type="checkbox"/> MEDICARE		<input type="checkbox"/> MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN (DVA)	FSCA BUILDING (DVA)	OTHER (DVA)	1a. INSURED'S I.D. NUMBER 033873940-0101-059	(For Program in Item 1)						
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (DVA/DoD)		<input type="checkbox"/> (Member ID)					4 INSURED'S NAME (Last Name, First Name, Middle Initial) BARNELL, DANIELLE							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY 08-30-1980	SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	5. PATIENT'S ADDRESS (No., Street) 56 BERSHAREN DR	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)				
CITY AMHERST NY		STATE NY		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		8. RESERVED FOR NUCC USE X		CITY CITY STATE ZIP CODE TELEPHONE (Include Area Code)								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FSCA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH MM DD YY M F							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO NY	b. OTHER CLAIM ID (Designated by NUCC)							
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N yes, complete items 9, 9a, and 9d								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								
SIGNED <u> </u> ON <u> </u> DATE <u>03-06-2016</u>										SIGNED <u> </u> ON <u> </u> DATE <u> </u>								
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10-31-2015 QMUL										15. OTHER DATE QMAU	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRAHAM, PA										17a. NP		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	\$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24B) ICD 9c										22. RESUBMISSION CODE	ORIGINAL REF NO							
A. IC79.1	B. 	C. 	D. 	E. 	F. 	G. 	H. 	I. 	J. 	L. 								
24. A. DATES OF SERVICE From MM DD YY To MM DD YY										B. PAYOR EMR	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. MODIFIER	F. DIAGNOSIS PENTER	G. DAYS OR UNITS	H. SPRT Per Unit	I. L. ID QMAU	J. Z RENDERING PROVIDER ID #
08-15-17-08-15-17-13																		
08-18-17-08-18-17-11																		
08-22-17-08-22-17-11																		
08-26-17-08-26-17-11																		
25. FEDERAL TAX ID NUMBER SSN SIN										27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 220.00	29. AMOUNT PAID \$ 0.00	30. Paid for NUCC Use 220.00					
47-0989449 <input type="checkbox"/> <input checked="" type="checkbox"/>										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. PATIENT'S ACCOUNT NO BARNELL, D	33. BILLING PROVIDER INFO & PH# 716 725-0264	GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEERFIELD, NY 14043					
													GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEERFIELD, NY 14043					

SIGNED DATE 11/11/11

10 of 10

62011

BECAUSE THIS FORM IS USED BY VARIOUS GROUPS OF PEOPLE TO RECORD THE STATUS OF CHILDREN, THE GOVERNMENT OF INDIA HAS ISSUED THIS FORM.

NOTICES: Any person who knowingly files or documents a claim containing a complaint, cause of action, or defense, or who neglects or fails to file a claim containing a complaint, cause of action, or defense, may be liable for attorney's fees and costs.

Figure 4B shows the results of the model calculations for the case of a 100% conversion of the initial reactants. The calculated values of the rate constants for the first two steps of the reaction are in excellent agreement with the corresponding experimental values. The calculated value of the rate constant for the third step is also in good agreement with the experimental value, although the latter was obtained under different conditions.

¹⁰ See also the discussion of the relationship between the two concepts in S. M. Hart, "The Rule of Law," 1969, 107 L. & P. 91.

¹⁰ See also the discussion of the 'moral economy' in the following section.

In addition to the above, the following are also included in the study: (1) the relationship between the amount of time spent in the classroom and the achievement of the students; (2) the relationship between the amount of time spent in the classroom and the achievement of the students; (3) the relationship between the amount of time spent in the classroom and the achievement of the students.

For TRICARE plans, a member may file a grievance if he or she is denied a claim benefit, or if he or she believes he or she has been discriminated against by the Department of Defense or another entity in accordance with the applicable law.

Ma-Pan, B. Nolla, and E. Pachita-Ornatowicz / Journal of Polymer Science: Part A: Polymer Chemistry 40 (2002) 2723–2734

Table 1. Summary of characteristics of the 151 isolates from 100 patients with *Candida* infection in the United States, 1988-1990

NOTICE TO PATIENTS ABOUT THE COLLECTIVE ACTION AGAINST THE PHARMA INDUSTRY AND PUBLIC CLIMATE ACTORS (NO. 19-1474) NOT STATED IN THE COMPLAINT This notice is being provided to you by the Plaintiff in the above-captioned case. The Plaintiff is asking the Court to rule that the Defendants violated the First Amendment of the United States Constitution by enacting the California Consumer Privacy Act ("CCPA") and the California Privacy Rights Act ("CPRA").

The information contained in this document is the sole property of the Company and is confidential. It may not be reproduced, distributed or disclosed without the prior written consent of the Company.

The information may be used to plan for the prevention of further outbreaks and to get those who have been infected to self-isolate. It can also be used to identify other people who may have been exposed to the virus.

For the above-quoted "factual statement" of witness No. 177, see the "Report of the Commission," which bears the before-quoted date of Feb. 20, 1917, page 37540, Vol. I, Part 2, of the present volume.

For more information about the EEA, visit www.eea.europa.eu.

After the initial screening, the remaining 1000 subjects were randomly assigned to receive either the standard treatment or the new drug. The results showed that the new drug was significantly more effective than the standard treatment, with a 60% reduction in symptoms compared to 40% for the standard treatment.

HRH 1-19. Higher-level benefit and cost analysis. In addition to the benefit and cost analysis described above, a more detailed analysis of the proposed program can be conducted at the request of the Office of the Secretary of Transportation or the Secretary of Transportation's designee. This analysis will include an examination of the potential impact of the proposed program on the transportation system, including the potential impact on safety, traffic, economic, and environmental factors. The analysis will also consider the potential impact of the proposed program on the transportation system, including the potential impact on safety, traffic, economic, and environmental factors.

If you need any help or if you have any questions, feel free to contact me via email at alexander.schaefer@uni-ulm.de or via phone at +49 712 60 44 00 11.

You should be encouraged to talk to the Columbia teacher and/or to Park City High staff members about the difficulties you may have in dealing with your child.

3574-1471(200005)14:2;1-2

¹ This is consistent with the argument that the steering committee's role in the process makes it difficult to distinguish between the steering committee and the government in the final report. Cf. *ibid.*, 100–101.

NAME OF PHYSICIAN (OR DOCTOR) WHO IS TREATING YOU AND THE DATE OF YOUR LAST VISIT

同时，该报告还建议：在今后的五年内，将“对新成立的公司和企业给予特别优惠”（即“特区”）的范围扩大到整个中国。

¹⁰ In addition to his personal library, James A. Garfield also had a large collection of books at the U.S. Capitol. These included the works of George Washington, Abraham Lincoln, and other presidents, as well as a large collection of historical documents and manuscripts.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14048

Office: (716) 725-0824

Fax: (716) 725-0165

Client Name: Danielle Harwell Date: 8/15/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Shoulder feels better since massage; neck and upper traps not as hypertonie. LB + QM mm. Better. Neck soft decreases after massage and movement. Feels worse.

Action's Applied: (Check All that Apply) when resting

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat Ice / Heat Ice / Heat

Therapist: Melanie

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14048

Office: (716) 725-0824

Fax: (716) 725-0165

Client Name: Danielle Harwell Date: 8/18/17Client Status: (Circle) Better Progressing Worse Same/No Change
6/6 NeckPain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R/L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Neck mm still tight w/ l. Rom. and dizziness at times. Walked @ 5cm w/ fraction to cen. mm. @ LB walk from glutes, hips, QLs, hamstrings, fo.

Action's Applied: (Check All that Apply) hips glutes

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat Ice / Heat

Therapist: Melanie

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 8/20/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Neck slightly better. Still from neck to L5. Deltoids +
scm hypertonicity here too (5)
to L5. Al tightness calc g/fates

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombrolene/Freeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat

Therapist: Danielle HarrellDanielle Harrell

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0624

Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 8/20/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: MB between scapula's really tight @ brachline & just above cervical
more hypertonie esp c except L5

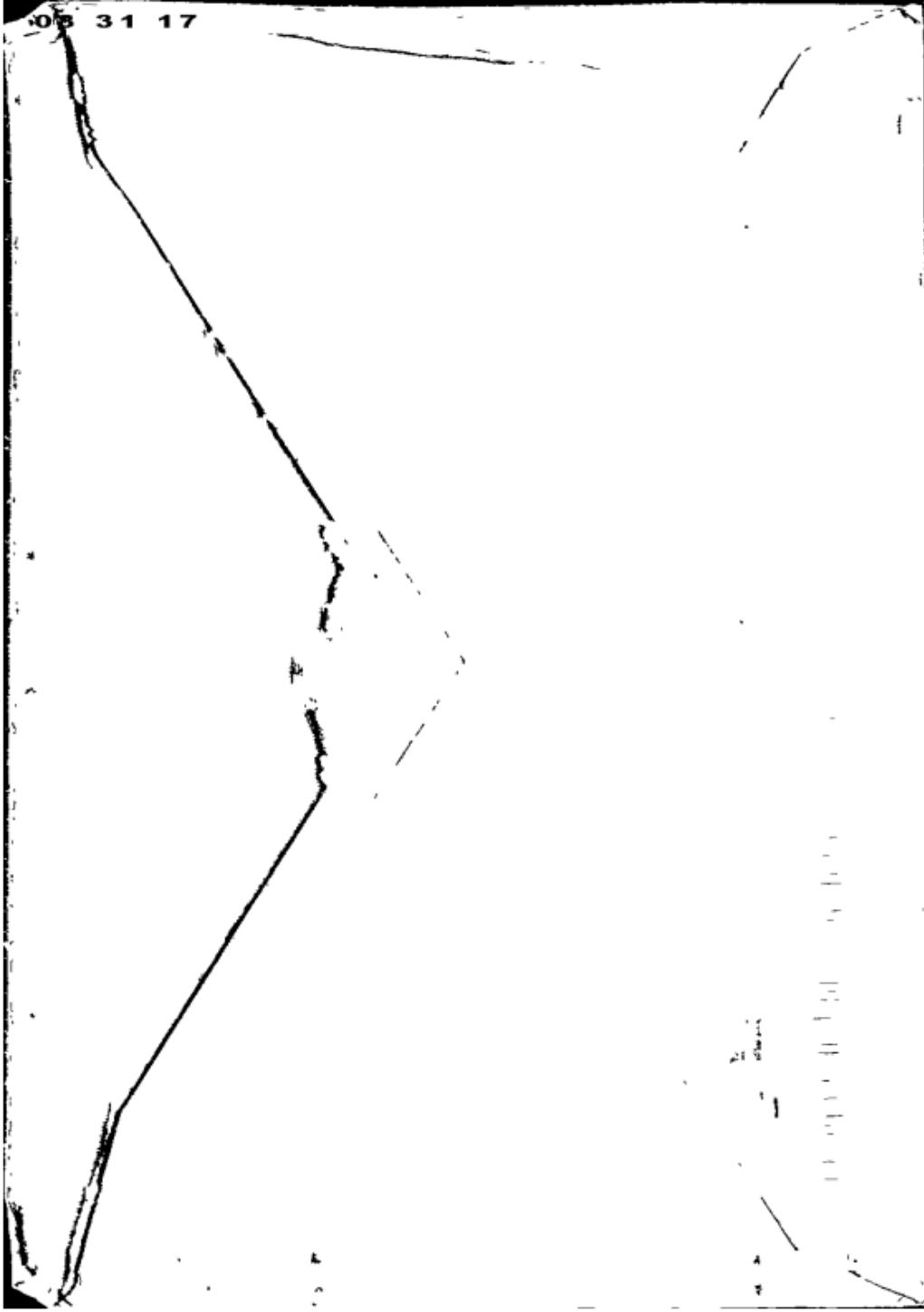
Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombrolene/Freeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

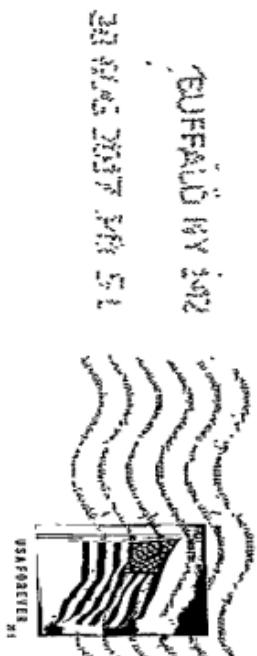
- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Don't Meds Ice / Heat

Therapist: Danielle HarrellDanielle Harrell



Great Lakes Therapeutic Massage

Colleen Marx, LMT
375 Dick Road, Suite #2
Buffalo, NY 14043



GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

N240G-152607



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

HICPA

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

013873940 0101059

PICA

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BUKLING		OTHER		1a INSURED'S ID NUMBER 013873940011059		(For Program in Item 1)							
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (DADsD)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (DAD)		<input type="checkbox"/> (DAD)		<input type="checkbox"/> (DAD)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input checked="" type="checkbox"/> X		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE											
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT													
CITY CHEEKTOWAGA				STATE NY				CITY AMHERST				STATE NY											
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951						ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
b. RESERVED FOR NUCC USE								b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>NY</u> PLACE (State)															
c. RESERVED FOR NUCC USE								c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
d. INSURANCE PLAN NAME OR PROGRAM NAME								10d. CLAIM CODES (Designated by NUCC)															
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																							
SIGNED SIGNATURE ON FILE DATE																							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115								15. OTHER DATE QUAL 454 MM DD YY 111215								16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <input type="checkbox"/> NPI 17b. <input type="checkbox"/> NPI								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))								22. RESUBMISSION CODE ORIGINAL REF. NO															
A M50.222 B I51.26 C I51.27 D I54.12 E S23.3XXA F M99.01 G M99.03 H M99.02 I M99.05 J I54.2 K M54.5 L M54.6								23. PRIOR AUTHORIZATION NUMBER															
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR#		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Enter Unusual Circumstances) CPT/HCPCS		E. MODIFIER		F. CHARGES		G. DAYS OF UNITS		H. SPRT/FRM/PM		I. ID #		J. RENDERING PROVIDER ID #							
08142017		08142017		11		98941		ABCD		32 28 1		NPI		1710014188									
08142017		08142017		11		97010		ABCD		10 53 1		NPI		1710014188									
25. FEDERAL TAX ID NUMBER		SSN SSN		26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT? I/DO NOT WANT MY BILL TO BE MAILED TO ME		28. TOTAL CHARGE		29. AMOUNT PAID		30. Reserved for NUCC Use											
364500165		<input checked="" type="checkbox"/>		343871256		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 42.81		\$ 1													
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and have made a copy thereof.) PETER GOZINSKI DC																							
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849																							
33. BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849																							
SIGNED 08302017 DATE 1235256546								# 1235256546															

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
August 30, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday August 14, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 08/14/2017 at 4:01pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient returned today stating that her neck pain continues, but massage does help. Follow up with Dr. Siddique in November 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, right upper arm, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she has not had a headache since last visit. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; activities of daily living; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back and left posterior thigh pain remains the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, stiff, tight. *Range:* 3->4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain lower neck; extension: WNL 60/60 with no pain; left rotation: 30/80 with pain left lower neck ; right rotation: 45/80 with pain left lower neck ; left lateral bending: 25/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders.

Encounter dated 08/14/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/30/2017

Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive lower neck; maximum right lateral compression: Positive lower neck. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C1, C2, C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Mild to Moderate. **Trigger points:** bilateral rhomboids. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: WNL 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Tenderness & Hypertonicity** lumbar paraspinal bilateral mild to moderate; TFL / ITB left mild to moderate. **Tenderness on palpation:** left SI: mild to moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees. **Spinal subluxation level(s):** L4, L5, Left SI, Right SI. **Subluxations detected by:** motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving, no headaches since last visit. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** unchanged.

Lumbar assessment: unchanged. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Encounter dated 08/14/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 08/30/2017

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x every 2 weeks for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left AS (prone mobilization); Cervical (manual traction); SI right PI (prone mobilization); C1 right lateral flexion restriction (Instrument adjustment Arthrostim); C2 right lateral flexion restriction (Instrument adjustment Arthrostim). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back pm for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to August 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 08/14/2017 at 4:01pm

Abbreviations .

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits



Item# 43568
Patent Pending



09 05 17

\$3.29⁰⁰
US POSTAGE
FIRST-CLASS
0628007459301
14043



030308

09/05/17

MAILING LIST
CUTTING LINE
345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9501
Frederickburg, VA 22403

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FEDERAL EXCELLING (AM) <input checked="" type="checkbox"/> OTHER <input type="checkbox"/>												1a. INSURED'S I.D. NUMBER (For Program in Item 1) 0138739400101059											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE (MM DD YY) 08 29 80				SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE					
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE							
CITY CHEEKTONWAGA				STATE NY				CITY CHEEKTONWAGA				STATE NY											
ZIP CODE 14225				TELEPHONE (Include Area Code) ()				ZIP CODE 14225				TELEPHONE (Include Area Code) ()											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO				11. INSURED'S POLICY GROUP OR FEEA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER Y4 0138739400101059												b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. INSURED'S DATE OF BIRTH (MM DD YY) 08 29 80							
b. RESERVED FOR NUCC USE												d. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) NY				e. OTHER CLAIM ID (Designated by NUCC) Y4 0138739400101059							
c. RESERVED FOR NUCC USE												f. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				g. INSURANCE PLAN NAME OR PROGRAM NAME Geico							
d. INSURANCE PLAN NAME OR PROGRAM NAME												h. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items b, 9a, and 9d</i>											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED Signature On File DATE 8/18/2017												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the underlined physician or supplier for services described below. SIGNED Signature On File											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 15				15. OTHER DATE (MM DD YY) QUAL 439 10 31 15				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DM J PETER GUYINSKI				17a. 17b. 17c.				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD IND 0												22. RESUBMISSION CODE ORIGINAL REF. NO.											
A M51.26		B I M53.3		C M47.816		D L		E DIAGNOSIS POINTERS \$ CHARGES				F G H I J L ID QM. RENDERING PROVIDER ID. #											
E L		F L		G L		H L																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 08 02 17 To 08 02 17												B. PRICE OF SERVICE EMR 99213				C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				E. MODIFIER			
																F. G. H. I. J. \$ CHARGES QM. R. ID QM. L. RENDERING PROVIDER ID. #							
																OB 248830 NPI 1023202355							
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																NPI							
25. FEDERAL TAX ID. NUMBER SSN EN 030445678 <input checked="" type="checkbox"/>												26. PATIENT'S ACCOUNT NO. 102251				27. ACCEPT ASSIGNMENT BY PAYOR YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				28. TOTAL CHARGE \$ 51.54 29. AMOUNT PAID \$ 0.00 30. REND FOR NUCC USE			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER <i>(Please print legibly. Please initial all signatures.)</i> Jafar Siddiqui												32. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery, Inc 180 Park Club Lane, STE 250				33. BILLING PROVIDER INFO & PH# (716) 218-1030 UB Neurosurgery, Inc PO Box 8000 DEPT 883							
SIGNED 8/18/2017 DATE												a. 1306896220 b. 248830				c. 1306896220 d. 248830							



Brett J. Levy, MD, MBA, FACS, FAANS
Gregory J. Castillo, MD, FACS

Ivan M. Berlin, MD, FPMR

John G. Tschabitscher, MD

Karen L. Glazebrook, MD, FRCR, FRANZ

Vincent E. MD

Deborah B. Moreland, MD, FRCR

Susan Meier, MD, MPH

Robert J. Plunkett, MD

John Pollicino, MD, FRCR

Jonathan Ritter, MD

Ronald Royeckoff, MD

Mian H. Siddiqui, MD, PhD, FACS, FAJU

Ronald V. Snyder, MD, PhD

Michael R. Stoecklin, MD, FRCR, FAIRMS

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Asfar H. Siddiqui, MD, FAAPMR, QASPM

Chiropractors

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Sandy Keyser, DC

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Buffalo, NY 14202
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E/M Fax: 716/829-7430 & 7481

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Women & Children's Hospital of Buffalo
215 Bryant Street
Buffalo, NY 14222
716/828-7385

E/M Fax: 716/828-1577

The Park Center
100 Park Chieftain
Williamsville, NY 14221
716/639-9402

E/M Fax: 716/639-3370

3330 Mayfield Road • Suite 3000
(Dr. Michael Steinmann)
Niagara Falls, NY 14201
716/298-1000

E/M Fax: 716/295-8199

Interventional Pain Management
Dr. Asfar H. Siddiqui, Dr. Andrew Wong
150 Park Chieftain
Suite 250
Williamsville, NY 14221
716/218-1088

E/M Fax: 716/218-1079

August 2, 2017

James Panzarella DO
1208 Niagara Falls Boulevard
Tonawanda, NY 14150

Patient Name: Danielle Harwell
Date of Birth: 08/29/1980
No-Fault Carrier: NF Geico
CL#: 0138739400101059
Date of Injury: 10/31/15

Physiatry Re-evaluation: August 2, 2017

Chief Complaint(s): Neck pain, headaches, low back pain and leg pain.

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle in our Park Club Lane office for re-evaluation on August 2, 2017.

HISTORY/CHIEF COMPLAINT

This is a 36-year-old female presenting today for re-evaluation. She is status post left L5-S1 transforaminal epidural steroid injection with Dr. Siddiqui on June 1, 2017. The patient does state the injection helped with her left leg pain. She reports her relief to be approximately 50%, which is ongoing. This seemed to work better than the previously performed caudal epidural steroid injection. The patient continues to follow with Dent Neurologic Institute for chronic headaches. She recently underwent an occipital nerve block for headache flare-up and is currently on a Medrol Dosepak for this. She also utilizes occasional naproxen. She reports naproxen is no longer effective at treating her back pain and is inquiring about other medications to take. She continues with chiropractic care and medical massage therapy as well. She rates her pain between 3 and 4 out of 10 on the visual analog scale most days. Standing, lifting and walking aggravate her pain and lying down and also keeping active help. She denies unsteady gait, electric-shock sensations, bowel or bladder dysfunction or weakness.

Review of systems is notable for numbness, tingling, headaches and joint pain.

PHYSICAL EXAMINATION

BP Sitting: 125/85 **Pulse:** 80 **Resp:** 16 **Ht:** 63" **Wt:** 200lb **BMI:** 35.4

General: This is a 36-year-old female, in no acute distress. She is awake, alert and appropriate. Speech is fluent and coherent.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are

pink and moist.

Cardiovascular: Normal S1, S2.

Abdomen: Obese, non-distended.

Neuromusculoskeletal: The patient demonstrates well-preserved strength throughout the lower extremities. Sensory examination is intact to light touch throughout. She demonstrates symmetric muscle bulk and tone without spasticity or rigidity. Straight leg raise sign is negative. Patrick testing is negative. She ambulates with a non-antalgic gait.

Psychiatric: Judgement and cognition are within normal limits.

ASSESSMENT

M51.26 - Other intervertebral disc displacement, lumbar region, M53.3 - Sacrococcygeal disorders, not elsewhere classified, M47.816 - Spondylosis without myelopathy or radiculopathy, lumbar region

IMPRESSION/RECOMMENDATIONS:

This is a 36-year-old female with low back pain and left leg pain in the setting of multi-level lumbar degenerative disc disease and spondyloarthropathy with disc bulges/herniations L4-5 and L5-S1. I will introduce ibuprofen to be used in lieu of naproxen for her low back pain. We discussed potentially trying a muscle relaxant or gabapentin, although the patient is a caregiver to her three young children and husband, so this may be a factor in utilizing a medication such as this. We will hold off from further interventions at this time, but we may consider a repeat procedure as clinically warranted. The patient will return to the office in 3-4 months or sooner as clinically warranted.

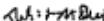
The patient was advised today regarding treatment with the above named medication(s). The risks, benefits, common side effects and alternative treatments were discussed with the patient. The patient verbalized understanding and was told to call with any concerns.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

Sincerely,



Electronically signed by Sarah O'mara, PA-C on 08/21/2017 at 8:13 am
Sarah O'mara, PA-C



Electronically signed by Jafar Siddiqui, M.D. on 08/21/2017
Jafar Siddiqui, M.D.

SO/abb

cc: Peter Guzinski DC

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

fjfp

**GEICO INSURANCE - NE
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403**

XXX PICA

PICA XXX

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FECA) <input checked="" type="checkbox"/> (Other)												14. INSURED'S ID. NUMBER 0138739400101059 (For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE 08 29 1980 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>							
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DR												6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							
CITY CHEEKERTOWAGA			STATE NY			8. RESERVED FOR NUCC USE			CITY CHEEKERTOWAGA			STATE NY							
ZIP CODE 14225-1257			TELEPHONE (Include Area Code) ()						ZIP CODE 14225-1257			TELEPHONE (Include Area Code) ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												b. OTHER CLAIM ID (Designated by NUCC) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
c. RESERVED FOR NUCC USE												c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d. RESERVED FOR NUCC USE												11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 10/31/15							
e. INSURANCE PLAN NAME OR PROGRAM NAME												12. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>							
f. INSURANCE PLAN NAME OR PROGRAM NAME												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorizes segment of medical benefit to the undersigned physician or supplier for services described below.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorizes the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												14. SIGNATURE ON FILE DATE 02 09 16 15. SIGNATURE ON FILE							
SIGNED PETER J GUZINSKI			DATE 02 09 16			SIGNED PETER J GUZINSKI			DATE 02 09 16			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY) 09 17			15. OTHER DATE QUAL. 439 10 51 15			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE PETER J GUZINSKI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
16. DATES OF REFERRING PROVIDER OR OTHER SOURCE DN			17a. 1G U62607			17b. 1710014188			19. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			20. CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD IND. 0												22. RESUBMISSION CODE EI ORIGINAL REF. NO.							
A. M791			B. I			C. L			D. L			23. PRIOR AUTHORIZATION NUMBER							
E. I			F. L			G. L			H. L			24. A. DATE(S) OF SERVICE From 09 08 To 09 08 MM 09 DD 17 YR 17 B. PLACE OF SERVICE 20553 C. CPT/HCPCS 1699588 D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727 E. MODIFIER A F. D. DAYS CHRG UNITS 95 74 G. I. ID. QUAL. EI 161582336 H. REND. PROVIDER ID. # NPI 1649596495							
25. FEDERAL TAX ID. NUMBER 161582336												26. PATIENT'S ACCOUNT NO. 1699588 27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 95 74 29. AMOUNT PAID 0 00 30. Reserved for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof) JENNIFER W MCVIGE, MD												32. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727				33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002			
34. DATE 09 15 17												35. SIGNATURE *1497850911				36. SIGNATURE *1497850911 EI 161582336			



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Christopher Zaleski, FNP-C

Sydney B. Grabau, PA

Procedure Note

Date: 09/08/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 37 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Migraines, trigger points. Shoulder and neck pain

History of Present Illness

General:

The patient has migraine headaches, cervicalgia and associated trigger points. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine and bupivacaine. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. Patient tolerated the procedure.

Patient has had trigger point injections with good results in the past. She tried to go 2 months between injections, and unfortunately has seen an increase in neck pain. She is considering decreasing the amount of massage therapy in her current regimen, she feels quite overloaded with appointments at the moment. She states the occipital block 2 weeks ago was quite helpful for her headache. She is also currently titrating onto Topamax.

Current Medications

- Taking nortriptyline 10 mg capsule 2 cap(s) orally QHS
- Taking Medrol Dosepak 4mg tablet as directed orally on package
- Taking Topamax 25 mg tablet 1 tab(s) orally Take 1 QHS x 1 week; Increase to 1 tab in AM & 1 tab in PM x 1 week; Increase to 2 tabs AM & 2 tabs PM x 1 week
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 iu units capsule 1 cap(s) orally once a day
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours. MDD = 2, MWD = 3
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

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ADMINISTRATIVE SUPPORT

Gregory Cook, Client Manager
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Kaitlin Bevier

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INFUSION CENTERS

Christina Massi, MBA, Director

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- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed: Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches.

Vital Signs

BP sitting 118/74, HR 76, RR 16, Ht 63, Wt 236.8, BMI 41.94, BSA 2.18.

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Gregory Cook, Clinic Manager
 Amanda McFayden, Manager
 Katrina Bowar
 Ashley Heerlives
 Katie Kraft
 Alise Thielinski

INFUSION CENTERS

Christine Mann, MBA, Director

Examination**Neurological:**

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

No notable rash or lesions visualized at the area of injection sites.

Assessments

1. Myofascial pain - M79.1 (Primary)

Continue all previously prescribed medicines at the current doses.

The patient is to continue with the current treatment plan.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures**Injections:**

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezieli and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 09/08/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 09/08/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 09/08/2017.

Follow Up

4 Weeks

from Dr. Harwell

J

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INFUSION CENTERS

Christine Marie, MBA, Director

Patient: Harwell, Danielle | DOB: 08/29/1980 | Procedure Note

Page 4 of 4

Electronically signed by Sydney Grabau , PA on 09/08/2017 at 10:06 AM EDT**Sign off status: Completed**

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL, UNIFORM CLAIM COMMITTEE (NUCC) 08/12

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PICA

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
September 13, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday August 28, 2017 Provider: Peter Guzinski DC RE-EXAM

Electronically signed by Peter Guzinski DC on 08/30/2017 at 1:15pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Follow up with Dr. Siddique for pain management is in November 2017. Due to the pain, she is unable to lift heavy weights, she has slight headaches which come frequently, she has a fair degree of difficulty with concentrating, she can do most of her usual work, but no more and her sleep has been moderately disturbed (1-2 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* worse. *since last re-examination on June 12, 2017.* *Pain:* achy, dull, sharp, tingling, shooting; level: 5/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, but they no longer last all day. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Cervical Disability Index:* 36%. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* worse.

**Encounter dated 08/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/13/2017**

since last re-examination on June 12, 2017. **Pain:** achy, dull, sharp, shooting; level: 5/10. **Pain is frequent.** **Exacerbates symptoms:** movement; bending; lifting; reaching; activities of daily living. **Alleviates symptoms:** nothing. **Numbness:** none. **Weakness:** none. **Oswestry score:** 32%.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. Due to the pain, she is unable to lift heavy weights, she is unable to walk greater than 1 mile, she is unable to sit greater than 60 minutes, she is unable to stand greater than 60 minutes and she is unable to travel on journeys greater than 2 hours. **Onset:** October 31, 2015. **Cause of symptoms:** MVA, rear impact. **Prior low back pain:** none. **Changes in this condition:** worse. *since* last re-examination on June 12, 2017. **Pain:** achy, dull, sharp, shooting, tingling; level: 5/10. **Pain is frequent.** **Pain radiates to:** left posterior thigh and leg. **Exacerbates symptoms:** driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. **Alleviates symptoms:** chiropractic care; massage. **Numbness:** none. **Weakness:** none. **Bowel or bladder incontinence:** No. **Recent infection or fever:** No. **Night sweats or pain:** No. **OSWESTRY Disability Index:** 32%. **The Keele STarT Back Screening Tool:** Low risk. **Recent medical treatment for this condition:** Massage therapy. **Changes in past medical history:** None.

Activity of Daily Living Form Bathing/Showering: no impairment; Bending forward/backward: moderate impairment; Brushing teeth: no impairment; Buttoning shirt: no impairment; Driving: mild impairment; Drying Hair: mild impairment; Household chores: mild impairment; Laundry: moderate impairment; Lifting less than 10 lbs: mild impairment; Lifting more than 10 lbs: moderate impairment; Kneeling: mild impairment; Making Meals: mild impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: mild impairment; Restful night's sleep: no impairment; Seated to standing position: mild impairment; Sexual activity: mild impairment; Standing: mild impairment; Squatting: mild impairment; Taking out the trash: not performed; Tying shoes: mild impairment; Using lavatory: no impairment; Walking: no impairment.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain left lower neck; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. **Posture:** rounded shoulders. **Strength:** all upper extremity musculature (C5-T1) were WNL and graded 5/5. **Sensation:** all upper extremity sensory exams (C5-T1) were WNL to Pin prick. **Hypertonicity & Tenderness:** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Reflexes:** bilateral upper extremity reflexes (C5, C6, C7) 2+. **Orthopedic tests:** left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness:** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Encounter dated 08/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/13/2017

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with no pain; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Heel to toe walking:* WNL. *Gait pattern:* normal. *Strength:* all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. *Sensation:* all lower extremity sensory exams (L1-S1) were WNL to Pin prick. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Reflexes:* bilateral lower extremity reflexes (L4 and S1) 2+. *Orthopedic tests:* Patrick's Fabere: Positive left for lower back pain; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative; Minor's sign: Negative; Slump Test: Negative bilateral; Spinal Percussion L1-L5: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for lower back pain on a cough or sneeze. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-examination on June 12, 2017 her neck condition has regressed. Her active cervical flexion decreased from 50 to 40 degrees and left rotation decreased from 60 to 45 degrees. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL, improve active cervical ROM to WNL and to decrease the frequency and intensity of headaches. *Diagnosis:* M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last re-examination on June 12, 2017. She is now able to sit 30 minutes and travel 60 minutes longer with less pain. Further treatment is medically necessary to help improve her active lumbar ROM to WNL and improve her ability to sit, stand, bend, perform household chores and lift with less pain. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Encounter dated 08/28/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/13/2017

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x every 2 weeks for 8 weeks; Re-examination for 8 weeks. *Visit number* 1 of 4. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit and stand longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 08/30/2017 at 1:15pm

Abbreviations:

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

09 18 17



Item# 43568
Patent Pending



09.18.17



Geico
P.O. BOX 9507
Fredericksburg, VA 22403

345 Dick Rd.
Depew, NY 14043



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GRICO INS CO NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA													
1. MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TRICARE <input type="checkbox"/> DOD/DoD	CHAMPVA <input type="checkbox"/> Member/ID	GROUP HEALTH PLAN <input type="checkbox"/> (N/A)	FECA EXCLUDED <input type="checkbox"/> (N/A)	OTHER <input type="checkbox"/> (N/A)	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 013873940-0101-059						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY 08 19 1980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) - 84198 -						
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)							
56 BERBEAVER DR CITY AMHERST ZIP CODE 14228		STATE NY	8. RESERVED FOR NUCC USE X			CITY STATE		ZIP CODE ()			TELEPHONE (Include Area Code) (716) 536-0951		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <u>INJY</u>			a. INSURED'S DATE OF BIRTH MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F				
b. RESERVED FOR NUCC USE			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)							
d. RESERVED FOR NUCC USE			10e. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME							
d. INSURANCE PLAN NAME OR PROGRAM NAME						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			If yes, complete items 9, 9a, and 9d				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													
SIGNED <u> </u> ON FILE <u> </u>			DATE 01-06-2016			SIGNED <u> </u> ON FILE <u> </u>			DATE 01-06-2016				
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 1-0-31-2015 QUAL: <u> </u>			15. OTHER DATE QUAL: <u> </u> MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA			17a. <u> </u> 17b. NPI: <u> </u>			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO			5 CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-H to service line below (SME))			ICD IND: <u> </u>			22. RESUBMISSION CODE			ORIGINAL REF NO				
A. <u> </u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>				
24. A. DATES OF SERVICE From MM DD YY To MM DD YY			B. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS			E. DIAGNOSIS MODIFIER PONTER			F. S CHARGES	G. DATES OR UNITS	H. RSP PER UNIT FEE	I. ID OR NAME	J. RENDERING PROVIDER ID #
1 09-01-17-09-01-17-11	87340								55-00-00-3			MPI	1344465201-1
2 09-11-17-09-11-17-11	87340								55-00-00-3			MPI	1344462011
3 												MPI	
4 												MPI	
5 												MPI	
6 												MPI	
25. FEDERAL TAX I.D. NUMBER 47-0989449	SSN BIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. HARWELL, D	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 110-00	29. AMOUNT PAID \$ 0-00	30. RES FOR NUCC USE 110-00							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043			33. BILLING PROVIDER INFO & PH # 716-725-0264			GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043				
COLEEN MARX, INT SIGNED DATE			a. 1144462011 b. 1144462011			a. 1144462011 b. 1144462011							

BECAUSE THIS FORUM IS USED BY VARIOUS COUNTRIES AND TERRITORIES OF THE UN, DISCUSSIONS WHICH PROVE SENSITIVE AND/OR WHICH ARE INAPPROPRIATE, NOTICE: Any person who knowingly files a document containing open or closed source code, including, but not limited to, programming information may be guilty of a criminal act punishable under laws and may be subject to criminal action.

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MEDICARE AND TERCARE PAYMENTS. A practice is permitted to bill Medicare for services provided to a patient who is also receiving Tercare payments. The physician must bill Medicare first and then bill Tercare separately. The physician may bill Medicare and Tercare simultaneously if the physician has obtained a waiver from the state Medicaid program. See 42 CFR 431.202.

$\hat{S}_{\text{max}} = 0.48 \pm 0.01$ J/K²

The probability mass function of the total reward until t is given by $P_{\pi}(S_t = s, R_t = r | S_0 = s_0, \pi)$.

In addition to the above-mentioned potential sources of error, there are other factors which may contribute to the observed differences between the two data sets. The first is the difference in the time period over which the data were collected. The second is the difference in the sampling methods used to obtain the data. The third is the difference in the way the data were analyzed.

$P_{\text{c}} = \text{TRU/RE}$ where TRU is the total number of true events and RE is the total number of reconstructed events.

With Part B Medicaid benefits, many low-income individuals are eligible for a range of services, including home and community-based services.

807 TCE Any one, whose remuneration or funds exceed the maximum limit of Rs. 10,000/- per annum, shall be liable to pay a sum equivalent to four times his/her remuneration.

NO FEE TO PATIENT ABOVE THE COLLEGE FOR MEDICAL AND DENTAL STUDENTS IN THE STATE OF NEW YORK. MEDICAL SERVICES ARE PROVIDED FREE.

TPM information (e.g., status examples, clear under-hood arguments, etc.) will be given to members over email, but full details of discussions and responses can be found in these minutes and in emails that would come in the file.

The information may then be given to other providers of care, such as a physician, hospital, or dental office, or to Federal agencies, or to the Office of Personnel Management that may utilize it. Information is usually given orally or in writing, and an off-the-record note can be taken for these programs. For example, many programs do not discuss information about a hospital stay because it is believed that the information is best kept in a system of records.

FOR MEDICARE CLAIMING: See the separate instruction booklet (or, if 70-0911, when Case 17-C-1000, James Bond), published in the Federal Register, Vol. 65 No. 197, page 37549, West, Sept. 12, 1990, as so titled, and amended.

¹⁰ See TONKIN, CLAUSES PÉNALISATRICES, QUOTATION IS-103. As mentioned, Article 4 of the Act, as amended by Law No. 103, provides that the Act "is intended to combat serious organized crime, and to combat serious forms of illegal conduct of individuals and

the distribution of the scores of the eight-point cumulative index of life.

DISCLAIMERS: Patients are responsible for paying the bill to their insurance company and for payment of claim costs. If services are provided by a third party, payment is the responsibility of the third party.

It is mandatory that you tell us if you know that another entity - especially the person before him (§ 2, dm. 110B) of the fiscal bottom line (§ 31 USt, 3801-3812 provide penalties for withheld taxes without a reason).

Some off-cut fibre, section B-3, 100-200 nm thick was used for electron microscopy (Fig. 1c). The sections were stained with uranyl acetate and lead citrate.

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I therefore agree to keep such records as are necessary to claim fully the tax credit of \$1,000 per year which I am entitled under the Statute Title XIII plan and to file a claim for such amount as claimed for providing such services as have been rendered on Dec. 31 of the taxable year 1990.

I further agree to pay up, as payment in full, the amount unpaid by the C.I. and paid jointly, as well as interest on payment under this Agreement, with the exception of refundable deductible insurance, no payment or similar cash-flowing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above are
safe, effective, and in accordance to the needs of the patient and were generally furnished by
me or my associates.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and/or diversion of the grant will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of such shall be made, are illegal and subject to legal action, including forfeiture.

According to the Drug-Free Workplace Act of 1995, no person in a management position shall be responsible for causing a willful violation of this provision. The Head OHSI controls the following information collection: 1986-1997. This information contains sensitive information about your organization. It is important to protect it from unauthorized access, and using the laws in the area of information security, we are working to ensure that this information remains secure. If you have any questions, or to request the release of the time period covered by this request, please contact OHSI, 22nd Street East, Suite 100, P.O. Box 1000, Baltimore, Maryland 21202-1000. The address is for comments and other correspondence. Call 301-549-1000, fax 301-549-1000, or e-mail OHSI@DOD.DOD.MIL.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0224

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 9/11/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

"Sore from neck to lower back."

Specific: Sacrum & attached mm very tight esp. @ QLs and glutes. With tight C. scapital ridge into Cerv. mm to upper traps.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Rinfroze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Myof.

Great Lakes

Therapist: Therapeutic Massage

NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0224

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 9/11/17

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 Numbness Tingling ↓ Strength Inability to Sleep
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 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client stated "really bad today."

Had to cancel last appointment due to hospitalization. Neck, L8 all really sore and tight

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Rinfroze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Myof.

Great Lakes

Therapist: Therapeutic Massage

NYS Licensed Therapist

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09 18 17

Great Lakes Therapeutic Massage

Colleen Marx, LMT

375 Dick Road, Suite #2

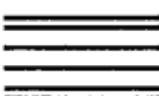
Buffalo, NY 14203

BUFFALO

NY 142

15 SEP '17

FRI 11



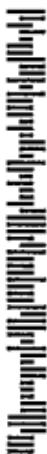
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FREDERICKSBURG VA 22403-9527





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

100% FSC

P10A-✓

1. MEDICARE	2. MEDICAID	3. TRICARE	4. CHAMPVA	5. GROUP MEMBER	6. BIRTH PLAN (PBM)	7. PEC (PBM)	8. OTHER (PBM)	9. INSURED'S ID NUMBER (For Program at Item 1)			
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD/DoD)	<input type="checkbox"/> (Member ID#)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	0138739400101059			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY			SEX M F X		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARWELL, DANIELLE			08 29 1980 M F X					HARWELL, DANIELLE			
5. PATIENT'S ADDRESS (No, Street)			6. PATIENT RELATIONSHIP TO INSURED					7. INSURED'S ADDRESS (No, Street)			
1131 CLEVELAND DR			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					1131 CLEVELAND DR			
CITY CHEEKTONWAGA		STATE NY		8. RESERVED FOR NUCC USE			CITY CHEEKTONWAGA		STATE NY		
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()					ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR PECB NUMBER					
			a. EMPLOYMENT? (Current or Previous)			DOI 10/31/15					
			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. INSURED'S DATE OF BIRTH MM DD YY					
			b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			c. OTHER CLAIM ID (Designated by NUCC)					
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			d. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM									If yes, complete items 9, 9a, and 9d		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below		
SIGNED SIGNATURE ON FILE									SIGNED SIGNATURE ON FILE		
DATE 02 09 16											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY Q391			15. OTHER DATE MM DD YY Q391 439 10 31 15			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN PETER J GUZINSKI			17a. LGI U62607 17b. NPI 1710014188			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below [24d]) ICD IND A M791 B C D E F G H I J K L									21. RESUBMISSION CODE ORIGINAL REF NO		
22. PRIOR AUTHORIZATION NUMBER									F. G. H. I. J. RENDERING PROVIDER ID #		
23. FEDERAL TAX ID NUMBER SSN EM									FBI 161582336 NPI 1649596495		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 09 08 17 * 09 08 17 11 20553									G. DATES OR UNITS CHARGES 95 74 1		
25. PATIENT'S ACCOUNT NO 1699588									H. DIRECT FEE OR QUAL I. ID QUAL J. RENDERING PROVIDER ID #		
26. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									B. TOTAL CHARGE \$ 95 74		
27. BILLED BY PHARMACY, SEE BELOW									C. AMOUNT PAID \$ 0 00		
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEBTS OR CREDITS & certify that the statements on the reverse apply to the bill and are made a part thereof: JENNIFER W MCVIGE, MD									29. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002		
30. SIGNATURE 09 15 17									31. SERVICE FACILITY LOCATION INFORMATION DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727		
32. SIGNATURE *1497850911 b									33. BILLING PROVIDER INFO & PH# (716) 2502010 DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002		
34. SIGNATURE SIGNED DATE									35. SIGNATURE *1497850911 FBI 161582336		

NJCC Instruction Manual available at: www.njcc.org

PLEASE PRINT OR TYPE

BD61652 APR

DRAFT OMB-0938-1197 EOBM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if it is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, and 2) they must be an integral, although incidental part of a covered physician service; 3) they must be of lends commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1882, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (8), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 801 et seq; and 30 USC 801 et seq, 30 USC 813; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carmer Medicare Claims Record," published in the Federal Register, Vol. 65 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 65 No. 40, Wed Feb. 28, 1990, See ESA-6, ESA-6, ESA-12, ESA-15, ESA-30, or as updated and republished

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988," permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under this program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1187. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-08-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 0472
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 09/18 07:14
 TX/RX TIME 01' 06
 PCS. 5
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

NUCC PICA

GEICO INSURANCE - NF NY PIP CLAIMS POBOX 9507 FREDERICKSBURG VA 22403											
(For Progress in Item 1)											
CARRIER											
<p>1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> HEALTH PLAN <input type="checkbox"/> PCDA <input type="checkbox"/> BUSINESS <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (DN)</p> <p>2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARRELL, DANIELLE 08 29 1980 M <input checked="" type="checkbox"/> HARRELL, DANIELLE</p> <p>5. PATIENT'S ADDRESS (No., Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DR Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 1131 CLEVELAND DR</p> <p>CITY STATE CITY STATE CHEEKTONWAGA NY CHEEKTONWAGA NY</p> <p>ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (Include Area Code) 14225-1257 () 14225-1257 ()</p> <p>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR PCDA NUMBER HARRELL, DANIELLE DO 10/31/15</p> <p>12. OTHER INSURED'S POLICY OR GROUP NUMBER 13. EMPLOYMENT? (Current or Previous) 14. INSURED'S DATE OF BIRTH 15. OTHER CLAIM ID (Designated by NUCC)</p> <p>15. AUTO ACCIDENT 16. PLACE (State) MM DD YY MM DD YY SEX <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 17. AUTO ACCIDENT 18. OTHER CLAIM ID (Designated by NUCC)</p> <p>19. OTHER ACCIDENT 20. OUTSIDE LAB? 21. INSURANCE PLAN NAME OR PROGRAM NAME <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO 22. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 23. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorizes payment of medical benefits to the undersigned physician or supplier for services described below.</p> <p>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of my medical or other information necessary to protect this claim. I also request payment of government benefits shall be equal to the party who accepts assignment below.</p> <p>SIGNATURE ON FILE DATE 02 09 16 SIGNATURE ON FILE</p> <p>14. CODES OF CURRENT ILLNESS, INJURY, OR PREGNANCY (ICD-9-CM) 15. OTHER DISEASES 16. DISABLED PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 001 00 VS QM 439 10 MM 91 15 Y FROM TO QML 439 10 MM 91 15 Y FROM TO</p> <p>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES DR. PETER J GUZINSKI LG U62607 MM DD YY MM DD YY 17B. NPI 1710014188 FROM TO</p> <p>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? 21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY 22. REPORT SUBMISSION Relate A to service line below (24E) ICD Ind. <input type="checkbox"/> CODE ORIGINAL REF. NO. A. M791 B. I. C. D. L. E. F. H. L. 23. PRIOR AUTHORIZATION NUMBER</p> <p>24. A. DATES(R) OF SERVICE B. PLACER OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. F. G. H. I. J. From MM DD YY To MM DD YY Place of Service FMS Procedures Services or Supplies Diagnosis Pointer Charge \$ Chances Date of Service On Same Day Ref ID. RENDERS PROVISIONS 1.8 1 09 08 17 09 08 17 11 20553 A 95 74 1 NPI 161582336 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100 1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 <</p>											



DENT
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Ajay Akad, MD

Jessica Ambrosini, PA-C

Kerly A. Bonciata, PA-C

Abbey Bedick, PA-C

Hillary L. Gend, PA-C

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Yashin Harsh, MD - Fellow

Megan Kuschke, PA-C

Cheryl L. Lyons, APRN

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Rachel Pernica, PA-C

Maria Rizzo, PA-C

Gretz T. Schuster, FNP

Christopher Zukowski, FNP-C

Sydney B. Grabau, PA

Procedure Note

Date: 09/08/2017

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 37 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- Migraines, trigger points Shoulder and neck pain

History of Present Illness

General:

The patient has migraine headaches, cervicalgia and associated trigger points. The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine and bupivacaine. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. Patient tolerated the procedure.

Patient has had trigger point injections with good results in the past. She tried to go 2 months between injections, and unfortunately has seen an increase in neck pain. She is considering decreasing the amount of massage therapy in her current regimen, she feels quite overloaded with appointments at the moment. She states the occipital block 2 weeks ago was quite helpful for her headache. She is also currently titrating onto Topamax.

Current Medications

- Taking nortriptyline 10 mg capsule 2 cap(s) orally QHS
- Taking Medrol Dosepak 4mg tablet as directed orally on package
- Taking Topamax 25 mg tablet 1 tab(s) orally Take 1 QHS x 1 week; Increase to 1 tab in AM & 1 tab in PM x 1 week; Increase to 2 tabs AM & 2 tabs PM x 1 week
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 iu/ml units capsule 1 cap(s) orally once a day
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14227 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

ADMINISTRATIVE SUPPORT

Gregory Cook, Clinic Manager
Amanda McFaydes, Manager
Kaitrina Bowser
Ashley Herren
Katie Kraft
Alice Trzaski

INFUSION CENTERS

Christine Mann, MBA, Director

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke
 Mother: alive, Asthma
 Siblings: alive
 1 brother(s) - healthy.

Social HistoryTobacco Use:

Smoking: Patient is a. non smoker.

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol

Illicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed. Stay at home mom.

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches.

Vital Signs

BP sitting 118/74, HR 76, RR 16, Ht 63, Wt 236.8, BMI 41.94, BSA 2.18.

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 Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

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 Amanda McFayden, *Manager*
 Katrina Bower

Ashley Hemmen
 Katie Kraft

Ailee Trzaski

INFUSION CENTERS

Christine Mann, MBA, *Director*

Examination**Neurological**

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions

No notable rash or lesions visualized at the area of injection sites

Assessments

1. Myofascial pain - M79.1 (Primary)

Continue all previously prescribed medicines at the current doses

The patient is to continue with the current treatment plan.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly

Dr. McVige is the supervising physician on site.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Procedures**Injections:**

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living. Patient counseled on the importance of healthy lifestyle. 09/08/2017.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 09/08/2017.

Exercise: Patient counseled on importance of moderate physical activity daily. 09/08/2017.

Follow Up

4 Weeks

from Dr. Harwell

J

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Katrina Bower
Ashley Henven

Katja Kraft
Alice Trzaski

INFUSION CENTERS

Christine Mann, MBA, Director

Electronically signed by Sydney Grabau , PA on 09/08/2017 at 10:06 AM EDT
Sign off status: Completed

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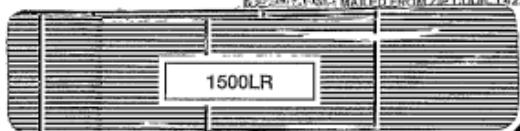


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**INSURANCE CLAIM
FORMS ENCLOSED**

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0212

GRICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (TRICARE) (CHAMPVA) (Group Health Plan) (FECA) (Other)												1a. INSURED'S I.D. NUMBER (For Program in Item 1)					
												013873940-0101-059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE SEX MM DD YY M F X					
												4. INSURED'S NAME (Last Name, First Name, Middle Initial) - SAME -					
5. PATIENT'S ADDRESS (No., Street) 56 BEEBEHAVEN DR												6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X		CITY		STATE									
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE		TELEPHONE (Include Area Code) - ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
												b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO [NY]					
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
d. INSURANCE PLAN NAME OR PROGRAM NAME												10e. CLAIM CODE(S) (Designated by NUCC)					
												11. INSURED'S POLICY GROUP OR FECA NUMBER					
												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					
												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.					
SIGNED = ON P.T.F. 2 =												DATE 01-06-2016					
												SIGNED = ON P.T.F. 2 =					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY) 10-31-2015			15. OTHER DATE QUAL QUL			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRAHAM, PA			17a. 17a. [NP]			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e))												22. RESUBMISSION CODE ORIGINAL REF NO					
A [X]79-1	B _____	C _____	D _____	E _____	F _____	G _____	H _____	I _____	J _____	K _____	L _____	23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPYHCPGS			C. MODIFIER			E. DIAGNOSIS POINTERS			F. \$ CHARGES	G. DAYS IN UNITS	H. AMOUNT PER UNIT	I. ID CAMP.	J. RENDERING PROVIDER ID #	
1 09-18-17-09-18-17-11												55-100-3				NPI 1144462011	
2 09-22-17-09-23-17-11												55-100-3				NPI 1144462011	
3 																NPI	
4 																NPI	
5 																NPI	
6 																NPI	
25. FEDERAL TAX I.D. NUMBER 47-0989449			26. PATIENT'S ACCOUNT NO. HARWELL, D			27. ADJUST ASSIGNMENT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			28. TOTAL CHARGE \$ 110.00			29. AMOUNT PAID \$ 0.00		30. Rev'd for NUCC Use \$ 110.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this form apply to this Bill and are made a part thereof.) COLLEEN MARK, LMZ												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPTW, NY 14043			33. BILLING PROVIDER INFO & PH# 716 725-0264		
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPTW, NY 14043					

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AGENCIES, IT MAY NOT BE APPROPRIATE FOR SOME PURPOSES. ITS USE SHOULD BE APPROVED BY AN ATTORNEY OR OTHER PROFESSIONAL.

NOTICE: Any person who tamperingly alters, erases or omits any information from this document or fails to sign it, shall be subject to criminal prosecution for tampering with leading information, as provided by law.

1960, the average age of the population was 29.4 years, and the median age was 25.0 years. The median age of the population in 1960 was 25.0 years, and the median age of the population in 1960 was 25.0 years.

$$d\Gamma/dt = \left(\frac{g^2 m^2}{16\pi^2} + \mu_0^2 \right) \left[1 + \frac{1}{2} \left(\frac{m^2}{\mu_0^2} - 1 \right) \right] \frac{\partial^2 f}{\partial t^2} - \mu_0^2 \partial_t^2 f(t) = \frac{1}{2} \frac{\partial^2 f}{\partial t^2} - \frac{1}{2} \frac{\partial^2 f}{\partial t^2} = 0$$

the first time in the history of the world, the people of the United States have been compelled to go to war to defend their country against a foreign power.

The PEGMA film thickness was determined by the weight loss method. The film thickness was calculated as follows:

DOI: <https://doi.org/10.1007/s00339-018-1000-1> © Springer Nature Switzerland AG 2018

Wing, 2000) and the corresponding Δ values are given in Table 1.

For more information about the study, contact the study coordinator at 1-800-458-6232 or e-mail at studycoordinator@nccih.nih.gov.

The value of a parameter in the model is determined by the value of the parameter in the real system. The value of the parameter in the real system is determined by the value of the parameter in the model. This is a recursive process.

在1995年，中国GDP增长率为12%，而美国仅为2.7%。同年，中国出口总额为1580亿美元，而美国仅为558亿美元。

For a detailed description of the methods used to estimate the parameters of the model, see the technical report by Gómez et al. (2010).

PROBLEMS RELATED TO PROBLEMS IN THE FIELD OF POLYMER SCIENCE ARE AS FOLLOWS: 1) THE PROBLEMS OF POLYMERIZATION AND POLYMER PHYSICS; 2) THE PROBLEMS OF POLYMER CHEMISTRY; 3) THE PROBLEMS OF POLYMER TECHNOLOGY.

1000 m², 100 kg, and 1000 kg, respectively. The first two values are the same as those used by Bazzaz et al. (1986) and the third value is the same as that used by Bazzaz et al. (1986) and Bazzaz & Reich (1993). The latter two values were obtained from the literature. The values of α_{max} and β_{max} were set to 0.001 and 0.0001, respectively.

从以上分析可知， \hat{y}_t 是由 $y_{t-1}, y_{t-2}, \dots, y_{t-n+1}$ 和 $x_{t-1}, x_{t-2}, \dots, x_{t-n+1}$ 通过线性组合得到的。因此， \hat{y}_t 可以表示为一个包含 y 和 x 的向量的线性组合。

Your diagnostic test or treatment: 100-200-3-1 - Diagnostic Test: 100-200-3-1 - Treatment: 100-200-3-1 - Other: 100-200-3-1

Finally, after 10 days of continuous C. elegans feeding, the *gpa-4* mutant was able to move at a rate similar to the wild-type, indicating that the *gpa-4* mutation does not affect the ability of *C. elegans* to move.

Multiple experiments have been carried out to determine the effect of different parameters on the performance of the system.

10. NATURE OF PAYMENT (ORIGINATOR): Enter the name of the institution or organization that made the payment to you or your employer under my personal direction.

According to the *Parliamentary Information Bureau*, a government committee on health care reform has proposed a bill that would expand the number of people covered by Medicaid.

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14205

Office: (716) 725-0824 Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 9/18/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obligues ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R) LIT
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Achy from head to toe. General mm stiffness from cervical up to lumbar region w/ hyperflexion in cervical +

Action's Applied: (Check All that Apply) MB Thoracic mm.

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat Great Lakes

Therapist: Therapeutic Massage

NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners
375 Dick Rd Depew, NY 14205

Office: (716) 725-0824 Fax: (716) 725-0265

Client Name: Danielle Harwell Date: 9/20/17

Client Status: (Circle) Better Progressing Worse Same/No Change
 neck shoulder

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obligues ASIS PSIS
- Lumbar Sacrum Coccyx Hips Glutes (R) LIT
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific Client very sore w/ restricted range on side of neck and shoulder. Tightness down erectors to gluteal glutes on both sides.

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat Great Lakes

Therapist: Therapeutic Massage

NYS Licensed Therapist

09 28 17



09 28 17

Great Lakes Therapeutic Massage

Colleen Marx, LMT

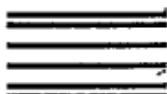
375 Dick Road, Suite #2

Buffalo, NY 14204

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NY 140

23 SEP '17

FN 31



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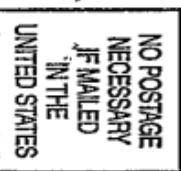
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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/92

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

PICA

1 MEDICARE <input type="checkbox"/> Medicare	MEDICAID <input type="checkbox"/> Medicaid	TIPCare <input type="checkbox"/> TIPCare	CHAMPVA <input type="checkbox"/> Member ID#	GROUP PLAN <input type="checkbox"/> ROM	FECA WORKING <input type="checkbox"/> ROM	OTHER <input type="checkbox"/> PDI	Is INSURED'S ID NUMBER 013873940011059-01059 (For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY 08291980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE			6 PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			7 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR., LEFT	
CITY CHEEKETOWAGA	STATE NY	8 RESERVED FOR NUCC USE			CITY AMHERST	STATE NY	
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951	
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11 INSURED'S POLICY GROUP OR FECA NUMBER 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X	
			b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NY			a. INSURED'S DATE OF BIRTH MM DD YY 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/> X	
			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)	
d INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)			c INSURANCE PLAN NAME OR PROGRAM NAME GEICO	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.							
SIGNED SIGNATURE ON FILE DATE							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115 QMUL 431							
15. OTHER DATE MM DD YY 454 111215							
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI 17b NPI							
18. HOSPITALIZATION/DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
20. OUTSIDE LAB? S CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) A M50.222 B IM51.26 C IM51.27 D IM54.12 E IS23.3XXA F IM99.01 G IM99.03 H IM99.02 I IM99.05 J IM54.2 K IM54.5 L IM54.6							
22. RESUBMISSION CODE ORIGINAL REF NO							
23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMR C. MODIFIER D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) E. DIAGNOSIS CODE F. CHARGES G. DAYS OF H. PRICE PER UNIT I. ID QUAL. J. RENDERING PROVIDER ID #							
1 09122017 09122017 11 98941 ABCD 32 28 1 NPI 1710014188							
2 09122017 09122017 11 97010 ABCD 10 53 1 NPI 1710014188							
3 NPI							
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5 NPI							
6 NPI							
26. FEDERAL TAX ID NUMBER SSN/BIN 28. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? (Check one box) YES NO 28. TOTAL CHARGE 29. AMOUNT PAID 30. Paid for NUCC Use 364500165 <input type="checkbox"/> * 343821258 \$ 42.81 \$							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side of this form are true and correct.) PETER GOZINSKI DC							
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849							
33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849							
SIGNED 09292017 DATE *1235256546* *1235256546*							

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
September 29, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday September 12, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 09/12/2017 at 4:50pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. Follow up with Dr. Siddique for pain management is in November 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting; level: 5/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 3-4 x a week. She states that the duration varies, but they no longer last all day. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling; level: 5/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain left lower neck; extension: WNL 60/60 with no pain; left

Encounter dated 09/12/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/29/2017

rotation: 70/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders.

Hypertonicity & Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: WNL 60/60 with no pain; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal.

Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus.

Orthopedic tests: Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: unchanged. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Encounter dated 09/12/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 09/29/2017

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Treatment schedule: 1x every 2 weeks for 6 weeks; Re-examination for 6 weeks. *Visit number* 2 of 4.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit and stand longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to September 30, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 09/12/2017 at 4:50pm

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
WNL: within normal limits

10 02 17



Item# 43568
Patent Pending



10 02 17

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6/2/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA											
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER (Medicare) (Medicaid) (TRICARE) (Member ID#) (DVA) (VET) (DVA)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE SEX MM DD YY M F HARRELL, DANIELLE 08 29 1960 M F					
4. INSURED'S NAME (Last Name, First Name, Middle Initial) - NAME -											
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
7. INSURED'S ADDRESS (No., Street)											
CITY AMBERT, NY		STATE NY		CITY		STATE					
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		ZIP CODE		TELEPHONE (Include Area Code) ()					
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						9. IS PATIENT'S CONDITION RELATED TO, a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO UNK						a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						b. OTHER CLAIM ID (Designated by NUCC)					
d. INSURANCE PLAN NAME OR PROGRAM NAME						c. INSURANCE PLAN NAME OR PROGRAM NAME					
10. CLAIM CODES (Designated by NUCC)						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 8, 8a, and 9d					
11. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED <u> </u> ON FILE						DATE 01-06-2016 SIGNED <u> </u> ON FILE					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 15. OTHER DATE (MM DD YY) 1-0-21 2015 QUA						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to codes listed below (24E)) ICD IND A <input checked="" type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/>						22. RESUBMISSION CODE ORIGINAL REF. NO					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE ENG C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTERS 1. 09 26 17 09 26 17 12 97140 A 55-100 3 NPI 114462011 2. 09 28 17 09 28 17 11 97140 A 55-100 3 NPI 114462011 3. NPI 4. NPI 5. NPI 6. NPI						F. \$ CHARGES G. DATES OR UNITS H. DRG/PAY PER UNIT I. ID QM/L J. RENDERING PROVIDER ID. #					
25. FEDERAL TAX ID NUMBER SSN EN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						28. TOTAL CHARGE 29. AMOUNT PAID 30. Rev'd for NUCC Use					
47-0989449 <input type="checkbox"/> HARMELL, D						\$ 110.00 \$ 0.00 110.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPTM, NY 14043					
33. BILLING PROVIDER INFO & PH# 716 725-0264						GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPTM, NY 14043					
COLLEEN MARX, LMT 09-29-2017 SIGNED DATE 114462011						S 114462011 b					

NOTICE: Any person who knowingly files a return that is due, or has been filed, before the final due date of the return, in consequence of mailing such return may be guilty of a felony and subject to imprisonment.

1. 1998-02-20 <http://www.123.com/123.htm>, 2001-01-20, 2001-01-20, 2001-01-20.

1.EFEDP AND TANF PAYMENTS: A parent requesting a TANF payment or an EFEDP payment must provide the information previously in Blocks 1 through 12 to the agency in charge of the program. This includes the parent's name and address, the amount and when the payment is to be made, and the reason for the request. The agency will review the Medicaid application and either approve or deny the request. If approved, the agency will issue a TANF or EFEDP payment. If denied, the agency will issue a denial letter. If denied, the parent may appeal the decision by following the procedures outlined in the Uniform Services Information on Medicaid, Section 10, Article 10, Section 10, Part 1, Article 10, Section 10.

W. H. G. 1955-1956

¹See also Körber, 'Arbeitsmarkt und Sozialer Wohnungsbau in der DDR' (1990) 10(1) *Europäische Sozialwissenschaften* 11-20.

ENERGY SUPPLY AND DEMAND IN THE UNITED STATES: A COMPARISON OF THE 1970S AND 1980S

In calculating cash flow for partners, from which the firm's cash flow statement is derived, we must distinguish between cash inflows resulting from sales of products or services, and program invocations, which are available for investment in the firm's own equipment and payment of debts. For this calculation we must take into account all program activities for investment purposes, as well as those that are not directly related to the firm's own equipment. The remaining cash available for investment is the difference between the amount of money received from sales of products and services and the amount spent on equipment purchases.

For TRICARE claims, I further certify that I (or my employer) is the subscriber or carrier, and that I am the duly appointed Uniformed Services member or an employee of the United States Government, civilian or military, and that I (B100-Ba88), the Deck Officer claim, I find it necessary that the services performed were for a Blue Line-related deployment.

No Part B Modules benefits may be paid unless this form is received by the carrier by the due date and requirements of GHI 10489.

NOTICE: Any one who may present or fail to present information to receive payment of Long Term Care Insurance premiums by the Insurer may upon conviction be subject to fine and imprisonment under applicable Provincial laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF PROSTATE, CERVICAL, PELVIC, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We and others did by GATC, HMGME and OWCW to study the role of the nucleic acid in the regulation of the lacZ gene, trpR, CAP, and Pribnow sequences. Authors to whom all correspondence should be addressed are as follows: B. B. B. 1000; M. C. G. 1000; G. G. 1000; and T. S. 1000.

The information you provide to complete forms such as the *Request for an Extended Right-to-Work* and to determine your eligibility to continue to work at the service center or supplier you're calling off.

The information may be relevant to a provider's decision-making process or to a consumer's decision to seek treatment. It also requires that the information be relevant to the consumer's decision to seek treatment. This is equivalent to the concept of "information about the benefit" and is the second element.

FOR MEDICINE OF ANGUS See also *Angus, Robert*. *Angus, Robert*, 1670-1743, English physician, 1670-1743, and *Angus, Robert*, 1670-1743, his son, 1698-1752, both physicians.

FOR OFFICE USE ONLY: Indicate if Licensee is a manufacturer or distributor of Class II, III and/or IV Devices as defined above. If applicable, check all that apply. Note: If 'No' is checked, then 'Yes' is implied.

FOR THICCAR CLASS: F1M1000 PURA'S BSC. To receive a clearing for one's file, one provided by common carrier, and to make payment upon a statement of eligibility and deformation of the name, signature, address, or identification number.

NOTIFICATION UPDATES: Information from claims and related documents may be used by the U.S. Department of Health and Human Services, under the Health Information Technology for Economic and Clinical Health Act ([HIT Act](#)), to the U.S. Department of Transportation, or to the Federal Aviation Administration, in connection with the International Revenue Service, postal collection agencies, and tax user reporting systems, to the Internal Revenue Service, and to Oregon state offices in advance to inquire about the employment history of the person to whom a return was sent.

DISCLOSURE: Voluntary, however, factors, to provide information will assist in prompt or more timely arrival of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any such information, except as noted above, could delay payment of the claim. Failure to provide medical information, except as noted above, could result in denial of the claim.

It is mandatory that you tell us if you know that another party is reaping dividends from your location. Section 1102 of the Small Business Act and 16 USC 1801-1812 provide penalties for withholding this information.

You should be aware that it is best to have your own Mathematica notebook for each of these programs, as well as the ones corresponding to the other chapters, in order to experiment with them.

广联达BIM平台化解决方案(CIM平台)

Hourly wages in the job market have been rising in decline until the mid-1970s, "exceptional". Since the mid-1970s, they fall 20% plus, and decline further when the economy grows, as shown by the long-term trend in the figure below. The rate of growth of real wages has fallen sharply.

However, specific payment will not be arranged until the day before the event, or at least one week before the event, so as to keep the number of students who have paid confirmation, up to payment or understand their demands.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): Ken Borrelli, M.D., 2000 E. Mississippi St. #100, Milwaukee, WI 53210-3100, physician who furnished services or furnished by me to my employee during my personal duration.

NOTICE: This is a legally binding document that creates a binding contract. It is intended to bind the parties to an individual contract, and that contract, statement or document, or commitment, shall supersede any oral understanding, understanding, or statement.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0834

Fax: (716) 725-0865

Client Name: Danielle Haworth Date: 9/24/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/confusing pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LB stiff & sore AS shoulder & neck
really tight QL tightness into glute
mm. Cerv mm hyper tonic @ occiput esp on
Especially upper traps

Action/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Merit

Practice: Therapeutic Massage Initials:
 NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0834

Fax: (716) 725-0865

Client Name: Danielle Haworth Date: 9/28/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/confusing pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: QL lumbar euctors + QL is still
tight. Client having a hard time
getting up from seated position.
Qled to w/ trap + shoulder still
hot and sore.

Action/s Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat Merit

Practice: Therapeutic Massage Initials:
 NYS Licensed Therapist

0 05 17

8 - R

10 05 17



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DEPT OF YOUTH
NY 140
BUFFALO

375 Dixie Road, Suite #2
Depew, NY 14043
Attn: C. Marr

Great Lakes Therapeutic Massage
& Bodywork Practitioners



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 8/11

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARRIER

FICA

1 MEDICARE										MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BUILDING (DVM)		OTHER (DVM)		1a. INSURED'S ID. NUMBER <i>013873940-0101-059</i>		(For Program Item 1)					
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (DVM)		<input type="checkbox"/> (DVM)		<input type="checkbox"/> (DVM)		<input type="checkbox"/> (DVM)		<input type="checkbox"/> (DVM)		<input type="checkbox"/> (DVM)															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY		SEX M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <i>BARNELL, DANIELLE</i>															
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)															
CITY <i>AMHERST</i>					STATE <i>NY</i>					CITY					STATE														
ZIP CODE <i>14228</i>					TELEPHONE (Include Area Code) <i>(716) 536-0951</i>					ZIP CODE					TELEPHONE (Include Area Code) <i>()</i>														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>INT.</i> PLACE (State)										a. INSURED'S DATE OF BIRTH MM DD YY SEX <i>N F</i>									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										b. OTHER CLAIM ID (Designated by NUCC)									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)										c. INSURANCE PLAN NAME OR PROGRAM NAME									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below										13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d										14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below									
SIGNED <u>DANIELLE BARNELL</u> DATE <u>01-06-2016</u>										SIGNED <u>DANIELLE BARNELL</u> DATE <u>01-06-2016</u>										SIGNED <u>DANIELLE BARNELL</u> DATE <u>01-06-2016</u>									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY <i>10 31 2015</i>					15. OTHER DATE QUAL <i>Q1A</i>					16. OTHER DATE MM DD YY <i>MM DD YY</i>					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY <i>MM DD YY</i>														
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <i>SYDNEY GRABAU, PA</i>										17b. <i>17b NPI</i>										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY <i>MM DD YY</i>									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										\$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24e)										22. RESUBMISSION CODE <i>ORIGINAL REF. NO.</i>										23. PRIOR AUTHORIZATION NUMBER									
A <u>M79.3</u>	B <u> </u>	C <u> </u>	D <u> </u>	E <u> </u>	F <u> </u>	G <u> </u>	H <u> </u>	I <u> </u>	J <u> </u>	K <u> </u>	L <u> </u>																		
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY <i>10-02-17</i>										B. PLACE OF SERVICE EMR <i>99140</i>		C. PROCEDURES, SERVICES, OR SUPPLIES (English/Universal Circumstances) CPT/HCPCS <i>99140</i>		D. MODIFIER <i> </i>		E. DIAGNOSIS PONTER <i> </i>		F. \$ CHARGES <i>55.00</i>		G. DAYS H. RATE I. UNITS <i>3</i>		L. ID J. CUM. <i>NPI</i>		J. RENDERING PROVIDER ID # <i>114462011</i>					
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? FOR THIS BILL, OR BOTH <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE <i>\$ 110.00</i>		29. AMOUNT PAID <i>\$ 0.00</i>		30. Reserved for NUCC Use <i>110.00</i>											
47-0989449										BARNELL, D																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)										32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043										33. BILLING PROVIDER INFO & PH # <i>716 725-0264</i>									
COLLEEN MARK, LMP 10.06.2017										GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043																			
SIGNED <u>COLLEEN MARK, LMP</u> DATE <u>10.06.2017</u>																													

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0608-1183 EOBM 1500 (03-12)

BECAUSE THIS PAPER IS USED BY VARIOUS COMPANIES, IT IS NOT UNCOMMON TO FIND THIS PAPER IN A NUMBER OF PLACES, SUCH AS IN THE TRUNKS OF CARS, IN THE BACKS OF CHAIRS, AND IN THE BAGS OF PERSONS WHO ARE TRAVELING.

¹ See also the discussion of the relationship between the two concepts in the section on "The Concept of Social Capital."

Deutsche Presse-Agentur (dpa) - Presseamt Berlin

For more information about the study, please contact Dr. Michael J. Kupferschmidt at (415) 502-2555 or via email at kupferschmidt@ucsf.edu.

Transfers for the most part between the two groups of countries are negligible.

¹ B. D'Amico P. G. S. M., "A 1.5-1.8 GHz 1.2 μ m CMOS VCO," p. 7.

In addition to the general education requirements, students must also complete a minimum of 12 hours of approved electives. These electives may include courses such as art, music, drama, or physical education, as well as other academic subjects like psychology or sociology.

For H2O/HFO blends, it has been found that the higher the mole fraction of H2O, the lower the viscosity, indicating that the addition of water to the blend decreases the viscosity.

No Part II Model Law Statutes may be used unless at least one Part II or Part III is included as a qualified statute section, law, or regulation in Part II, Part III, or Part IV.

NOTICE: Any one who has failed or failed to respond to an initial or subsequent Commission's Request for Information may be subject to civil and criminal penalties under applicable Federal law.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF INFORMATION FOR THE AMERICAN SPANISH LANGUAGE SURVEY

We are authorized by CHS, TRICARE and OIG to collect information from you for administrative review in the administration, claims for TRICARE, TRICARE, TRICARE and Direct Line programs. A failure to collect information is an offense under 10 USC 8012, 1079, and 1074 or the Civil Recovery Act, section 104 of the CERCLA and may result in a fine up to USD 10,000.00 or imprisonment up to 5 years or both.

The information contained in this document is under license by the copyright holder. It is illegal to copy or distribute this document without the express permission of the copyright holder.

The information may also be given to other professionals who are involved in the treatment, such as the physician, and to other members of the treatment team. For example, if a physician is treating a patient with depression, it may be necessary to discuss information about the patient's history and current condition with the physician in order to provide the best care.

FOR MEDICARE CLAIMS: See the section entitled "Claims for Medicare Benefits," Chapter 10, Section 10, Chapter 10, Medicare, in Part 10, published in the Federal Register, Vol. 36 No. 177, page 37569, Wed Sept 16, 1992, or as amended and modified.

Rebuttal: USG's intervention from Israel and its local departments, at the beginning, the USG had no intention to be part of the fight against Hamas. However, after consistent with their "double track," they have been involved in the fight against Hamas since the beginning. The Internal Revenue Service, particularly, has been involved in this fight since the beginning. This is because the USG has been unable to implement most of the programs in its original budget. As a result, it has been forced to reallocate funds to other areas. In addition, the USG has been unable to implement a portion of its original budget due to lack of sufficient funds. In addition, the USG has been unable to implement a portion of its original budget due to lack of sufficient funds.

DISCLAIMER: In summary, however, failing to provide a statement will not result in a denial of coverage through a denial of claim. With the exception of specific disclaimers below, there are no presumptions under the policies for which a statement is required to satisfy information requests. Therefore, failure to provide a statement does not affect the insured's rights or the insurer's defenses if a claim is presented under a policy of liability insurance.

It is mandatory that you tell us a you know that another person incapable of paying for your treatment to you. Title 43 of the Texas Senate Article 31 USC 100-3812 provide provides for mandatory disclosure of information.

Note: Legend for regions: the 1950s (the 1950s), the 1960s (the 1960s), the 1970s (the 1970s), and the 1980s (the 1980s). The years are not chronological. Source: Authors' calculations based on the World Bank's World Development Indicators.

87 JAGGERS, THEORETICAL AND COMPUTATIONAL

I hereby agree, in keeping with the requirements of my employment, to provide the employer with access to my financial plan documents from time-to-time as may be required for reasonable administrative costs.

For more information on the project, visit www.pewtrusts.org, or contact the Pew Environment Group at (202) 540-6940.

SIGNATURE OF FIRM/OWNER AND EMPLOYER _____
The undersigned, being the owner, director, or representative of my firm and as a party to this agreement,
do hereby employ the above named executive.

MOPP times investigating the last group of individuals, and under similar conditions, reported a 100% survival rate and no deaths due to side effects.

According to the literature review, there is no clear evidence that the use of the Internet for health information purposes is associated with better health outcomes. The results of this study also suggest that the use of the Internet for health information purposes is not associated with better health outcomes.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0824

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 10/2/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: SI joint jammed w/extreme hypertonicity along Sacral border
 SI joint still really sore. Chiro
 2x a week until better. Sacral border into QL to myofascial line. Used hot packs before & after. Upper back
 Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat Great Lakes

Practice: Therapeutic Massage initials: M
NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office: (716) 725-0824

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 10/4/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: SI joint still really sore. Chiro

2x a week until better. Sacral border into QL to myofascial line. Used hot packs before & after. Upper back

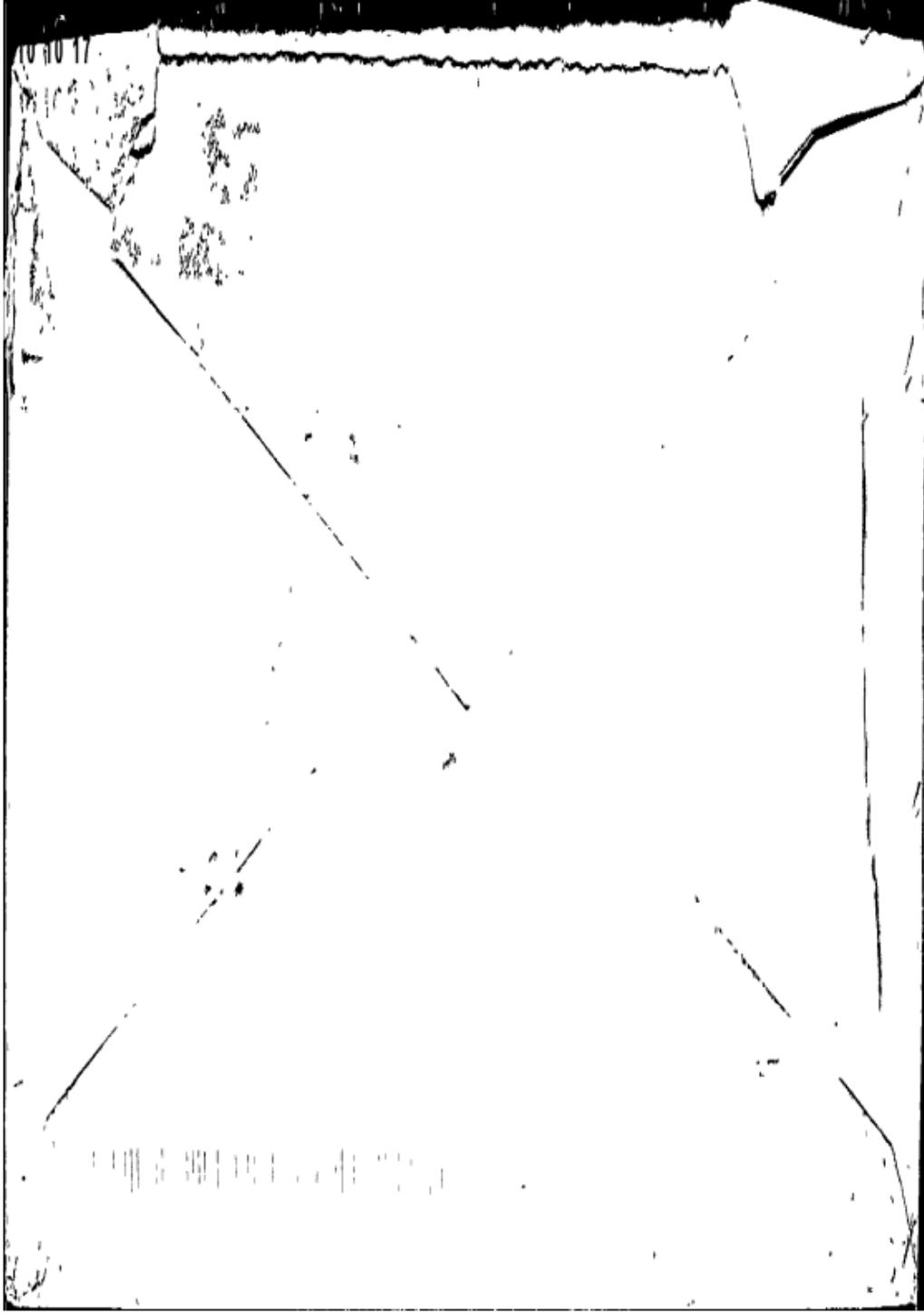
Action's Applied: (Check All that Apply) Heat Packs Cold Packs Sombra/Biofreeze ADL dysfunction

- Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat Great Lakes

Practice: Therapeutic Massaginitials: NF
NYS Licensed Therapist



10 10 17

Great Lakes Therapeutic Massage

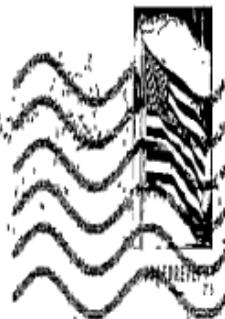
Colleen Marx, LMT

375 Dick Road, Suite #2

Buffalo, NY 14203

RANGESTER NY 14203

07 OCT 2017 PM 11



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-952607





HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

IPICA

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

PICA

1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BULKING		OTHER		1a. INSURED'S ID NUMBER		(For Program in Item 1)			
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (DOD/DoD)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (NHC)		<input type="checkbox"/> (DOD)		<input type="checkbox"/> (DOD)		013873940011059					
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)												3 PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARWELL DANIELLE												MM DD YY		<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X		HARWELL DANIELLE			
5 PATIENT'S ADDRESS (No., Street)												6 PATIENT RELATIONSHIP TO INSURED				7 INSURED'S ADDRESS (No., Street)			
1131 CLEVELAND DRIVE												S/o <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				56 BEREHAVEN DR., LEFT			
CITY		STATE		8 RESERVED FOR NUCC USE				CITY		STATE									
CHEEKETOWAGA		NY						AMHERST		NY									
ZIP CODE		TELEPHONE (Include Area Code)						ZIP CODE		TELEPHONE (Include Area Code)									
14225		(716) 536 0951						14228		(716) 536 0951									
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10 IS PATIENT'S CONDITION RELATED TO:							
												a EMPLOYMENT? (Current or Previous)							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
												b AUTO ACCIDENT?							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NY							
												c OTHER ACCIDENT?							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d INSURANCE PLAN NAME OR PROGRAM NAME												10d CLAIM CODES (Designated by NUCC)							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												11. INSURED'S POLICY GROUP OR FECA NUMBER							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												a INSURED'S DATE OF BIRTH							
												MM DD YY		SEX					
												<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X							
b RESERVED FOR NUCC USE												b OTHER CLAIM ID (Designated by NUCC)							
c RESERVED FOR NUCC USE												c INSURANCE PLAN NAME OR PROGRAM NAME							
												GEICO							
d INSURANCE PLAN NAME OR PROGRAM NAME												d IS THERE ANOTHER HEALTH BENEFIT PLAN?							
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, complete items 5, 8a, and 9d					
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												14. SIGNATURE ON FILE							
												15. SIGNATURE ON FILE							
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION												17. DATES HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
MM DD YY		MM DD YY		MM DD YY		MM DD YY		FROM		TO									
103115		0411 431		454		111215													
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
MM DD YY		MM DD YY		MM DD YY		MM DD YY		FROM		TO									
17a NPI		17b NPI																	
20. OUTSIDE LAB?												21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Please A-L to service line below (24E)							
												ICD 10							
a M50.222		b M51.26		c M51.27		d M54.12		22. RESUBMISSION CODE											
e I823.3XXA		f M99.01		g M99.03		h M99.02		ORIGINAL REF NO											
i M99.05		j M54.2		k M54.5		l M54.6		23. PRIOR AUTHORIZATION NUMBER											
24. A. DATES OF SERVICE												B. PROCEDURES, SERVICES, OR SUPPLIES							
From MM DD YY		To MM DD YY		PROCEDURE, SERVICE, OR SUPPLY (Explain unusual circumstances) CPT/NCPCS		E. MODIFIER		F. G. H. I. J.											
09252017		09252017		98941		ABCD		32	28	1	NPI	1710014188							
09252017		09252017		97010		ABCD		10	53	1	NPI	1710014188							
10032017		10032017		98941		ABCD		32	28	1	NPI	1710014188							
10032017		10032017		97010		ABCD		10	53	1	NPI	1710014188							
10052017		10052017		98941		ABCD		32	28	1	NPI	1710014188							
10052017		10052017		97010		ABCD		10	53	1	NPI	1710014188							
25. FEDERAL TAX ID NUMBER SSN EIN												26. PATIENT'S ACCOUNT NO							
364500165												343891259							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and any related treatment)												27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
PATRICK GOZINSKI DO												28. TOTAL CHARGE							
												\$ 128.43 6							
32. SERVICE FACILITY LOCATION INFORMATION												29. AMOUNT PAID							
CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849												30. Rcv'd for NUCC Use							
												33. BILLING PROVIDER INFO & PH# (716) 681-3333							
												CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849							
SIGNED 10112017 DATE 1235256546												* 1235256546							

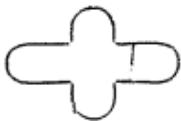
Encounter dated 10/05/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017

misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 10/05/2017 at 10:13am

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS, Visual Analog Scale
WNL: within normal limits



Item# 43568
Patent Pending



10 16 17



345 Dick Rd.
Depew, NY 14043

Geico
P.O. Box 9507
Fredericksburg, VA 22403

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
October 11, 2017

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday September 25, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 09/25/2017 at 9:27am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck has been O.K. Follow up with Dr. Siddique for pain management is in November 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left posterior scapula, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 2 x a week. She states that the duration varies, but they no longer last all day. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with increased left shoulder blade pain. She stated that massage therapy has been really working the area to help relieve the pain. "I can't lift my arm up very high and lay on the left side due to the pain". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* worse. *since last visit.* *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the continued chief complaint of lower back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improved. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Encounter dated 09/25/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017

Cervical: Range of motion: flexion: 40/50 with pain left lower neck; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. Posture: rounded shoulders. Hypertonicity & Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative. X-ray findings: Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C5, C6, left first rib. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Left Moderate; Thoracic paraspinal musculature Right Mild to Moderate. Trigger points: bilateral rhomboids. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: WNL 60/60 with no pain; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. Gait pattern: normal. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right mild. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Cervical assessment:** improving. VAS score improved from a 5 to 3 out of 10 and her headache frequency decreased from 3 to 4 to 2 a week. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. **Thoracic assessment:** worse, more difficult to lay on her left side.

Lumbar assessment: improving. VAs score improved from a 5 to 4 out of 10. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying

Encounter dated 09/25/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017

annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x every 2 weeks for 5 weeks; Re-examination for 5 weeks. *Visit number* 3 of 4. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral cervical electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; left lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit and stand longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to October 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 09/25/2017 at 9:27am

Tuesday October 3, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 10/03/2017 at 9:34am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Encounter dated 10/03/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017

Subjective

Cervical: Patient stated that her neck pain remains the same. Follow up with Dr. Siddique for pain management is in November 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left posterior scapula, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 2 x a week. She states that the duration varies, but they no longer last all day. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. since last visit. *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today with the chief complaint of increased lower back pain. She stated that the pain started Saturday gradually during the day. Due to the pain, getting dressed and sleeping have been difficult. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* worse. since Saturday. *Pain:* achy, dull, sharp, shooting, tingling; level: 8/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg, right posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain left lower neck; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Moderate; Thoracic paraspinal musculature Right Moderate to Severe. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 30/60 with pain lower back; extension: 5/25 with pain lower

Encounter dated 10/03/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017

back; left rotation: 25/30 with pain lower back; right rotation: 15/30 with pain lower back; left lateral bending: 10/25 with pain lower back; right lateral bending: 10/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right moderate to severe; TFL / ITB right moderate to severe. *Tenderness on palpation:* L4: moderate to severe; L5: moderate to severe; left SI: moderate; right SI: severe. *Trigger points:* left gluteus maximus, right gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive bilateral at 45 degrees for lower back pain; Bechterew: Positive right for right lower back pain. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: worse, VAS score increased from a 4 to an 8 out of 10 and her active lumbar ROM is no more limited with increased pain especially with flexion and bilateral rotation and lateral flexion. In addition her bilateral SLR decreased from 60 to 45 degrees with increased lower back pain. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 2x/week for 2 weeks due to increased lower back pain; Re-examination for 2 weeks. *Visit number 4 of 4. Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral thoracic

**Encounter dated 10/03/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017**

paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; bilateral TFL / ITB soft tissue massage. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: lumbar 4x day for 15 to 20 minutes per application for 3 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit and stand longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to October 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 10/03/2017 at 9:34am

Thursday October 5, 2017 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 10/05/2017 at 10:13am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient stated that her neck pain remains the same. Follow up with Dr. Siddique for pain management is in November 2017. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left posterior scapula, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* Patient stated that she states that she still experiences headaches 2 x a week. She states that the duration varies, but they no longer last all day. Nothing alleviates the pain. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting; level: 5/10. *Pain is frequent.* *Exacerbates symptoms:* movement;

Encounter dated 10/05/2017 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 10/11/2017

bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* nothing. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that she is "slightly better. I still have difficulty standing, sitting or doing anything too long". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* slight improvement since last visit. *Pain:* achy, dull, sharp, shooting, tingling; level: 7/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg, right posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: 40/50 with pain left lower neck; extension: WNL 60/60 with no pain; left rotation: 70/80 with pain left lower neck ; right rotation: 60/80 with pain left lower neck ; left lateral bending: 35/45 with pain lower neck ; right lateral bending: 35/45 with pain lower neck. *Posture:* rounded shoulders. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Moderate; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Left Moderate; Thoracic paraspinal musculature Right Moderate to Severe. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 30/60 with pain lower back; extension: 5/25 with pain lower back; left rotation: 25/30 with pain lower back; right rotation: 15/30 with pain lower back; left lateral bending: 10/25 with pain lower back; right lateral bending: 10/25 with pain lower back. *Gait pattern:* normal. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left mild to moderate; lumbar paraspinal right moderate to severe; TFL / ITB right moderate to severe. *Tenderness on palpation:* L4: moderate to severe; L5: moderate to severe; left SI: moderate; right SI: severe. *Trigger points:* left gluteus maximus, right gluteus maximus. *Orthopedic tests:* Straight leg raise: Positive bilateral at 45 degrees for lower back pain; Bechterew: Positive right for right lower back pain. *Spinal subluxation level(s):* L4, L5, Left SI, Right SI. *Subluxations detected by:* motion and static palpation.

Assessment

Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Cervical assessment:* unchanged. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment

Encounter dated 10/05/2017 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 10/11/2017

without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac.

Differential diagnosis: Thoracic disc herniation. *Thoracic assessment:* unchanged.

Lumbar assessment: slightly better, VAS score improved from an 8 to 7 out of 10. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Visit# 1 of 4 planned treatments. Treatment schedule:* 2x/week for 2 weeks due to increased lower back pain; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (anterior); T9 extension restriction (anterior); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI right PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; bilateral TFL / ITB soft tissue massage. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec. *Home care:* ice: lumbar 4x day for 15 to 20 minutes per application for 3 days. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit and stand longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to October 31, 2017 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts,



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0812

GBICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER →

PIKA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FROA <input type="checkbox"/> OTHER <input type="checkbox"/> <input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (Group Health Plan) <input type="checkbox"/> (FROA) <input type="checkbox"/> (Other)												1a INSURED'S ID NUMBER (For Program or Item 1) 013873940-0101-059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -																	
5. PATIENT'S ADDRESS (No., Street) 56 BEREBEAVEN DR												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY AMBERST		STATE NY		7. INSURED'S ADDRESS (No., Street)													
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951		X			CITY		STATE		ZIP CODE ()		TELEPHONE (Include Area Code) ()				
8. RESERVED FOR NUCC USE																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>LNK</u> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR PEOA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					
b. RESERVED FOR NUCC USE												b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE												c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												e. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below												SIGNED - <u>ON FILE</u> - DATE 01-06-2016					
SIGNED - <u>ON FILE</u> - DATE 01-06-2016			SIGNED - <u>ON FILE</u> - DATE 01-06-2016														
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 01-31-2016 QUA Q			15. OTHER DATE (MM DD YY) 01-31-2016 QUA Q			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM 01-31-2016 TO 01-31-2016											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA			17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM 01-31-2016 TO 01-31-2016											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LABS \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E))												22. RESUBMISSION CODE NPI ORIGINAL REF. NO.					
A. LN79-1	B. 	C. 	D. 	E. 	F. 	G. 	H. 	I. 	J. 	K. 	L. 						
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EXPN/UNR/EMR/CPT/HCPCS			C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Universal Cross-references) D. MODIFIER			E. DIAGNOSIS POINTER			F. G. DATES OR UNITS H. DATES OR UNITS I. ID J. RENDERING PROVIDER ID					
1	20-09-17	30-09-17	11	11	97340	11	11	11	55-100	3				NPI 1144462012			
2	10-17-17	30-17-17	11	11	97340	11	11	11	55-100	3				NPI 1144462013			
3	10-21-17	30-21-17	11	11	97340	11	11	11	55-100	3				NPI 1144462011			
4														NPI			
5														NPI			
6														NPI			
25. FEDERAL TAX I.D. NUMBER 47-0989449	SSN BIN <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO. BARNELL, D			27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE 165.00		29. AMOUNT PAID \$ 0.00		30. REND FOR NUCC USE 165.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARK, LMT 10.21.2017 SIGNED												32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043			33. BILLING PROVIDER INFO & PH # 716 725-0264		
												GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043					
												a. 1144462011			b. 1144462011		

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any false statement or any false, incomplete or misleading information is guilty of a criminal act punishable under law and may be subject to civil penalties.

Figure 10 shows the effect of the number of hidden neurons on the performance of the proposed model.

As a result, the duration of the disease in the patients with the most severe forms of hepatitis C was longer than in those with milder forms of the disease. The duration of the disease in the patients with chronic hepatitis C was longer than in those with acute hepatitis C.

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For application of the model to the study of the effect of the environment on the incidence of disease, see the following section.

For example, the `border-radius` property can be used to create rounded corners on an element's border. The value can be a single length or a pair of lengths, representing the radius of the top-left and top-right corners respectively.

The information in the About section of the Home page is also displayed in the About section of the Home page.

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PORT OF BREMEN/PORT OF BREMEN: See the entries under Bremen, Germany.

DOI: 10.1089/cellbio.2004.16.1049 © 2004 Society for Cell Biology, 16(10), 1049–1060, DOI: 10.1089/cellbio.2004.16.1049

MULTIPLE CHOICE. Below are four multiple-choice questions. Each question has four possible answers. You must choose the best answer for each question. There is only one correct answer for each question. If you are not sure about an answer, guess. You will receive one point for each correct answer. You will receive zero points for each incorrect answer. You will receive no points for each unanswered question. You will receive one point for each correct answer. You will receive zero points for each incorrect answer. You will receive no points for each unanswered question.

DSST-ORIENE. Results of this study suggest that the power of the DSST-ORIENE test is higher than that of the DSST-ORIENE test.

If you are interested in this research, please contact Dr. Michael J. Sparer at the Department of Psychology, University of California, Berkeley, CA 94720-1550, or by e-mail at sparer@berkeley.edu.

More information can be found at <http://www.ams.org/amsip>, the Committee's website, and at amsip.ams.org.

I hereby agree to keep such account as an attorney in the office and I warrant that I will not disclose the State's title and plan, or furnish information or grading pay

¹ See also the discussion of the relationship between the two concepts in the introduction to the present volume.

SIGNATURE OF DIRECTOR OR SUPERVISOR: *[Signature]* **DATE:** *[Date]* **POSITION:** *[Position]* **EMPLOYER:** *[Employer]*

NOTE: The following chart lists the frequency distribution of the number of days between the date of application and the date of issuance of the first certificate of title.

As a result of the Pugwash Conference, the first international conference on disarmament was held in 1955 at Geneva. The Geneva Conference, composed exclusively of their powers, was convened by the United States and the Soviet Union. It was attended by the United Kingdom, France, and Canada, as well as the Soviet Union and the United States.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

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Great Lakes Therapeutic Massage & Bodywork Practitioners

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Office: (716) 725-0224

Fax: (716) 725-0265

Client Name: Danielle Harrel Date: 10/9/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: (R) L5/S1 joint still hypertonic w/ SI joint area jammed. QL on R tight leading into glutes. Upper trap tight due to pushing off to

Actions Applied: (Check All that Apply) get up because
 Heat Packs Cold Packs Sombra/Icepacks
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Great Lakes

Practice: Therapeutic Massage Initials: MRC
 NYS Licensed Therapist

Client Name: Danielle Harrel Date: 10/17/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 7 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
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 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: (R) SI joint still jammed. Walked client in side-lying position to work them along the sacrum and psis. Neck and Shoulders getting sore from client having to push

Actions Applied: (Check All that Apply) herself up from
 Heat Packs Cold Packs Sombra/Icepacks
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Great Lakes

Practice: Therapeutic Massage Initials: MRC
 NYS Licensed Therapist

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Office: (716) 725-0634

Fax: (716) 725-0635

Client Name: Danielle Harrel Date: 10/21/17

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
- Upper Thoracic (Anterior) Upper Thoracic (Posterior)
- Mid/Thoracic Ribs Scapula (R) Scapula (L)
- Abdomen/Obliques ASIS PSIS
- Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: QL & sacrum still very tight

and low: Some LB Soreness/tightness
on D side due to compensation neck
and thoracic mm hypertonic from
squatting LB when getting up from

Action's Applied: (Check All that Apply) Seated position

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Great Lakes

Practice: Therapeutic Massage Initials: MKF
NYS Licensed Therapist

Client Name: _____ Date: _____

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
- Low Energy Pain Restlessness Restricted Sore
- Numbness Tingling ↓ Strength Inability to Sleep
- Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
- Cervical (Posterior) Cervical (Anterior)
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- Mid/Thoracic Ribs Scapula (R) Scapula (L)
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- Lumber Sacrum Coccyx Hips Glutes (R?) (L?)
- IT Band Quads Hamstrings Knee (R) Knee (L)
- Calve Muscles (R) Calve Muscles (L)
- Ankle (R) Ankle (L) Foot (R) Foot (L)
- Shoulder (R) Shoulder (L)
- Upper Arm (R) Upper Arm (L)
- Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: _____

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Practice: _____ Initials: _____

10 26 17

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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10 26 17



FREDERICKSBURG VA 22403-9527

PO BOX 9507

NY PIP

GEICO

POSTAGE WILL BE PAID BY ADDRESSEE

FIRST-CLASS MAIL PERMIT NO. 1010 WASHINGTON DC

BUSINESS REPLY MAIL

Great Lakes Therapeutic Massage

Colleen Marx, LMT

375 Dick Road, Suite #2

Buffalo, NY 14215

PM 3 LL

23 OCT 17

NY 310

BUFFALO

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES





013-873-940-0101-059

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

 PICA

CARRIER

PICA												
1 MEDICARE <input type="checkbox"/> (Medicare)	2 MEDICAID <input type="checkbox"/> (Medicaid)	3 TRICARE <input type="checkbox"/> (TRICARE)	4 CHAMPVA <input type="checkbox"/> (Member ID#)	5 GROUP HEALTH PLAN <input type="checkbox"/> (GHP)	6 FECA RELEASING <input type="checkbox"/> (GHP)	7 OTHER <input type="checkbox"/> (ID#)	8 INSURED'S LD. NUMBER <input type="checkbox"/> (For Program in Item 1)	013873940-0101-059				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE			5. PATIENT'S ADDRESS (No., Street) 56 BERBRAVEN DR		
6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)									
CITY AMHERST		STATE NY	8. RESERVED FOR NUCC USE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			CITY STATE			ZIP CODE ()			
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951										
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												
10. IS PATIENT'S CONDITION RELATED TO:												
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <u>UNK</u>												
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)												
e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below												
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below												
SIGNED <u>— ON-FILE</u> DATE <u>01-06-2015</u> SIGNED <u>— ON-PREV</u>												
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 30-07-2015 QUAL			15. OTHER DATE MM DD YY QUAL			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA			17a. <input type="checkbox"/> 17b. <input type="checkbox"/> NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) ICD Ind A. <input type="checkbox"/> ICD-9-CM B. <input type="checkbox"/> ICD-10-CM C. <input type="checkbox"/> ICD-9-CM D. <input type="checkbox"/> ICD-10-CM E. <input type="checkbox"/> ICD-9-CM F. <input type="checkbox"/> ICD-10-CM G. <input type="checkbox"/> ICD-9-CM H. <input type="checkbox"/> ICD-10-CM I. <input type="checkbox"/> ICD-9-CM J. <input type="checkbox"/> ICD-10-CM K. <input type="checkbox"/> ICD-9-CM L. <input type="checkbox"/> ICD-10-CM												
22. RESUBMISSION CODE ORIGINAL REF NO												
23. PRIOR AUTHORIZATION NUMBER												
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE ENR C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS PICKLIST F. \$ CHARGES G. DATES OR UNITS H. DRG/PICK REF I. ID QUAL J. RENDERING PROVIDER ID. #												
1	01-02-18	01-02-18	97140	A	55.00	3	NPI	1144662011				
2	01-08-18	01-08-18	97140	A	55.00	3	NPI	1144662011				
3							NPI					
4							NPI					
5							NPI					
6							NPI					
25. FEDERAL TAX ID NUMBER 47-0989449	26. PATIENT'S ACCOUNT NO. HARWELL, D	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE \$ 110.00	29. AMOUNT PAID \$ 0.00	30. Row for NUCC Use 716 725-0264							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DICKIN, NY 14043			33. BILLING PROVIDER INFO & PH# GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DICKIN, NY 14043						
COLLEEN MARK, LMT 01-08-2018 SIGNED			B. <input type="checkbox"/> 1144662011			B. <input type="checkbox"/> 1144662011						

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AGENCIES AND PRIVATE INDIVIDUALS, LOCATIONS SEE NON-BASIC INSTRUCTIONS ISSUED BY APPROPRIATE AUTHORITY.

NOTICE: Any person who knowingly files a written report of an investigation or audit, or any other document, which contains false or misleading information, or which fails to contain all pertinent facts, may be subject to criminal penalties under the Sarbanes-Oxley Act of 2002.

For the first time, we have shown that the *in vitro* growth of *Candida albicans* biofilms is inhibited by the addition of *in vivo* active metabolites of the antifungal agent.

LIFECODE and TRICAPLE PAYMENT is a general programming language which can be interpreted by the BBS. It has two uses, one is to send and receive messages and the other is to store and retrieve information and data in the memory. In this paper, I will introduce the basic concepts of LIFECODE and how it can be used to implement various applications. I will also discuss the advantages and disadvantages of using LIFECODE over other languages.

Digitized by srujanika@gmail.com

The specific agreement could be arranged by the shareholders of the company. The shareholders of the company could agree to sell their shares to the new investors.

$\delta_{\text{eff}}(T)/\delta_{\text{eff}}(0) \approx 1 - 3\pi^2/16 \approx 0.75$ at $T = 1.5 T_c$ (see Fig. 1).

In our long class for meadow management, I highly value the importance of soil health, soil biology, and organic matter. This means: Management that preserves soil structure, soil organisms, soil stability and promotes carbon storage in the soil. This is the way to build healthy ecosystems, not to prepare soil for growing plants and to produce yields. In our class we made the connection between soil health and yield. Yield is a result of soil health, not the other way around. Yield is a result of soil health, not the other way around.

On the 1st of January, 1863, the Legislature of the Commonwealth of Massachusetts passed a law, entitled "An Act to regulate the sale of spirituous liquors," which law was approved by the Governor on the 10th of January, 1863, and became a law.

¹² See, e.g., *U.S. v. Gandy*, 415 U.S. 853, 863 (1974) ("[T]he right to counsel is a fundamental right which must be protected by the Due Process Clause of the Fourteenth Amendment.").

POEM: *Wieder auf dem Berg* (1914) by Paul Klee, 1914, oil on canvas, 100 x 120 cm, Kunstmuseum Basel, Switzerland.

PRINCIPAL INVESTIGATOR: DR. DALE D. HARRIS
ASSISTANT INVESTIGATOR: DR. JAMES C. TROTTER
INVESTIGATOR: DR. ROBERT W. BROWN
INVESTIGATOR: DR. RICHARD A. COOPER
INVESTIGATOR: DR. ROBERT L. HORN
INVESTIGATOR: DR. ROBERT M. KELLY
INVESTIGATOR: DR. ROBERT E. MCNAUL
INVESTIGATOR: DR. ROBERT W. MURRAY
INVESTIGATOR: DR. ROBERT W. PEARCE
INVESTIGATOR: DR. ROBERT W. REED
INVESTIGATOR: DR. ROBERT W. SCHAFFNER
INVESTIGATOR: DR. ROBERT W. SPENCER
INVESTIGATOR: DR. ROBERT W. TROTTER
INVESTIGATOR: DR. ROBERT W. VANDERKAM

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The administration may also be given the power to make regulations for carrying out the purposes of this section. The regulations may relate to the administration of the circumstances referred to in subsection (1) and may provide for the making of rules for the regulation of the exercise of powers by the commission in discharge of its functions under this section.

代碼：[點此](#) | 留言：[點此](#) | 時間：2024-01-15 | 電話：02-2626-1234 | 地址：123, 台北市, 中華人民共和國

SCGTA II 13-14/15 - Información de datos y datos adicionales

¹⁰⁵ See, *J. L. H. Waterman*, 'Toleration and the Right to Religious Freedom', *Journal of Law and Religion* 1993, 11, 1, 1–20; *John C. Green*, 'Religious Toleration in Early America', *Journal of American History* 1992, 79, 1, 1–20.

It is important that you tell us if you know that anyone gathered around you, or your children, are using the Internet to bully or harass you. If they do, we can help you deal with it.

You should be aware that P.E. 800-803, the "Centralized Nonresident Tax Return," is used by 45 states and the District of Columbia.

Ergonomics in Design, Vol. 19, No. 1, March 2008, 11–20

lance by and to keep such records as are necessary to determine whether or not the services rendered to an individual under this section are reasonable and fair, having due regard to any payments claimed for providing such services as the basis for their adjustment, if such amounts may require.

Whether you're a beginner or a pro, the unique features of the app help you to communicate effectively, easily, and quickly.

SIGNATURE OF PHYSICIAN FOR SUPPLIER: I certify that the information above is true and accurate to the best of my knowledge and belief, and that it was furnished by me or my employees under my personal direction.

According to the Paperwork Reduction Act of 1995, no person is required to respond to a collection of information if it contains an "agency form" or "OMB control number." The OMB control number for this information collection is 1103-0057. This is a comment response to a proposed information collection. It is estimated that this collection will require approximately 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you estimate any additional time or cost for completing this collection of information, please write to OMB at 1205 New Jersey Avenue, NW, Washington, DC 20585-0001, or send comments to OMB via email at dsm@omb.eop.gov.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Harrel Date: 1/2/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior) _____
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Client still has ① leg numbness from epidural. Upper thoracic and cervical areas are very tight from taping so use upper body is left torso because of

Action's Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Practice: Therapeutic Massage Initials: MHC
NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0634

Fax: (716) 725-0265

Client Name: Danielle Harrel Date: 1/8/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior) _____
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Q leg numbness / loss of sensation still present. Did feel "cramping" sensation w/ deep glute and piriformis work. Still mm & fo upper traps hyper tonic due to taping

Action's Applied: (Check All that Apply) to use upper body more

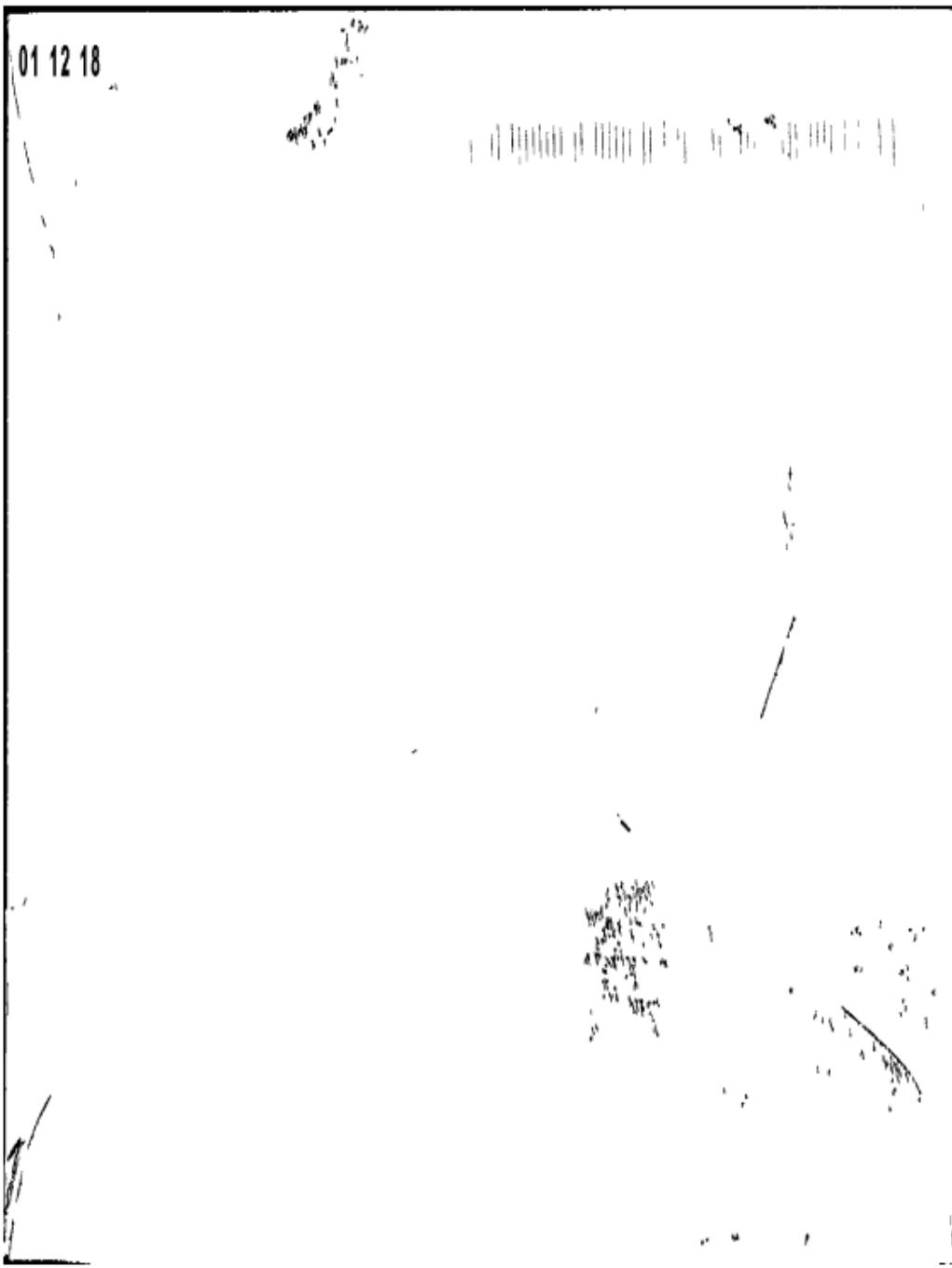
- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Practice: Therapeutic Massage Initials: MHC
NYS Licensed Therapist

01 12 18



011218



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375 Dick Road, Suite #2
Altamont, NY 14049

DEPew, NY 14043

GREAT LAKES THERAPEUTIC MASSAGE



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE - NE
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

CARRIER

NUCC

PATIENT AND INSURED INFORMATION

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BUILDING	OTHER	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)			
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP HEALTH PLAN	<input type="checkbox"/> FECA BUILDING	<input checked="" type="checkbox"/> OTHER	0138739400101059				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)							3. PATIENT'S BIRTH DATE				
HARWELL, DANIELLE							MM / DD / YY	SEX			
							<input type="checkbox"/> M	<input checked="" type="checkbox"/> F			
							08 / 29 / 1980				
4. PATIENT'S ADDRESS (No., Street)							5. PATIENT'S RELATIONSHIP TO INSURED				
1131 CLEVELAND DR							<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
CITY: CHEEKTONAGA ZIP CODE: NY 14225-1257							6. RESERVED FOR NUCC USE				
							CITY: CHEEKTONAGA ZIP CODE: NY 14225-1257				
7. INSURED'S ADDRESS (No., Street)							STATE: NY				
1131 CLEVELAND DR											
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)							9. IS PATIENT'S CONDITION RELATED TO:				
HARWELL, DANIELLE							a. EMPLOYMENT? (Current or Previous)				
							<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
b. AUTO ACCIDENT?							b. OTHER ACCIDENT? (Designated by NUCC)				
							<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
c. OTHER ACCIDENT?							c. INSURANCE PLAN NAME OR PROGRAM NAME				
							<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
d. INSURANCE PLAN NAME OR PROGRAM NAME							d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
							<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							If "NO", complete items 9, 10, and 11.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.							13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
SIGNED... SIGNATURE ON FILE							DATE: 02-09-16				
SIGNED... SIGNATURE ON FILE							DATE: 02-09-16				
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)							15. OTHER DATE				
MM / DD / YY	QUAL	MM / DD / YY	QUAL	MM / DD / YY	QUAL	MM / DD / YY	QUAL				
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM	TO	FROM	TO	FROM	TO	FROM				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	17b. UCR	17c. HCPN	17d. UCR	17e. HCPN	17f. UCR	17g. HCPN				
DN PETER J GUZINSKI	17100014188	17100014188	17100014188	17100014188	17100014188	17100014188	17100014188				
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							19. OUTSIDE LAB?				
NDC 00409379501							<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO			
20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Indicate A-L to service line below (24E))							\$ CHARGES				
A. L44309 B. L443009 C. L832X9 D. M791											
E. L8060X05 F. L4479 G. M5442 H. L											
I. L K. L											
21. DATE(S) OF SERVICE							F. CHARGES	G. DATES CH. UNITS	H. PAYMENT TYPE/PAY. PER. <td>J. RENDERING PROVIDER ID.#</td>	J. RENDERING PROVIDER ID.#	
From MM DD YY	To MM DD YY	B. PLACE OF SERVICE END	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) MODIFIER	E. DIAGNOSIS PONTER						
1 01/11/18	01/11/18	11	96372	59	AB	18-43-1			II. 161582336		
2 N400409379501,	01/11/18	01/11/18	11	J1805					NPI 1640956495		
3 01/11/18	01/11/18	11	99214	25	ABCD	74-79-1			II. 161582336		
4									NPI		
5									NPI		
6									NPI		
22. REINBUREMENT CODE							ORIGINAL REF. NO.				
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE							F. CHARGES	G. DATES CH. UNITS	H. PAYMENT TYPE/PAY. PER.	J. RENDERING PROVIDER ID.#	
From MM DD YY	To MM DD YY	B. PLACE OF SERVICE END	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) MODIFIER	E. DIAGNOSIS PONTER						
1 01/11/18	01/11/18	11	96372	59	AB	18-43-1			II. 161582336		
2 N400409379501,	01/11/18	01/11/18	11	J1805					NPI 1640956495		
3 01/11/18	01/11/18	11	99214	25	ABCD	74-79-1			II. 161582336		
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER							26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For Govt. Sched. 8000, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Reserve for NUCC Use
161582336	SN EN <input checked="" type="checkbox"/> X	1785755	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	\$ 101	22-8	0.00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the documents on this reverse copy to this bill and are made a part thereof.)							32. SERVICE FACILITY LOCATION INFORMATION				
JENNIFER W MCVIGE, MD							DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727				
SIGNED: 01/07/18	1497850911							(716) 2502010			

PHYSICIAN OR SUPPLIER INFORMATION

MCKESSON

McKesson Medical-Surgical
9954 Mayland Drive Suite 4000
Richmond, VA 23233

Bill To: 1101833

P030494000000000000

Invoice
Page 1 of 2

10101833-01

Shipped From:
MCKESSON MEDICAL SURGICAL (ROCH)
028 ROCHESTER
2404 INNOVATION WAY
ROCHESTER, NY 14624

01020001 MB 0420 "AUTD T30 LPI14206-17276 C0-P086714 MMS DLY

DENT NEUROLOGIC INSTITUTE
ATTN ACCOUNTS PAYABLE
3980 SHERIDAN DR STE 500
AMHERST NY 14226-1727

McL-31193

(010-01-10-00-00) \$45.46
(010-01-10-00-00) \$ 61.89

Sales Order Number	20170001	Invoice Number	[REDACTED]
Sales Order Date	10/07/2017	Invoice Date	[REDACTED]
PO Number	2017-10-07-BATAVIA	Payment Due Date	10/11/2017
Sales Rep Name	CARDINAL-III, JOSEPH FRANCIS	Invoice Amount	[REDACTED]

Notes: See back for Terms and Conditions.
Please contact us regarding electronic payment options at
MMS.Treasury@McKesson.com

Invoice Detail:

Item Number	Vendor / Vendor Cat #	Description	Qntfied	Unit	Shipped	Unit Price	Amount	Sales Tax
398541	Vendor: HOSPITAL RETROGRADE TRACHEOSTOMY KIT	RETROGRADE TRACHEOSTOMY KIT	1	EA	1	1.85	1.85	0.00
	NDC Num: 6 0540 0079 001	PO LN 2						
	1ZY780710312210R78							
1017003	Vendor: BSHRHW	ORANGE IRON HOL. 30V 4MM X 1	7	EA	7	.80	4.20	0.00
	NDC Num: 6 23150 0047 41	PO LN 3						
	1ZY743710312214977							
77850	Vendor: BSHRHW	MANTRONIC HOL. MDV 0.8% 80Z	3	EA	3	4.80	14.40	0.00
	NDC Num: 6 0540 0010 00	PO LN 4						
	1ZY752710312211077							
541800	Vendor: BSHRHW	DISKARMEZONE VL 7MMX100ML	2	EA	2	6.90	13.80	0.00
	NDC Num: 6 03852 0010820	PO LN 5						
	1ZY785710312211077							
189500	Vendor: BD	SYRINGE SAFETY-LOK LL 30C 10	1	BX	1	17.28	17.28	1.38
	Vend Cat#: 308606	PO LN 7						
	1ZY75571031221077							

Units - \$ 8.00

Danielle Harwal

MCKESSON Claim # 01387394 001/01059

McKesson Medical-Surgical
9954 Mayland Drive Suite 4000
Richmond, VA 23233

DENT NEUROLOGIC INSTITUTE
ATTN ACCOUNTS PAYABLE
3980 SHERIDAN DR STE 500
AMHERST NY 14226

Invoice

P030494000000000000

Account Number	1101833
Document Number	13589659
Date	10/27/2017
Amount	\$107.36

Please contact us regarding electronic payment options at MMS.Treasury@McKesson.com.
Please Rebill To:

MCKESSON MEDICAL SURGICAL
PO BOX 933027
ATLANTA GA 31193-3027



DENT
NEUROLOGIC INSTITUTE

Vernon Bates, MD	Sanjay Gupta, MD	Bennett Myers, MD
Bela Ajmal, MD	Tomas Holmlund, MD	Malli Patel, MD
Alfred Balas III, MD	J. Maurice Houriellane, MD	Mohammad M. Qasimneh, MD
Hercule Capote, MD	Anupama M. Kale, MD	Michelle M. Rainka, PharmD
Ana N. Cervantes, MD	Xiali Li, MD	Luis Rojas, MD
Deanne M. Czarnecki, PhD	Amir C. Mazarri, MD	Nicole Silkoff, MD
J. Aubrey Daquin, PhD	Leslie Moeller, MD	Lixia Zhang, MD, PhD
Mark S. Frost, MD	Jennifer W. McVige, MD	Joseph V. Fritz, PhD, CEO
Francis M. Gengen, PharmD	Kenneth R. Murray, MD	

Abbey L. Burdick, PA-C

Re-Evaluation
Date: 01/11/2018

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 37 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- NF- Requires Opinion
- Patient is here following up for migraines

History of Present Illness

General:

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic reevaluation regarding a motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a 37-year-old female with previous history of migraine headaches who initially presented to this office on 2/19/16 after a motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/16 showed mild multilevel degenerative changes with disk extrusions seen at C4-C5 and C5-C6. She had an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 were normal aside from a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8.

Danielle has tried ibuprofen, Tylenol, Motrin, Lamictal, Nortriptyline, magnesium, Naproxen, Rizatriptan, and Topamax. Chiropractic care, massage therapy, vestibular therapy and physical therapy. Lamictal was not found to be helpful. Vestibular therapy and physical therapy have both proven helpful in symptom management, and she had since been discharged from both. Massage therapy and regular trigger point injections have been helpful with decreasing her cervical myofascial spasm.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal.

The patient has since been experiencing continued symptoms. She was referred to restart physical and vestibular therapies and was started on Topamax. She continued with chiropractic therapy twice per week. At her last reevaluation on 10/19/17, dosing of both Nortriptyline and Topamax was increased. Cambia was recommended as a rescue medication due to GI upset caused by other NSAIDs. She continued with regular trigger point injections and occipital nerve blocks.

The patient returns today with continued symptoms. She is still experiencing about 4 headache days per week. Migraines are occurring about 2-3 times per month. She unfortunately has not been able to start physical or vestibular therapy yet. She underwent her fourth lumbar facet injection with Dr. Siddiqui last

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MR/CT	Neuropsychology
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ImPACT	PNG
Injuries	

month. She states that he used a different technique, and she has unfortunately been experiencing numbness and weakness of her left lower extremity since this procedure. She states that imaging with MRI of lumbar spine is planned. She has continued with massage and chiropractic therapy. She did find Cambia effective as a rescue medication, however this unfortunately is not covered through her insurance. Rizatriptan provides only modest relief for migraineous headaches. She has been tolerating 150 mg of Topamax daily with no side effects. She continues with magnesium daily, and takes Norptriptyline intermittently for sleep.

Current Medications

- Taking Topamax 25 mg tablet 3 tab(s) orally BID
- Taking norptriptyline 10 mg capsule 2 cap(s) orally QHS
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Nasoprosin 500 mg tablet 1 tab(s) orally prn headache, up to BID
- Taking rizatriptan 10 mg tablet 1 tab(s) orally prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Cambia potassium 50 mg powder for reconstitution 50 mg orally PRN Headache. Okay to take again after 2 hours. MDD = 2, MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Working:

Employed: Stay at home mom.

Driving:

Does Patient Drive: Yes.

Caffeine:

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Betas	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	PNG
Defasias	

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Blaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headache, dizziness, weakness, numbness, unsteadiness, sleep problem, double vision, ringing in ears, vertigo, joint pain and stiffness, neck and lower back pain, muscle aches, easy bruising. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 120/78, HR 80, RR 16, Ht 83, WT 246.1, BMI 43.59, BSA 2.23.

Examination

General Examination:

General Appearance: Well-nourished, well-developed, in mild distress, participated with the exam. Well groomed. Eyes: Disc margins clear, no vessel abnormalities, no papilledema. Neck: Supple. Range of motion limited with lateral flexion. Trigger points palpated within cervical musculature bilaterally.

Cardiovascular: peripheral pulses within normal limits. Extremities: Full range of motion of extremities x4. No edema.

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper extremities bilaterally, 3/5 left lower extremity. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Romberg positive.. Sensory: Decreased sensation left lower extremity.

Cranial Nerves:

Cranial Nerve II: Visual fields are full. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

Assessments

1. Posttraumatic headache - G44.309 (Primary)
2. Migraine without aura - G43.009
3. Vestibular dysfunction - H83.2X9
4. Myofascial pain - M79.1
5. Concussion, without loss of consciousness, sequela - S06.0X0S
6. Sleep difficulties - G47.9

DIAGNOSTICS & SERVICES	
MR/CT	Neuropsychology
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Bone	Sleep Studies
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7. Left-sided low back pain with left-sided sciatica, unspecified chronicity - M54.42

Danielle is a 37-year-old female who returns today for reevaluation regarding postconcussive symptoms. At this point, headaches have been her most bothersome and continuous symptom. Patient is having over 15 headache days per month. She has tried multiple preventative agents as listed above. At this point I do believe she would benefit very much from Botox. We will submit for this today. We will also increase her Topamax to 100 mg twice a day. Rather than Rizatriptan, we will have the patient try Sumatriptan as an alternative rescue medication for her migraines. Unfortunately, Cambia was not approved through her insurance. We will send Diclofenac tablets to see if this may provide some relief for her non-migrainous headaches. She will continue with massage therapy and chiropractic therapy. She does plan to continue following with Dr. Siddiqui's office regarding her low back and lower extremity issues. Hopefully, she will be able to attend physical and vestibular therapies again in the near future as these were beneficial for her as well. She will also continue with trigger point injections and occipital nerve blocks. As the patient does have a severe headache at today's appointment, we'll provide her with a Toradol injection in the office today. We will see her back in 2 weeks for trigger point injections, and in 3 months for reevaluation, sooner if needed. This dictation was created with Dragon voice recognition system. Although efforts were made to ensure accuracy, voice recognition errors may be present.

Dr. McVige is the supervising physician on site.

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment**1. Posttraumatic headache**

Stop Topamax tablet, 25 mg, 3 tab(s), orally, BID

Continue magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day

Stop Naprosyn tablet, 500 mg, 1 tab(s), orally, prn headache, up to BID

Stop rizatriptan tablet, 10 mg, 1 tab(s), orally, prn migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3

Stop Cambia powder for reconstitution, potassium 50 mg, 50 mg, orally, PRN Headache. Okay to take again after 2 hours. MDD = 2; MWD = 3

Start topiramate tablet, 100 mg, 1 tab(s), orally, BID, 30 day(s), 60 Tablet, Refills 5

Start Imitrex tablet, 100 mg, 1 tab(s), orally, PRN Migraine; MDD = 2 MWD = 3, 30 days, 9, Refills 5

Start diclofenac tablet, potassium 50 mg, 1 tab(s), orally, prn headache, MDD=2, no more than 3 days per week, 30 day(s), 20, Refills 5

2. Migraine without aura

Notes: submit for Botox.

3. Sleep difficulties

Continue nortriptyline capsule, 10 mg, 2 cap(s), orally, QHS

Continue Melatonin tablet, 3 mg, 1 tab(s), orally, once (at bedtime)

Procedures**Toradol:**

Assessment: Received patient signed informed consent. Patient was in the sitting position. Sterile prep utilizing an alcohol swab was performed. A total of 60 mg Toradol was injected into the left deltoid, with a 27 gauge needle utilized. No complications occurred. Hemostasis was easily maintained. Post injection instructions given to patient. The patient was stable at discharge. Administered by Andrew Sargent, LPN.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 01/11/2018.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 01/11/2018.

Exercise: Patient counseled on importance of moderate physical activity daily. 01/11/2018.

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	Pantoneography
	Sleep Studies
	Doppler/TCD
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	EEG
	Ultrasound
	EMG
	TMS
	ImPACT
	PNG
	Injection

Patient: Harwell, Danielle | DOB: 08/29/1980 | Re-Evaluation

Page 5 of 5

Follow Up
as scheduled

Electronically signed by Abbey Burdick , PA-C on 01/11/2018 at 12:15 PM EST

Sign off status: Completed

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<i>EEG</i>	<i>Ultrasound</i>
<i>EMG</i>	<i>TMS</i>
<i>InPACT</i>	<i>PNG</i>
<i>Infusion</i>	

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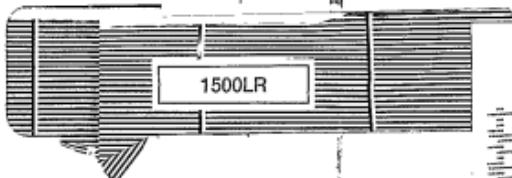
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**INSURANCE CLAIM
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NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

2022年，中国将完成“十四五”规划的制定，开启全面建设社会主义现代化国家新征程。在此背景下，中国将如何调整政策，以应对全球气候变化、促进可持续发展？

$$(\alpha_1 + \beta_1) \otimes 2^{\frac{m}{2}} \in F_{\frac{m}{2}} \otimes 2^{\frac{m}{2} - \frac{m}{2} = 0} = F_{\frac{m}{2}}$$

19. Использование вспомогательных средств для изучения языка
и культуры национальностей, проживающих в России

¹ See T. B. Macaulay, *The Law of War and Peace* (London, 1899).

Figure 10. The effect of the number of hidden neurons on the performance of the neural network.

94.5% (67,755) of 100% of the 2011-12 PCP were met, according to the

Following the first few weeks of the study, the children were asked to draw a picture of their family. The drawings were collected and analyzed to determine the extent to which the children's drawings reflected the reality of their family situation. The results showed that the children's drawings were often inaccurate or incomplete, reflecting a lack of understanding or knowledge about their family members and their relationships.

In India, where the first recorded case was reported in December 2013, the number of diagnosed cases has increased to 1,000,000 as of April 2016.

²⁰ See also the discussion of the relationship between the two in the section on the "Cultural Turn" below.

Wetland areas, which are often flooded, are at risk of drowning as sea levels rise. This is particularly true for coastal wetlands, such as salt marshes, which are highly vulnerable to flooding and erosion.

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Finally, we can use the fact that $\mathbf{P}^{\text{opt}}(\mathbf{y}, \mathbf{x})$ is a convex function of \mathbf{y} to show that $\mathbf{P}^{\text{opt}}(\mathbf{y}, \mathbf{x}) \leq \mathbf{P}^{\text{opt}}(\mathbf{y}', \mathbf{x})$ whenever $\mathbf{y}' \in \mathcal{Y}$ and $\mathbf{y}' \neq \mathbf{y}$.

The mean number of days between the first and last day of the month for each month is shown in Table 1. The mean number of days between the first and last day of the month for each month is shown in Table 1.

For example, the following C# code creates a new `File` object and writes "Hello World" to it:

For CNET's full coverage of CES 2013, check out our CES 2013 hub.

For more information about the study, please contact Dr. Barbara J. Ganzini at (415) 502-2519 or email her at barbara.ganzini@ucsf.edu.

During the US-Soviet summit meeting in Moscow in December 1987, Gorbachev and Bush agreed to eliminate all intermediate-range nuclear missiles from Europe. This was followed by the INF Treaty in 1988, which prohibited the production and deployment of intermediate-range nuclear missiles. The US and Soviet Union had agreed to eliminate all intermediate-range nuclear missiles from Europe by 1991.

¹⁰ See also, e.g., *W. H. Lewis, The Economics of Inflation* (London, 1972), pp. 11-12.

Fig. 10. The effect of the number of nodes.

Having said all of this, it is important to remember that the most important thing is to have fun and enjoy the process of learning and exploring new things.

При $\alpha = \beta = 0$ в дифференциальных уравнениях (1) и (2) коэффициенты a_1 и b_1 равны нулю, а коэффициенты a_2 и b_2 не равны нулю, что соответствует случаю, когда в исходном уравнении (1) коэффициент a_1 равен нулю.

According to the author, the main reason for the lack of interest in the study of the history of the Soviet Union is the absence of a clear historical perspective.

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1017083	Vendor: DHEPPH NDC Num: & 23159164741 12ZY753710312211077	ORGANISTRON HCL, 50% 4ML/2ML PO LN 3	7	EA	7	.60	4.20	0.00
77680	Vendor: HOSPIRA NDC Num: & 004091610450 12ZY753710312211077	MARCINEK RCL, MCIV 0.5% 80ML PO LN 4	8	EA	8	4.88	14.84	0.00
5411850	Vendor: BAYER NDC Num: & 03323016830 12ZY753710312211077	DEXAMETHASONE, VL 4MG/ML 10ML PO LN 5	2	EA	2	8.99	17.98	0.00
189500	Vendor: BD Vend Cat #: 308606 12ZY753710312211077	SYRINGE, SAFETY-LOK LL 3CC (10 PO LN 7	1	BX	1	17.28	17.28	1.38

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Danielle Harwell

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Abbey L. Burdick, PA-C

Re-Evaluation

Date: 01/11/2018

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 37 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- NF- Requires Opinion
- Patient is here following up for migraines

History of Present Illness

General:

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic reevaluation regarding a motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a 37-year-old female with previous history of migraine headaches who initially presented to this office on 2/19/16 after a motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes with disc extrusions seen at C4-C5 and C5-C6. She had an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 were normal aside from a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8

Danielle has tried ibuprofen, Tylenol, Motrin, Lamictal, Nortriptyline, magnesium, Naproxen, Rizatriptan, and Topamax. Chiropractic care, massage therapy, vestibular therapy and physical therapy. Lamictal was not found to be helpful. Vestibular therapy and physical therapy have both proven helpful in symptom management, and she had since been discharged from both. Massage therapy and regular trigger point injections have been helpful with decreasing her cervical myofascial spasm.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal.

The patient has since been experiencing continued symptoms. She was referred to restart physical and vestibular therapies and was started on Topamax. She continued with chiropractic therapy twice per week. At her last reevaluation on 10/19/17, dosing of both Nortriptyline and Topamax was increased. Cambia was recommended as a rescue medication due to GI upset caused by other NSAIDs. She continued with regular trigger point injections and occipital nerve blocks.

The patient returns today with continued symptoms. She is still experiencing about 4 headache days per week. Migraines are occurring about 2-3 times per month. She unfortunately has not been able to start physical or vestibular therapy yet. She underwent her fourth lumbar facet injection with Dr. Siddiqui last

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EMG	EEG
In/PACT	Ultrasound
Infusion	TMS
	VNG

month. She states that he used a different technique, and she has unfortunately been experiencing numbness and weakness of her left lower extremity since this procedure. She states that imaging with MRI of lumbar spine is planned. She has continued with massage and chiropractic therapy. She did find Cambia effective as a rescue medication, however this unfortunately is not covered through her insurance. RizatRIPTAN provides only modest relief for migraineous headaches. She has been tolerating 150 mg of Topamax daily with no side effects. She continues with magnesium daily, and takes Nortriptyline intermittently for sleep.

Current Medications

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- Taking nortriptyline 10 mg capsule 2 cap(s) orally QHS
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking Naprosyn 500 mg tablet 1 tab(s) orally pm headache, up to BID
- Taking nzafiptan 10 mg tablet 1 tab(s) orally pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 intl units capsule 1 cap(s) orally once a day
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Taking Cambia potassium 50 mg powder for reconstitution 50 mg orally PRN Headache. Okay to take again after 2 hours. MDD = 2; MWD = 3
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy

Family History

Father: alive, Stroke

Mother: alive, Asthma

Siblings: alive

1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking: Patient is a non smoker.

Fall History:

Have you fallen. No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs. Denies

Working:

Employed: Stay at home mom

Driving:

Does Patient Drive: Yes.

Caffeine:

<u>DIAGNOSTICS & SERVICES</u>	
MDCT	Neuropsychology
Arthrogram	Posturography
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infusion	

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 Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14271 | Fax: (716) 250-0315
 Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headache, dizziness, weakness, numbness, unsteadiness, sleep problem, double vision, ringing in ears, vertigo, joint pain and stiffness, neck and lower back pain, muscle aches, easy bruising. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 120/78, HR 80, RR 16, Ht 63, Wt 246.1, BMI 43.59, BSA 2.23.

Examination

General Examination.

General Appearance: Well-nourished, well-developed, in mild distress, participated with the exam. Well groomed. Eyes: Disc margins clear, no vessel abnormalities, no papilledema. Neck: Supple. Range of motion limited with lateral flexion. Trigger points palpated within cervical musculature bilaterally.

Cardiovascular: peripheral pulses within normal limits. Extremities: Full range of motion of extremities x4. No edema

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper extremities bilaterally, 3/5 left lower extremity. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Romberg positive.. Sensory: Decreased sensation left lower extremity

Crani Nerves:

Crani Nerve II: Visual fields are full. Crani Nerves III, IV, VI: Extraocular movements intact PERRLA. Crani Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Crani Nerve VII: Face was symmetric and strength was equal bilaterally. Crani Nerve VIII: Hearing was intact to finger rub bilaterally. Crani Nerves IX, X: Swallowing and palate elevation was within normal limits. Crani Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Crani Nerve XII: Tongue was midline.

Assessments

- 1 Posttraumatic headache - G44.309 (Primary)
- 2 Migraine without aura - G43.009
- 3 Vestibular dysfunction - H83.2X9
- 4 Myofascial pain - M79.1
- 5 Concussion, without loss of consciousness, sequela - S06.0X0S
- 6 Sleep difficulties - G47.9

DIAGNOSTICS & SERVICES	
(716) 250-2000	MRVCT
www.dentinstitute.com	Arthrographer
	Bone
	Doppler/TCD
	EEG
	EMG
	ImPACT
	Infrared
	Neuropsychology
	Positronigraphy
	Sleep Studies
	SPECT
	Ultrasound
	TMS
	VNG

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 Batavia Office | 35 Batavia City Centre • Batavia, NY 14020 | Fax: (716) 250-2045

7. Left-sided low back pain with left-sided sciatica, unspecified chronicity - M54.42

Danielle is a 37-year-old female who returns today for reevaluation regarding postconcussive symptoms. At this point, headaches have been her most bothersome and continuous symptom. Patient is having over 15 headache days per month. She has tried multiple preventative agents as listed above. At this point I do believe she would benefit very much from Botox. We will submit for this today. We will also increase her Topamax to 100 mg twice a day. Rather than Rizatriptan, we will have the patient try Sumatriptan as an alternative rescue medication for her migraines. Unfortunately, Cambia was not approved through her insurance. We will send Diclofenac tablets to see if this may provide some relief for her non-migrainous headaches. She will continue with massage therapy and chiropractic therapy. She does plan to continue following with Dr. Siddiqui's office regarding her low back and lower extremity issues. Hopefully, she will be able to attend physical and vestibular therapies again in the near future as these were beneficial for her as well. She will also continue with trigger point injections and occipital nerve blocks. As the patient does have a severe headache at today's appointment, we'll provide her with a Toradol injection in the office today. We will see her back in 2 weeks for trigger point injections, and in 3 months for reevaluation, sooner if needed. This dictation was created with Dragon voice recognition system. Although efforts were made to ensure accuracy, voice recognition errors may be present.

Dr. McVige is the supervising physician on site.

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment

1. Posttraumatic headache

Stop Topamax tablet, 25 mg, 3 tab(s), orally, BID

Continue magnesium oxide tablet, 250 mg, 1-2 tab(s), orally, once a day

Stop Naprosyn tablet, 500 mg, 1 tab(s), orally, pm headache, up to BID

Stop rizatriptan tablet, 10 mg, 1 tab(s), orally, pm migraine, okay to repeat dose in 2 hours, MDD = 2, MWD = 3

Stop Cambia powder for reconstitution, potassium 50 mg, 50 mg, orally, PRN Headache. Okay to take again after 2 hours. MDD = 2, MWD = 3.

Start topiramate tablet, 100 mg, 1 tab(s), orally, BID, 30 day(s), 60 Tablet, Refills 5

Start Imitrex tablet, 100 mg, 1 tab(s), orally, PRN Migraine; MDD = 2 MWD = 3, 30 days, 9, Refills 5

Start diclofenac tablet, potassium 50 mg, 1 tab(s), orally, pm headache, MDD= 2, no more than 3 days per week, 30 day(s), 20, Refills 5

2. Migraine without aura

Notes: submit for Botox.

3. Sleep difficulties

Continue nortriptyline capsule, 10 mg, 2 cap(s), orally, QHS

Continue Melatonin tablet, 3 mg, 1 tab(s), orally, once (at bedtime)

Procedures

Toradol

Assessment: Received patient signed informed consent. Patient was in the sitting position. Sterile prep utilizing an alcohol swab was performed. A total of 60 mg Toradol was injected into the left deltoid, with a 27 gauge needle utilized. No complications occurred. Hemostasis was easily maintained. Post injection instructions given to patient. The patient was stable at discharge. Administered by Andrew Sargent, LPN.

Preventive Medicine

COUNSELING: Healthy Living. Patient counseled on the importance of healthy lifestyle 01/11/2018

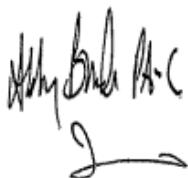
Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 01/11/2018.

Exercise: Patient counseled on importance of moderate physical activity daily 01/11/2018.

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DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Arthrogram	Pain/Imaging
Beta	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
InPACT	VNG
Infrared	

Follow Up
as scheduled

Electronically signed by Abbey Burdick , PA-C on 01/11/2018 at 12:15 PM EST

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
MRI/CT	Neuropsychology
Angiograms	Posturography
Botox	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
EMG	TMS
ImPACT	VNG
Infusion	

*** FAX TX REPORT ***

TRANSMISSION OK

JOB NO. 4900
 DESTINATION ADDRESS 18562945154
 SUBADDRESS
 DESTINATION ID Geico PIP Claims
 ST. TIME 01/17 09:56
 TX/RX TIME 01' 47
 PGS. 7
 RESULT OK



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 9212

1. PICA

GEICO INSURANCE - NF
 NY PIP CLAIMS
 POBOX 9507
 FREDERICKSBURG VA 22403

PICA

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FICA	SECOND	OTHER	15. INSURED'S ID NUMBER	(For Program In Item 1)
<input type="checkbox"/> (Veteran)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (TRICARE)	<input type="checkbox"/> (CHAMPVA)	<input type="checkbox"/> (Group Health Plan)	<input type="checkbox"/> (FICA)	<input type="checkbox"/> (Second)	<input type="checkbox"/> (Other)	0138739400101059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE				4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARWELL, DANIELLE				MM DD YY	SEX	HARWELL, DANIELLE			
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)	
1131 CLEVELAND DR				<input type="checkbox"/> Son	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	1131 CLEVELAND DR	
CITY	STATE	8. RESERVED FOR NUCC USE				CITY	STATE		
CHEKTOMAGA	NY					CHEKTOMAGA	NY		
ZIP CODE	TELEPHONE (Include Area Code)					ZIP CODE	TELEPHONE (Include Area Code)		
14225-1257	()					14225-1257	()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)									
10. IS PATIENT'S CONDITION RELATED TO,									
a. EMPLOYMENT? (Current or Previous)									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
b. AUTO ACCIDENT?									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
c. OTHER ACCIDENT?									
<input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME									
11. IS THIS ANOTHER HEALTH BENEFIT PLAN?									
<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 10a, and 10d									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authenticates the release of any medical or other information necessary to process this claim. I also accept payment of government benefits either to myself or to my attorney who accepts assignments below.)									
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorizes payment of medical benefits to the healthcare provider or supplier for services described below.)									

SIGNED... SIGNATURE ON FILE		DATE 02-09-16		SIGNED SIGNATURE ON FILE	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)		15. OTHER DATE QUAL 439 10 31 15		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN: PETER J GUZINSKI		17a. US2607 17b. MPI 171.0014188		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21. RE-ADMISSION CODE ORIGINAL REF. NO.	
NDC 00409378501		22. REF-ADMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE MM DD YY		B. ICD-10 C. ICD-9-CM D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS CODE F. RENDIMENTS G. MODIFIER		H. ICD-10 I. ICD-9-CM J. RENDIMENTS K. MODIFIER	
1. 01/11/18 01 11 18 11		96372 59 AB 10 43 1		RJ 161582336	
2. 01/04/0409378501 01 11 18 11 J1885 AB N 00 4				RJ 161582336	
3. 01/11/18 01 11 18 11 99214 25 ABCD 74 75 1				RJ 161582336	
				NM 1640506495	

SUPPLIER INFORMATION

CARRIER

PATIENT AND INSURED INFORMATION



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA

PIRA

1. MEDICARE (Medicare #)	2. MEDICAID (Medicaid #)	3. TRICARE (DAVAO#)	4. CHAMPVA (Member ID#)	5. GROUP HEALTH PLAN (ID#)	6. FECA BLK LUNG (ID#)	7. OTHER (ID#)	8. INSURED'S ID. NUMBER (For Programs In Italic)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		5. INSURED'S NAME (Last Name, First Name, Middle Initial) - Same -	
HARNESS, DANIELLE		08 29 1980					
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
56 BEREAVEN DR							
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X		CITY STATE	
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Just Name, First Name, Middle Initial)							
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO NY							
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)							
11. INSURED'S POLICY GROUP OR FECA NUMBER							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.							
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below							
REREAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.							
SIGNED - ON FILE - DATUM 06-2016 SIGNED - ON FILE -							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 10 31 2015 QUA:		15. OTHER DATE QUAL: MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAU, PA		17a. MM DD YY 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)							
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Refer A-L to service line below (24e) ICD IND: A 1679-1 B C 1 D 1 E 1 F G 1 H 1 I J K L							
22. RESUBMISSION CODE ORIGINAL REF NO.							
23. PRIOR AUTHORIZATION NUMBER							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE E/MG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		D. MODIFIER E. DIAGNOSIS POWERER F. \$ CHARGES G. DAYS OR WEEKS H. DASH I. ID QUA. J. RENDERING PROVIDER ID #	
1	01 12 18 01 12 18 11			97140			55 00 3 NPI 3144462011
2	01 16 18 01 16 18 11			97140			55 00 3 NPI 3144462011
3							NPI
4							NPI
5							NPI
6							NPI
7							
25. FEDERAL TAX ID NUMBER 47-0989449	SSN EIN	26. PATIENT'S ACCOUNT NO. HARNESS, D	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (For Govt clients, see back)	28. TOTAL CHARGE \$ 110 00	29. AMOUNT PAID \$ 0 00	30. FEE FOR NUCC USE 110 00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.)							
32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPWA, NY 14043							
33. BILLING PROVIDER INFO & PH # 716 725-0264							
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPWA, NY 14043							
COLLEEN MARX, LMHC 01.18.2018 SIGNED DATE f144462011 b f144462011 b							

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a), if item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown in Medicare assigned or TRICARE participation cases; the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary; this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in 'Insured', i.e., items 4, 6, 7, 9 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (OR MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment, including but not limited to the Federal anti-fraud statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form are medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license # or SSN) of the primary individual rendering each service is reported in the designated section. For services to be used incident to a physician's professional service, 7) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be integral, although incidental part of a covered physician's service; 8) they must be of kinds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refers to 5 USC 8536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA and Black Lung programs. Authority to collect information is in section 205(a), 1602, 1672 and 1674 of the Social Security Act as amended, 42 CFR 411.24(p) and 424.3(a)(8), and 44 USC 3101.41 CFR 101 et seq and 10 USC 1079 and 1085 5 USC B101 et seq, and 30 USC 901 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that require other third parties pay to Federal program and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37349, Wed. Sept. 11, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, 'Republication of Notice of Systems of Records,' Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-39, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

DISCLOSURE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURE PURPOSES: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1129B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the 'Computer Matching and Privacy Protection Act of 1988', permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of the claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-26, Baltimore, Maryland 21244-1830. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office (716) 725-0204

Fax (716) 725-0265

Client Name: Dawelle Harrie Date: 1/2/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area's of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior) _____
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Still experiencing Right leg numbness but feels burning & tingling when Right leg is walked. Type A thoracic Cervical Low back restricted to the right side and Cervical myofascial hypertonicity decreasing slowly client self

Actions Applied: (Check All that Apply) Boiling Statwy w/

- Heat Packs Cold Packs Sombra/Biofreeze X M.D. waist
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat
 Great Lakes

Practice: Therapeutic Massage Initials: MFR
NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14243

Office (716) 725-0204

Fax (716) 725-0265

Client Name: Dawelle Harrie Date: 1/6/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area's of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior) _____
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R?) (L?)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Slowly getting some sensation back in right side and entire leg. Cervical low back restricted to the right side. Hypertonic upper trap, scalene & latiss. scap.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat
 Great Lakes

Practice: Therapeutic Massage Initials: MFR
NYS Licensed Therapist

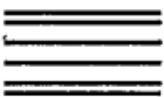
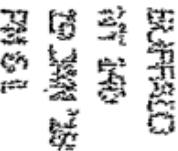
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GREAT LAKES THERAPEUTIC MASSAGE

*Attn: Colleen Marx
375 Dick Road, Suite #2
Depew, NY 14043*



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 10110 WASHINGTON D.C.

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FREDERICKSBURG VA 22403-9527

[Page 170]

14985



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIRA

PIRA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FEGI OTHER (Medicare #) (Medicaid #) (DOD/DoD) (Member ID#) (NIN) (BLK LUM) (DOD) X (DOD)												1c. INSURED'S ID. NUMBER (For Program Item 1) 013873940-0101-059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -			
5. PATIENT'S ADDRESS (No., Street) 56 BEREHAVEN DR												6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
CITY AMHERST		STATE NY		8. RESERVED FOR NUCC USE X		CITY STATE											
ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536-0951				ZIP CODE ()		TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FEGI NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
a. OTHER INSURED'S POLICY OR GROUP NUMBER												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <small>PLACE (S/N)</small>		b. OTHER CLAIM ID (Designated by NUCC)			
b. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			
c. RESERVED FOR NUCC USE												d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. If yes, complete items 9, 9a and 9b.			
d. INSURANCE PLAN NAME OR PROGRAM NAME												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
SIGNED - ON FILE												DATE 01-06-2016		SIGNED - ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 2015 QMUL												15. OTHER DATE MM DD YY QUL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE EDWARD GRABAU, PA												17a. MM DD YY 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A/L to service line below (24E)												22. RESUBMISSION CODE ORIGINAL REF. NO.					
A. M79.1		B.		C.		D. ICD IND I		E.		F.		G.		H.		I. ID. QUAL	
E.		F.		G.		H.		I.		J.		K.		L.		J. RENDERING PROVIDER ID #	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMR		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS		D. MODIFIER		E. DIAGNOSIS CODER NUMBER		F. \$ CHARGES		G. DAYS OR UNITS		H. UNIT PER DAY		I. ID. QUAL	
1. 01 22 18 01 22 18 11		2. 01 26 18 01 25 18 11		3. 1 1 1 1 1 1 1		4. 1 1 1 1 1 1 1		5. 1 1 1 1 1 1 1		6. 1 1 1 1 1 1 1		7. 1 1 1 1 1 1 1		8. 1 1 1 1 1 1 1		9. 1 1 1 1 1 1 1	
97140		97140		1		1		1		55 00		3		55 00		3	
NPI 1144462011		NPI 1144462011		NPI		NPI		NPI		NPI		NPI		NPI		NPI	
25. FEDERAL TAX ID NUMBER 47-0989449		SSN EMR <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO HARWELL, D		27. ACCEPT ASSIGNMENT? <small>Per Govt. Stat., see back</small> <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 110 00		29. AMOUNT PAID \$ 0 00		30. RESID FOR NUCC USE 110 00					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If certify that the statements on the reverse apply to this bill and are made a part thereof.) COLLEEN MARX, LMFT SIGNED DATE		32. SERVICE FACILITY LOCATION INFORMATION GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPew, NY 14043		33. BILLING PROVIDER INFO & PH# 716 725-0264													
34. BILLING PROVIDER INFO & PH# 1144462011		35. BILLING PROVIDER INFO & PH# 1144462011		36. BILLING PROVIDER INFO & PH# 1144462011													

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS. A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-lit, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 8 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE preferred provider cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE local intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE local intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured": i.e., items 1a, 4, 6, 7, 8, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal Anti-Kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license # or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 434.32).

NOTICE. Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2051(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 42 U.S.C. (b), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1088, 5 USC 8101 et seq and 30 USC 801 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, comers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice matching system No 09-70-0501, titled, "Carmer Medicare Claims Record," published in the Federal Register, Vol 55 No 177, page 37540, Wed Sept. 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol 55 No 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLAIMERS: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1126B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE. This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claim, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05 Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0324

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 1/22/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 5 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior) _____
 Upper Thoracic (Anterior) Upper Thoracic (Posterior) _____
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: Cervical/mid/lower back
Shoulder very tight. LBP esp on L side still present, but feeling
and tingling are being felt instead of just numbness. (Left mid/lower back)

Actions Applied: (Check All that Apply) SL Hyper tonic

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Practice: Therapeutic Massage Initials: MKF
NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0324

Fax: (716) 725-0265

Client Name: Danielle Howell Date: 1/24/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior) _____
 Upper Thoracic (Anterior) Upper Thoracic (Posterior) _____
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: feeling starting to come back
in L leg and foot. RMS and neck
very sore. Hypertonicity (B) shoulder/mid
back down, between shoulder blades
into rhomboids.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretching Con't Meds Ice / Heat

Practice: Therapeutic Massage Initials: MKF
NYS Licensed Therapist

04-29-86

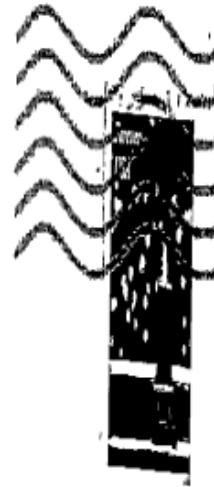
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GREAT LAKES THERAPEUTIC MASSAGE

Attn: Colleen Marx
375 Dick Road, Suite #2
Depew, NY 14043

BUFFALO NY 142

26 JAN 2018 PM 2 L



GEICO INS CO of NY
P.O. BOX 9507
FREDRICKSBURG, VA 22403

22403-952607



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO
NY PIP
P O BOX 9507
FREDERICKSBURG VA 22403

CARRIER →

PICA												PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPAVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (Medicare) (Medicaid) (TRICARE) (Member ID#) (Plan #) (FECA BULLENG) (Other)													1a INSURED'S ID NUMBER 0138739400101059 (For Progress in Part 1)								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE				3. PATIENT'S BIRTH DATE MM DD YY 08 29 1980 M <input checked="" type="checkbox"/>				SEX <input checked="" type="checkbox"/> F				4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE									
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE				6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE													
CITY CHEEKSTOWAGA				STATE NY				CITY CHEEKSTOWAGA				STATE NY									
ZIP CODE 14225		TELEPHONE (Include Area Code) (716)-536-0951		ZIP CODE 14225		TELEPHONE (Include Area Code) (716)-536-0951															
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE													10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
													b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO _____ PLACE (State) _____								
													c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO _____								
													d. INSURANCE PLAN NAME OR PROGRAM NAME 10d CLAIM CODES (Designated by NUCC) READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE	e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d							
													f. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE								
													SIGNED DATE 02 13 2018								
													SIGNED								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) 10 31 2015				15. OTHER DATE QUAL. MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN SARAH OMARA PA-C				17b G2 17b NPI 1396057287				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)													20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES								
													21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24e)) A. M5126 B. M5127 C. M5136 D. M5137 E. M2578 F. M47896 G. M48061 H. M4807 I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF ID							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY				B. PLACE OF SERVICE EMR				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS				D. MODIFIER				E. DIAGNOSIS POINTERS	F. \$ CHARGES	G. DAYS ON WATER	H. PER ITEM AMT	I. ID QUAL.	J. RENDERING PROVIDER ID #
1 2 3 4 5 6	02/02/18 	 	 	 	 	 	 	 	 	 	ABCD 	733.04 	1 	NPI 	1528173747 						
25. FEDERAL TAX ID NUMBER 262448643	SSN EN <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 88430	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO REASON FOR REJECTION _____	28. TOTAL CHARGE \$ 733.04	29. AMOUNT PAID \$ 0.00	30. Rev'd for NUCC Use 															
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) ALAM, UZMA, MD				32. SERVICE FACILITY LOCATION INFORMATION BUFFALO DIAGNOSTIC IMAGING 4925 MAIN STREET AMHERST NY 14226-4081				33. BILLING PROVIDER INFO & PH # 716-839-3333 BUFFALO DIAGNOSTIC IMAGING, PLLC 4925 MAIN STREET AMHERST NY 14226-4081													
SIGNED 02 13 18				DATE 4821262866				DATE 				DATE * 1821262866									

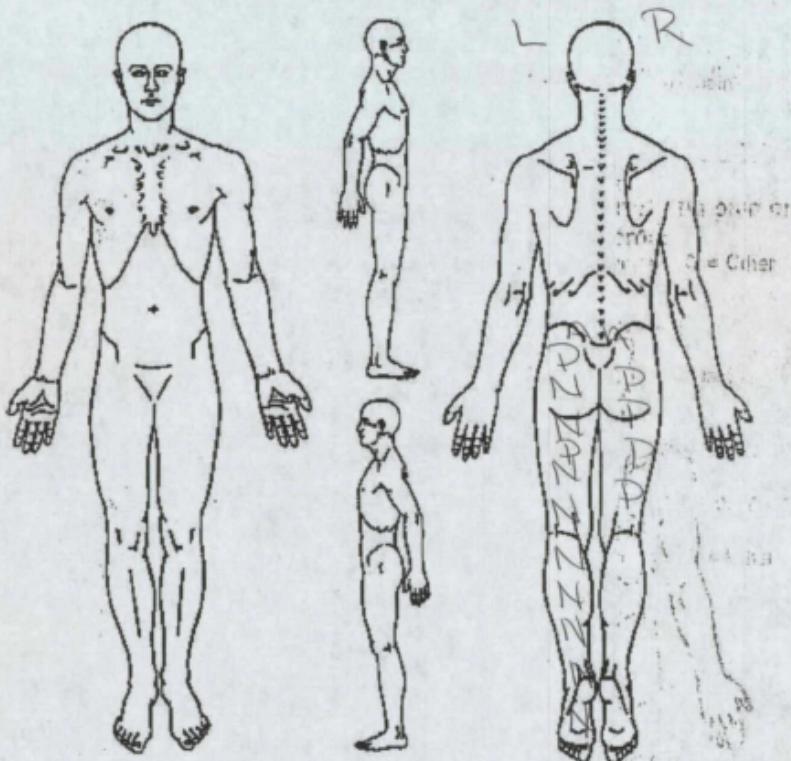
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PAIN DIAGRAMPATIENT'S NAME Danielle Harwell

On the diagram below, please indicate where you are experiencing pain or other symptoms. Use the following to describe your symptoms:

A = Ache B = Burning N = Numbness P = Pins & Needles S = Stabbing O = Other



Please rate your current level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's Signature: Danielle Harwell Date: 2/2/18

02 19 18

After 1989, the Chinese government has been making significant efforts to improve its environmental protection laws and regulations, and has made some progress in this area.

ISSN 2333-8330 • 10000000000000000000

At 10:00 AM and 11:00 AM of October 1, 1973, the author witnessed the most interesting bird of my travels, the Chestnut-tailed Starling. This bird was seen in the same area as the Chestnut-tailed Starling, but it was a different species. The Chestnut-tailed Starling was seen in the same area as the Chestnut-tailed Starling, but it was a different species. The Chestnut-tailed Starling was seen in the same area as the Chestnut-tailed Starling, but it was a different species.

1983年3月1日

¹⁰ See also *ibid.*, 47–50, which discusses the relationship between the two forms of the law.

SIGN-ON PAGE FOR INFORMATION ON ALL FUEL, OIL AND LUBE TRADES, BE SURE TO ASK ABOUT THE NEW

For example, the following statement creates a new table named *Customer* with three columns: *CustomerID*, *Name*, and *Address*:

1971 at 1812 minutes, the witness saw a plane fly over his house. The plane was flying from west to east by making turns and oscillations (142 CTR-124-24).

NOTES: All dimensions are in inches unless otherwise specified. All parts are to be machined from solid aluminum except where noted. Dimensions are to center of hole or centerline.

ROUTINES TO PRACTICE A BOMB, ITS OWN LETTER TO THE BOMBING CASE TRIMMED, RECALLED AND LEADS REPORTER TO THE PRISONER'S ATTORNEY'S OFFICE.

enforcement in 10 CFR 1023.41-1023.42, and sections 1023.43-1023.44, if only Act 10 is amended, 10 CFR 41.204(a) and 493.5(b)(8), and 10 USC 1010-1014 (4 CFR 101-104 and 10 USC 1010-1014).

The information, related to current circumstances in the program, is to determine who and to whom you apply. It is also used to determine the services and benefits you receive. The information is collected by the program operator.

The information includes the following: Information about your family, including your name, address, telephone number, date of birth, marital status, sex, race, ethnicity, and education level; information about your employment, including your occupation, industry, employer, and wage rate; information about your income, including your gross income, net income, and assets; information about your health, including your medical history, medications, and treatments; information about your housing, including your type of housing, location, and condition; information about your transportation, including your vehicle type, license plate, and maintenance costs; information about your financial resources, including your bank accounts, investment portfolios, and other assets; information about your social support network, including your family members, friends, and neighbors; information about your legal status, including your criminal record, and information about your military service, if applicable.

For: DIEDRICHSEN, S.A.M. (Sergeant Major) (1900-1963); Filed: 06/11/1968; Chancery Court rather than Probate Court; File No. 177; page 875/2
Date: 06/12/1968; Jurisdiction: Probate.

FOR CITATION: *Adolf Hitler's Mein Kampf*, trans. by Ralph Manheim, trans. ed. by Leo Baeck, introd. by Sir Stephen Spender (London: Weidenfeld and Nicolson, 1972). For ISBN 5 7536 0881 2 £3.25. © 1925, 1926, 1928, 1930 by Adolf Hitler.

FOR PRACTICE: CLINICAL PRINCIPLES OF INFECTION To get the clearest fix in your mind of what is involved in infection, it is best to go through each of the following clinical situations.

¹⁰ See also the discussion of the role of the state in the development of the economy in Chapter 1. The argument presented here is that the Chinese state has been instrumental in the growth of the economy through its role as a major player in the market.

If you prefer, click on "File > Open Log", then double-click on "Logfile for dynamic layout test". Screens 1-129 of the "Card Games" set and 1-130-132 of the "Bingo" set should now appear.

You should be comfortable with Part 1 and 2 of the Canadian Leadership and Personal Development Guidebook and have completed the first two modules of the Leadership and Personal Development course.

1500: 351-404 15126 00000000000000000000

There are also opportunities to increase the "fully developed" component of the BSA's APR, which can be used to reduce energy costs, and potentially offset energy costs through the "Green Power" program.

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NOTICE: This is a confidential document of the Commonwealth of Massachusetts. It is loaned to the recipient for the sole purpose of assisting in the preparation of the defense against the Federal grand jury's indictment.

According to the PRC's "Regulations on the Protection of Minors" (1999), the state protects minors in accordance with the following principles: "Minors shall be protected from physical abuse, mental abuse, and other forms of maltreatment." The term "minor" refers to individuals under the age of 18.

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammography

Bone Density/DEXA

SARAH OMARA, PA
180 PARK CLUB LANE
BUFFALO, NY 14221-5259

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 2/2/2018 1:46:00 PM

MRI LUMBAR SPINE W/O CONTRAST 20MIN**REASON FOR STUDY AND CLINICAL INFORMATION:** Back pain.**COMPARISON:** 1/4/2016.**IMAGING SEQUENCES:** Unenhanced multiplanar 3-T MR Imaging of the lumbar spine is performed.**FINDINGS:** The lumbar spine is imaged from T11-12 to the L5-S1 level. L5-S1 is the last labeled level for the purpose of the study.

The height of the lumbar vertebral bodies is well-maintained. A hemangioma is seen within the T12 and L4 vertebral body.

The conus terminates at the level of the T12 vertebral body and within limits of the study, no suspicious signal is seen in the distal conus.

At T12-L1 and L1-2, the discs are well-hydrated. The canal and neural foramina are patent.

At L2-3, the disc is well-hydrated. The canal and neural foramina are patent.

At L3-4, note is made of severe disc space narrowing with endplate spurring and there is an annular bulge that does flatten the thecal sac. These changes result in mild canal narrowing. The neural foramina are patent. This is unchanged from the prior study.

At L4-5, there is disc space narrowing with facet arthropathy. There is a broad-based annular bulge that flattens the thecal sac resulting in overall mild canal stenosis similar to the prior study. Mild recess narrowing is seen. The far neural foramina maintain their caliber.

At L5-S1, there is disc space narrowing with a central broad-based disc protrusion and increased epidural fat is noted. Mild bilateral neural foraminal narrowing is seen and centrally there is mild canal stenosis. This is unchanged from the prior study.

IMPRESSION:

1. AT L3-4 THERE IS DISC SPACE NARROWING WITH ENDPLATE SPURRING AND DISC DESICCATION WITH CENTRAL DISC EXTRUSION CAUSING MILD CANAL STENOSIS SIMILAR TO THE PRIOR STUDY.
2. AT L4-5 A CENTRAL BROAD-BASED DISC PROTRUSION WITH ANNULAR TEAR IS SEEN TO CAUSE MILD CANAL STENOSIS. FACET ARTHROPATHY SEEN. THESE CHANGES RESULT IN MILD BILATERAL RECESS NARROWING. THE NEURAL FORAMINA ARE PATENT.

Buffalo Diagnostic
Imaging, PLLCSnyder Place
4925 Main Street
Amherst, NY 14226P: 716.839.3333
F: 716.839.3338
Toll-Free 888.MRI.3939

buffalomri.com

1 Tesla Open MRI

128 Slice CT

Ultrasound

X-Ray

Fluoroscopy

Soft Digital Mammography

Bone Density/DEXA

SARAH OMARA, PA
180 PARK CLUB LANE
BUFFALO, NY 14221-5259

Patient: DANIELLE HARWELL

DOB: 8/29/1980

ID: RAM1965183

DOS: 2/2/2018 1:46:00 PM

3. AT L5-S1 CENTRAL BROAD-BASED DISC PROTRUSION AND INCREASED EPIDURAL FAT CAUSE MILD CANAL STENOSIS. THERE IS BILATERAL MILD NEURAL FORAMINAL NARROWING AS WELL UNCHANGED FROM THE PRIOR STUDY.

Thank you very much for referring this patient to us.

Sincerely,

Signed by UZMA ALAM, MD at 2/2/2018 6:20:04 PM

2/2/2018 3:25:58 PM



Buffalo Diagnostic
Imaging, PLLC

Snyder Place
4925 Main Street
Amherst, NY 14226

P: 716.839.3333
F: 716.839.3338
Toll-Free 888.MRI.3939

buffalomri.com

Patient Xray Order Requisition

Harwell, Danielle
1131 CLEVELAND DRIVE
CHEEKTOWAGA, NY 14225

PATIENT

H-Phone: 716-536-0951 DOB : 08/29/1980
W-Phone:
C-Phone: 716-536-0951 Sex : F
Race : Declined to Specify / U Chart: 100716MS
Account: 102251

Cof: 86 Policy#: 0138739400101059
NF GRICO
PO BOX 9507
FREDERICKSBURG, VA 22403

PRIMARY INSURANCE

Insured Name: DANIELLE HARWELL
DOB : 08/29/1980
Group Number:
Plan Name :
Onset Date : 10/31/15

Cof: 20 Policy#: DBD16761Q00
IHA MEDISOURCE/ESSENTIAL
P O BOX 9066
BUFFALO, NY 14231-9066

SECONDARY INSURANCE

Insured Name: DANIELLE HARWELL
DOB : 08/29/1980
Group Number: 13207
Plan Name :
Expired Date: 06/00/00

FACILITY INFORMATION

Name : TO BE DETERMINED AT CHECK OUT

Phone:
Fax :

X-RAY ORDER

Status: Ordered
Doctor: O'mara, Sarah, PA-C
180 PARK CLOU LANE, SUITE
WILLIAMSVILLE, NY 14221-5259

UPIN : NPI:1396057287
Id : 03-0445678

Ordered : 01/02/18 8:07 am
Sched : 06/00/00
Acquired: 00/00/00
Req# : 227727
Phone : (716)-218-1000
Fax : (716)-580-7677

ORDER NOTES

Worsening left leg pain s/p epidural injection

Buffalo Diagnostic Imaging, PLLC
4925 Main Street
Amherst, NY 14226
Phone: 716-839-3333

IHA/ NIA Authorization: 18031B412
Valid: 1/31/18-4/1/18

CPT	Test Name	Priority	Acc#
72148	MRI, Lumbar Spine, W/O Contrast	Routine	227727-1493325
Dx: M47.26	Other spondylosis with radiculopathy, lumbar region		

Ordering Provider's Signature:

electronically signed by Sarah O'mara, PA-C on 01/02/18 at 8:07 am

Appointment Date: 2/2/2018 1:45:00 PM		Patient ID: RAM1965183
Study Type: MRI LUMBAR SPINE W/O CONTRAST 20MIN	Patient Name: DANIELLE HARWELL	
Date of Birth: 8/29/1980	Social Security #:	
Phone Number: (716)536-0951	Address: 56-BERKHAVEN DR BETH (BETHEL BY 1422)	
1131 Cleveland Dr Cheektowaga, NY 14222		

Follow-up Appointment Date/Time and Doctor	2/7/18
Referring Provider	SARAH OMARA, PA
Referring Provider Address	180 PARK CLUB LANE BUFFALO, NY 14221-5259

Primary Insurance:	GEICO	ID	0138739400101059	Group ID:	N
Secondary Insurance:	IHA MEDISOURCE	ID	DBD16761Q00	Group ID:	N
Type of fee: <input checked="" type="checkbox"/> Copay <input type="checkbox"/> Private Pay <input type="checkbox"/> Deductible <input type="checkbox"/> Payment for CD (\$5.00) <input type="checkbox"/> Payment for Films (\$20.00) <input type="checkbox"/> Mammogram Pad (\$7.00) <input type="checkbox"/> M2S Payment (\$225.00)	Amount Due: \$0.00 Amount Paid: Remaining Balance: <i>*These amounts are what are known at the time of service. After the final billing process, these amounts may change.</i>	Employee Initials: Type of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card <input type="checkbox"/> Check <input type="checkbox"/> Copay not collected <input type="checkbox"/> Copay unknown, bill Patient			

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of a summarization of the current Federal law protecting the privacy of your health information has been provided for your review. If you would like a copy of the summary of the law, please request it. We are also required by law to ask for your signature acknowledging only that you have seen a copy of the summarized law. By signing below you are acknowledging that we have shown you a copy of the summarized law. I have been offered a copy of the Notice of Privacy Practices for Protected Health Information (PHI) from Buffalo Diagnostic Imaging, PLLC.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE OF RECORDS

I hereby authorize Buffalo Diagnostic Imaging, PLLC to release any information, including the diagnosis, records, and services rendered to my doctor(s) and/or insurance company. I hereby give my authorization to release any of my medical records requested by Buffalo Diagnostic Imaging PLLC at Buffalo MRI. I hereby authorize direct payment(s) to Buffalo Diagnostic Imaging PLLC for services rendered. I understand I am financially responsible for and guarantee payment of all charges not covered by the insurance(s) I presented at the time of study or properly authorized by my insurance.

EFFECTIVE APRIL 1ST 2017: If you do not pay on your account within 30 days, you will be charged a monthly fee of \$20

An account referred to an outside collection agency will be charged an additional 25% collection fee on the unpaid balance. You will also be responsible for additional service fees, interest and attorney's fees while your account is in collection.

MRI SAFETY

My Medical History has not changed since my Prescreening Interview performed on: 1/31/18. Please let us know if you'd like a copy.

MEANINGFUL USE:

RACE: Declined

ETHNICITY: Declined

SMOKING STATUS: Declined

Updated information in Ransoft

I verify that the above information is accurate and confirm that I have read and agree to the statements above.

Patient/Guardian Signature

Danielle Harwell
Buffalo MRI
Healthcare for you

Date:

2/2/18

Buffalo MRI
High-Field & Open MRI Multi-Slice Spiral CT

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENTS OF BENEFITS FORM)**
(For Accidents Occurring on and After 3/1/02)

I, DANIELLE HARWELL ("Assignor") hereby assign to Buffalo Diagnostic Imaging, PLLC, all the right privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on the behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the action or conduct of the assignor.

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF THE MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM KNOWLINGLY MAKES OR KNOWLINGS ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, OR DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

PATIENT: DANIELLE HARWELL

2/2/18	Danielle Harwell
Date	Signature of Patient

BUFFALO DIAGNOSTIC IMAGING, PLLC
BUFFALO MRI
4925 MAIN STREET
AMHERST, NY 14226

Date	Signature of Provider

NYS FORM NF-AOB (REV 1/2004)

PLEASE READ AND SIGN

I certify my No Fault claim is an established, non-controverted claim and I am still receiving all medical benefits for the above injury. I understand I am also responsible for the No Fault deductible.

2/2/18	Danielle Hanwell
Date	Signature of Patient

Patient Name: Danielle Harwell Date: 2/2/18

Injury Description Template

Injured Body Part(s): Neck, Head, Back, Left arm

Type of Accident:



No Fault

Were you the Passenger or Driver? Driver

Type of vehicle you were in (SUV, Car, Truck, etc.) Van

Type of other vehicle in accident (SUV, Car, Truck, etc.) Car & SUV

Location of Accident (Parking Lot, moving traffic, etc.) Stopped



Workers Comp

Description of what happened/injured body part: _____



Other: _____



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

CARRIER ← →

013873940011059

PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA DEDCTNG OTHER to INSURED'S ID NUMBER (For Program in Item 1)												
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> (DADs/DI) <input type="checkbox"/> (Member ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) <input type="checkbox"/> (ID#) 013873940011059												
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)												
HARWELL DANIELLE 5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												
3 PATIENT'S BIRTH DATE MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F												
6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other												
7 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT												
CITY CHEEKTOWAGA		STATE NY		CITY AMHERST		STATE NY						
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951						
8 RESERVED FOR NUCC USE												
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												
a OTHER INSURED'S POLICY OR GROUP NUMBER												
b RESERVED FOR NUCC USE												
c RESERVED FOR NUCC USE												
d INSURANCE PLAN NAME OR PROGRAM NAME GEICO												
10 IS PATIENT'S CONDITION RELATED TO, a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NY c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
11 INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X												
12 IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d												
13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.												
SIGNED SIGNATURE ON FILE DATE SIGNED SIGNATURE ON FILE												
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 15 OTHER DATE MM DD YY 16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY												
103115 QUA 431 454 111215												
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17A <input type="checkbox"/> 17B <input type="checkbox"/> NPI												
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY												
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
20 OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 5 CHARGES												
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Retain A-L to service line below (24E) ICD IND <input type="checkbox"/> 0												
a M50.222 b M51.26 c M51.27 d M54.12 e I62.3 XXXA f M99.01 g M99.03 h M99.02 i M99.05 j M54.2 k M54.5 l M54.6												
22 RESUBMISSION CODE ORIGINAL REF NO												
23 PRIOR AUTHORIZATION NUMBER												
24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLAC/OF SERVICE ENG C. O. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D. MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EXPENDITURE PER UNIT I. 1,000 UNITS J. RENDERING PROVIDER ID #												
1	01152018	01152018	11	98941			ABCD	32 28	1	NPI	1710014188	
2	01152018	01152018	11	97010			ABCD	10 53	1	NPI	1710014188	
3	01182018	01182018	11	98941			ABCD	32 28	1	NPI	1710014188	
4	01182018	01182018	11	97010			ABCD	10 53	1	NPI	1710014188	
5	01232018	01232018	11	98941			ABCD	32 28	1	NPI	1710014188	
6	01232018	01232018	11	97010			ABCD	10 53	1	NPI	1710014188	
25	FEDERAL TAX ID NUMBER SSN EIN 364500165		26 PATIENT'S ACCOUNT NO 3438Z1270		27 ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28 TOTAL CHARGE \$ 128.43		29 AMOUNT PAID \$		30. Revd for NUCC Use	
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse side to the left and above made are true and correct.) PETER GOZINSKI DC CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849												
32. SERVICE FACILITY LOCATION INFORMATION												
33 BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849												
SIGNED 02132018 DATE "1235256546" "1235256546"												

Encounter dated 01/23/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (diversified prone); Occiput left posterior (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy; left lumbar ultrasound, 1.5w/cm² 1 MHz 100% (8 minutes). *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms; Stressed the importance of performing home exercises to help with pain and improved ROM. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

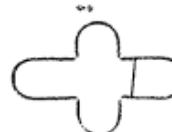
Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 01/23/2018 at 8:43am

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

02 19 18



Item# 43568
Print Pending



02 19 18



~~RECEIVED
CITY OF BUFFALO~~
346 Dick Rd.
Depew, NY 14043

Geico
P.D. Box 9507
Fredricksburg, VA 22403

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
February 13, 2018

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Monday January 15, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 01/15/2018 at 9:53am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. She stated that she has a follow up at DENT on January 11, 2018. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->4/10. *Pain is constant.* *Pain radiates to:* left shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* She states that her headaches remain the same. She states that the duration varies, but they no longer last all day. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches as well. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting. *Range:* 3->4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating "that I feel a little better. I can move my left big toe better." Patient still waiting for her lumbar MRI to be approved. Follow up with Dr. Siddique is January 31, 2018. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Encounter dated 01/15/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 02/13/2018

Cervical: Range of motion: flexion: WNL 50/50 with no pain; extension: WNL 60/60 with pain lower neck; left rotation: WNL 80/80 with pain left lower neck ; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain; right lateral bending: WNL 45/45 with no pain. Posture: rounded shoulders.

Hypertonicity & Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild to Moderate. Trigger points: left levator scapulae, bilateral upper trapezius. Orthopedic tests: left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. X-ray findings: Chest and cervical spine x-rays were performed at Immediate Care on November 1, 2015. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. Spinal subluxation level(s): C5, C6, left occiput, left first rib. Subluxations detected by: motion and static palpation.

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Moderate. Trigger points: bilateral rhomboids. Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.

Lumbar/Sacral/Pelvis: Range of motion: flexion: 40/60 with pain lower back; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. Gait pattern: normal. Strength: left extensor hallucis longus: 5/5; right extensor hallucis longus: 5/5; left tibialis anterior: 5/5; right tibialis anterior: 5/5; bilateral gluteus maximus: 4/5. Tenderness & Hypertonicity lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. Tenderness on palpation: left SI: moderate. Trigger points: left gluteus maximus. Orthopedic tests: Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by: motion and static palpation.

Assessment

Cervical assessment: Mrs. Harwell's condition has remained similar to her last visit. Diagnosis: M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). Prognosis: Guarded. Post-treatment analysis: patient tolerated treatment without incident. Set backs: Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. CPT code(s): 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained relatively unchanged since her last visit. Differential diagnosis: Thoracic disc herniation. Post-treatment analysis: patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last visit. Her VAS score

Encounter dated 01/15/2018 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 02/13/2018

improved from a 5 to 6 to 4 out of 10. In addition, Bechterew's Test was negative today and her left tibialis anterior and extensor hallucis longus were stronger and graded 5/5 from a 4/5. Furthermore, her left SLR improved from 45 to 60 degrees and without lower back or leg pain today. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Visit# 4 of 8 planned treatments.* *Treatment schedule:* 2x/week for 2 weeks; Re-examination for 2 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (no treatment rendered); C6 left lateral flexion restriction (no treatment rendered); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (diversified prone); Occiput left posterior (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy; left lumbar ultrasound, 1.5w/cm² 1 MHz 100% (8 minutes). *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts,

Encounter dated 01/15/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018

misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 01/15/2018 at 9:53am

Thursday January 18, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 01/18/2018 at 9:43am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. She stated that her left shoulder pain has been a little better. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->4/10. *Pain is constant.* *Pain radiates to:* left shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* She states that her headaches remain the same. She states that the duration varies, but they no longer last all day. Patient stated that she gets intermittent dizziness with the headaches. She states that does experience an irritation to bright lights with the headaches as well. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting. *Range:* 3->4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that she continues to feel better especially with her left leg pain. "My left leg is slowly coming back." Patient still waiting for approval of her lumbar MRI. Follow up with Dr. Siddique is January 31, 2018. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 4/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with pain lower neck; left rotation: WNL 80/80 with pain left lower neck ; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain; right lateral bending: WNL 45/45 with no pain. *Posture:* rounded shoulders. *Hypertonicity & Tenderness* Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left

**Encounter dated 01/18/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018**

Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Chest and cervical spine x-rays were performed at Immediate Care on November 1, 2015. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left occiput, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 40/60 with pain lower back; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Strength:* left extensor hallucis longus: 5/5; right extensor hallucis longus: 5/5; left tibialis anterior: 5/5; right tibialis anterior: 5/5; bilateral gluteus maximus: 4/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Mrs. Harwell's condition has remained similar to her last visit. *Diagnosis:* M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. *CPT code(s):* 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained relatively unchanged since her last visit. *Differential diagnosis:* Thoracic disc herniation. *Post-treatment analysis:* patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back continues to improve. Her left tibialis anterior and left extensor hallucis longus are remaining strong and graded 5/5. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with

Encounter dated 01/18/2018 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 02/13/2018

central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches.

Visit# 5 of 8 planned treatments. Treatment schedule: 2x/week for 2 weeks; Re-examination for 2 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (no treatment rendered); C6 left lateral flexion restriction (no treatment rendered); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (diversified prone); Occiput left posterior (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy; left lumbar ultrasound, 1.5w/cm² 1 MHz 100% (8 minutes). *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 01/18/2018 at 9:43am

Tuesday January 23, 2018 Provider: Peter Guzinski DC

Encounter dated 01/23/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018

Electronically signed by Peter Guzinski DC on 01/23/2018 at 8:43am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->4/10. *Pain is constant.* *Pain radiates to:* left shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* She states that she is still experiencing 1 to 2 headaches a week. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting. *Range:* 3->4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back remains sore. She stated that she went to squat yesterday and felt like her lower back locked up which made it difficult to stand upright. Patient still waiting for approval of her lumbar MRI. Follow up with Dr. Siddique is January 31, 2018. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 4->5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with pain lower neck; left rotation: WNL 80/80 with pain left lower neck ; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain; right lateral bending: WNL 45/45 with no pain. *Posture:* rounded shoulders.

Hypertonicity & Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Chest and cervical spine x-rays were performed at Immediate Care on November 1, 2015. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left occiput, left first rib. *Subluxations detected by:* motion and static palpation.

Encounter dated 01/23/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 02/13/2018

Thoracic: Hypertonicity & Tenderness Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Strength:* left extensor hallucis longus: 5/5; right extensor hallucis longus: 5/5; left tibialis anterior: 5/5; right tibialis anterior: 5/5; bilateral gluteus maximus: 4/5. *Tenderness & Hypertonicity:* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Mrs. Harwell's condition has remained similar to her last visit. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained relatively unchanged since her last visit. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has remained similar to her last visit. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. **Visit#** 6 of 8 planned treatments. **Treatment schedule:** 2x/week for 1 week; Re-examination for 1 week.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

0138739400101059 PICA

CARRIER →												
1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BILING OTHER 1a INSURED'S ID NUMBER (For Program in Item 1)												
<input type="checkbox"/> (Medicare) <input type="checkbox"/> (Medicaid) <input type="checkbox"/> (DOD/DoD) <input type="checkbox"/> (Member/Dep) <input type="checkbox"/> (EMR) <input type="checkbox"/> (FECA) <input type="checkbox"/> (DOD)						013873940011059						
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY			SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>			4 INSURED'S NAME (Last Name, First Name, Middle Initial)			
HARWELL DANIELLE			08291980						HARWELL DANIELLE			
5 PATIENT'S ADDRESS (No., Street)			6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)			
1131 CLEVELAND DRIVE CHEEKTONWAGA									56 BEREHAVEN DR, LEFT AMHERST			
CITY ZIP CODE		STATE		8 RESERVED FOR NUCC USE		CITY ZIP CODE		STATE				
14225		NY				14228		NY				
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10 IS PATIENT'S CONDITION RELATED TO			11. INSURED'S POLICY GROUP OR FECA NUMBER						
a. OTHER INSURED'S POLICY OR GROUP NUMBER			b. EMPLOYMENT (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>						
b. RESERVED FOR NUCC USE			c. AUTO ACCIDENT? PLACE (State) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY			b. OTHER CLAIM ID (Designated by NUCC)						
c. RESERVED FOR NUCC USE			d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO						
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N yes, complete items 9, 9a, and 9d						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												
SIGNED SIGNATURE ON FILE DATE						SIGNED SIGNATURE ON FILE						
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115			15. OTHER DATE MM DD YY 454 111215			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI			17b NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (24e)) ICD 10 A M50.222 B M51.26 C M51.27 D M54.12 E MODIFIER 0												
22. RESUBMISSION CODE ORIGINAL REF. NO												
23. PRIOR AUTHORIZATION NUMBER												
24. a. DATE(S) OF SERVICE b. PLACES OF SERVICE c. d. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) e. DIAGNOSIS CODES (CPT/HCPCS) f. g. h. i. j. MODIFIER CHARGES DATES OR UNITS HOURS PER UNIT L ID QTY. RENDERING PROVIDER ID #												
1	01252018	01252018	11	98941		ABCD	32	28	1	NPI	1710014188	
2	01252018	01252018	11	97010		ABCD	10	53	1	NPI	1710014188	
3	02012018	02012018	11	98941		ABCD	32	28	1	NPI	1710014188	
4	02012018	02012018	11	97010		ABCD	10	53	1	NPI	1710014188	
5			-	-	-					NPI		
6			-	-	-					NPI		
25	FEDERAL TAX ID. NUMBER	SSN BIN	26	PATIENT'S ACCOUNT NO	27	ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28	TOTAL CHARGE	29	AMOUNT PAID	30	RATE FOR NUCC USE
364500165	<input type="checkbox"/> *	343821271					\$ 851.62	\$ 8				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and my name is on the back) PETER GOZINSKI DC												
32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849												
33. BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849												
34. SIGNED 02132018 DATE * 1235256546 ^b * 1235256546 ^b												

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
February 13, 2018

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday January 25, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 01/25/2018 at 9:36am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3->4/10. *Pain is constant.* *Pain radiates to:* left shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* She states that she is still experiencing 1 to 2 headaches a week. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting. *Range:* 3->4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back remains sore. Patient still waiting for approval of her lumbar MRI. Follow up with Dr. Siddique is January 31, 2018. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 4->5/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with pain lower neck; left rotation: WNL 80/80 with pain left lower neck ; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain; right lateral bending: WNL 45/45 with no pain. *Posture:* rounded shoulders.

Encounter dated 01/25/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 02/13/2018

Hypertonicity & Tenderness Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild to Moderate. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. **X-ray findings:** Chest and cervical spine x-rays were performed at Immediate Care on November 1, 2015. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left occiput, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 50/60 with pain lower back; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Strength:** left extensor hallucis longus: 5/5; right extensor hallucis longus: 5/5; left tibialis anterior: 5/5; right tibialis anterior: 5/5; left gluteus maximus: 5/5; right gluteus maximus: 5/5. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Cervical assessment: Mrs. Harwell's condition has remained similar to her last visit. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained relatively unchanged since her last visit. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last visit. Her bilateral gluteus maximus were stronger and graded 5/5. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with

Encounter dated 01/25/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018

facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Visit# 7 of 8 planned treatments.* *Treatment schedule:* 2x/week for 1 week; Re-examination for 1 week. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (no treatment rendered); C6 left lateral flexion restriction (no treatment rendered); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy; left lumbar ultrasound, 1.5w/cm² 1 MHz 100% (8 minutes). *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms; Stressed the importance of performing home exercises to help with pain and improved ROM. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Encounter dated 01/25/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018

Thursday February 1, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 02/01/2018 at 3:55pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 3>4/10. *Pain is constant.* *Pain radiates to:* left shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* She states that she is still experiencing 1 to 2 headaches a week. *Recent medical treatment for this condition:* None. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting. *Range:* 3>4/10. *Pain is constant.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back remains sore. Patient saw Dr. Siddique yesterday and a new MRI has been ordered and will be performed tomorrow at Buffalo MRI. "Yesterday I was in so much ain probably a 7, but today I am back down to a 5 or 6". *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling, numb. *Range:* 5>6/10. *Pain is constant.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Pain management evaluation. *Changes in past medical history:* None.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with no pain; extension: WNL 60/60 with pain lower neck; left rotation: WNL 80/80 with pain left lower neck ; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain; right lateral bending: WNL 45/45 with no pain. *Posture:* rounded shoulders. **Hypertonicity & Tenderness** Sub-occipital musculature Left Moderate; cervical paraspinal musculature Left Moderate; scalene Left Moderate; sternocleidomastoid Left Moderate; pectoralis minor Left Mild to Moderate; cervical paraspinal musculature Right Mild to Moderate. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. **X-ray findings:** Chest and cervical spine x-rays were performed at Immediate Care on November 1,

Encounter dated 02/01/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 02/13/2018

2015. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s): C5, C6, left occiput, left first rib. Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s): T2, T3, T6, T7, T8, T9. Subluxations detected by motion and static palpation.*

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 50/60 with pain lower back; extension: 5/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. *Gait pattern:* normal. *Strength:* left extensor hallucis longus: 4/5; right extensor hallucis longus: 5/5; left tibialis anterior: 5/5; right tibialis anterior: 5/5; left hamstring: 4/5; right hamstring: 5/5. *Tenderness & Hypertonicity* lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. *Tenderness on palpation:* left SI: moderate. *Trigger points:* left gluteus maximus. *Orthopedic tests:* Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. *Spinal subluxation level(s): L4, L5, Left SI. Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Mrs. Harwell's condition has remained similar to her last visit. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained relatively unchanged since her last visit. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last visit. Her bilateral gluteus maximus were stronger and graded 5/5. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Encounter dated 02/01/2018 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 02/13/2018

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Visit#* 8 of 8 planned treatments. *Treatment schedule:* continue 2x/week for 1 week; Re-examination for 1 week. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (no treatment rendered); C6 left lateral flexion restriction (no treatment rendered); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization); Occiput left posterior (prone mobilization). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy; left lumbar ultrasound, 1.5w/cm² 1 MHz 100% (8 minutes). *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back pm for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms; Stressed the importance of performing home exercises to help with pain and improved ROM. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to January 31, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

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End of note. Electronically signed by Peter Guzinski DC on 02/01/2018 at 3:55pm

Abbreviations

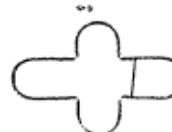
ADL activities of daily living

MVA motor vehicle accident

ROM range of motion

WNL within normal limits

02 19 18



Item# 43568
Print Pending



02 19 18



~~RECEIVED
CITY OF BUFFALO~~
346 Dick Rd.
Depew, NY 14043

Geico
P.D. Box 9507
Fredricksburg, VA 22403

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 06/12

PIRA

1. MEDICARE	NMEDICARD	TINCARE	CHAMPVA	GROUP BENEFITS PLAN (DOD)	FED BENEFITS (DOD)	OTHER (DOD)	1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TIN Card	<input type="checkbox"/> Member ID#	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> (DOD)	0138739400101059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
HARRELL, DANIELLE			MM	DD	YY	<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	HARRELL, DANIELLE	
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)		
1131 CLEVELAND DRIVE			<input checked="" type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	1131 CLEVELAND DRIVE	
CITY CHEERSTOWAGA	STATE NY	8. RESERVED FOR NUCC USE			CITY CHEERSTOWAGA	STATE NY	ZIP CODE 14225 TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH		
			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	MM	DD	YY	SEX	
b. RESERVED FOR NUCC USE			b. AUTO ACCIDENT?	PLACE (State)	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	NY	<input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/> X	
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC) Y4 0138739400101059	
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			c. INSURANCE PLAN NAME OR PROGRAM NAME		
						Geico		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.								

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature On File

DATE 2/13/2018

SIGNED Signature On File

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)	MM DD YY	15. OTHER DATE QUAL	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
10 31 15	GUAL 431	16 439	10 31 15	MM DD YY MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI	17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN J PETER GUKINSKI		17a. 171100141188	17b.	FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				
20. OUTSIDE LAB? \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (PL)) ICD IND 0				
A. M51.26	B. M54.16	C. L	D. L	E. L
F. L	G. L	H. L	I. L	J. L
22. RESUBMISSION CODE ORIGINAL REF. NO.				
23. PRIOR AUTHORIZATION NUMBER NOT REQUIRED				
F. \$ CHARGES G. DAYS OR UNITS H. L LINE ITEM I. ID GUL J. RENDERING PROVIDER ID #				
01 31 18	01 31 18 11	99214	AB	74 79 1 0B 248830
				NPI 1023202355
				NPI
25. FEDERAL TAX ID. NUMBER SSN BN 26. PATIENT'S ACCOUNT NO. 27. ACCORD ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Revd for NUCC Use				
030445678	<input checked="" type="checkbox"/>	102251	<input checked="" type="checkbox"/> YEB <input type="checkbox"/> NO	\$ 74 79 \$ 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and have made a copy thereof.)				
Jafar Siddiqui				
32. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery, Inc 180 Park Club Lane, STE 250				
33. BILLING PROVIDER INFO & PH# (716) 218-1030 UB Neurosurgery, Inc PO Box 8000 DEPT 883				
Williamsville, NY 14221 Buffalo, NY 14267				
a. 1306896220 b. 248830 c. 1306896220				

SIGNED 2/13/2018 DATE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



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100 High Street - Section B4
Buffalo, NY 14203
716/218-1800
EMR Fax: 716/879-8781

5555 Big Tree Road - Suite 103
Orchard Park, NY 14222
716/218-1800
EMR Fax: 716/677-4918

Objevi Children's Outpatient Center
Concourse Building
1000 Main Street - 3rd Floor
Buffalo, NY 14222
716/218-1040
EMR Fax: 716/924-2315

The Park Center
100 Park Club Lane
Williamsville, NY 14221
716/439-9492
EMR Fax: 716/736-3579

6930 Wilkeson Road - Suite 300B
(716) 656-9000
Niagara Falls, NY 14284
716/218-1000
EMR Fax: 716/655-8365

Interventional Pain Management
(Dr. Jafar Soltanine, Dr. Andrea Wong)
189 Park Club Lane
Suite 120
Williamsville, NY 14221
716/218-1000

January 31, 2018

James Panzarella DO
1208 Niagara Falls Boulevard
Tonawanda, NY 14150

Patient Name: Danielle Harwell
Date of Birth: 08/29/1980
No-Fault Carrier: NF Geico
CL#: 0138739400101059
Date of Injury: 10/31/15

Psychiatry Re-evaluation: January 31, 2018

Chief Complaint(s): Low back pain, left leg pain, weakness, numbness.

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle Harwell in our Park Club Lane office for re-evaluation on January 31, 2018.

HISTORY/CHIEF COMPLAINT

This is a 37-year-old female presenting today for re-evaluation. She is status post bilateral L5-S1 transforaminal epidural steroid injections with Dr. Siddiqui on December 6, 2017. One week following this procedure she contacted our office with severe left lower extremity pain. This pain was worse than it was prior to her injections. Along with this she was reporting progressive paresthesias and weakness. We did try a methylprednisolone dose pack, which, unfortunately, did not provide much relief. We were hoping to have an MRI at this evaluation to review, however, due to clerical oversight this was not completed. The patient is very frustrated. She reports significant weakness through all muscle groups of the left lower extremity, along with significant numbness. Her numbness is multi-dermatomal. She reports pain more pronounced in the left leg, feeling as if it shoots up from her foot. Her pain score today is 7/10. She is using ibuprofen and naproxen, but nothing else for pain. Any activity aggravates her symptoms. She states for a month following her injection she was unable to even bear weight on her leg. She reports no change in her bowel or bladder function.

Review of systems is notable for tingling, numbness, headaches, joint pain and muscle weakness, otherwise noncontributory.

PHYSICAL EXAMINATION

BP: 118/85 Pulse: 80 Resp: 16 Ht: 63" Wt: 200lb BMI: 35.4

General: She is awake, alert and oriented x3.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are pink and moist.

Cardiovascular: Normal S1, S2.

Abdomen: Soft, obese, non-distended.

Neuromusculoskeletal: The patient has full strength throughout all myotomes of the right lower extremity. In the left lower extremity the patient has 0/5 strength with extension of the great toe, dorsiflexion, plantar flexion, knee flexion and extension. Left hip flexion is 4/5 with pain. Sensory examination is diminished to light touch in all dermatomal distributions of the left lower extremity. Gait is non-antalgic. No foot drop is noted.

Psychiatric: Judgement and cognition are within normal limits.

ASSESSMENT

M51.26 - Other intervertebral disc displacement, lumbar region, M54.16 - Radiculopathy, lumbar region

IMPRESSION/RECOMMENDATIONS:

This is a 37-year-old female with worsening left leg pain with weakness and sensory deficit on exam today. Although I did advise the patient that her weakness and sensory deficit exceed beyond the region of her injection, her findings are concerning. With this in mind, I would like to order an MRI of the lumbar spine for further evaluation. The patient was initiated on gabapentin 300 mg nightly to be titrated up to twice daily for neurogenic pain. She was given a small supply of hydrocodone to help with breakthrough pain. She will continue with ibuprofen versus naproxen for anti-inflammatory relief. The patient will follow up with me in one week. MRI authorization was obtained at today's office evaluation. The patient expressed understanding and agreement with today's plan of care.

The patient was advised today regarding treatment with the above named controlled substance(s). The risk, benefits, common side effects and alternative treatments were discussed with the patient. Risks discussed include, but are not limited to: physical and/or psychological dependence, medication tolerance, drowsiness/sleepiness, balance or coordination problems, confusion, allergic reaction or other abnormal symptoms. The patient has been advised and agrees to use the medication only as prescribed and not to drive or operate heavy machinery or equipment. The patient understood and consented to under a narcotic/opiate regimen and has agreed to sign and comply with the University at Buffalo Neurosurgery controlled substance contract/agreement. The patient verbalized understanding and was told to call with any concerns.

The patient was advised today regarding treatment with the above named medication(s). The risks, benefits, common side effects and alternative treatments were discussed with the patient. The patient verbalized understanding and was told to call with any concerns.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

Sincerely,



Electronically signed by Sarah O'mara, PA-C on 02/12/2018 at 9:43 am
Sarah O'mara, PA-C

Danielle Harwell DD 01/31/2018

Page #3

Jafar Siddiqui

Electronically signed by Jafar Siddiqui, M.D. on 02/12/2018
Jafar Siddiqui, M.D.

SO/abb

cc: Peter Guzinski DC



P

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GWICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22403

CARRIER

PIC											
1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FICA BENEFITS (1095)	
<input type="checkbox"/> (Medicare #)		<input type="checkbox"/> (Medicaid #)		<input type="checkbox"/> (DOD/DoD)		<input type="checkbox"/> (Member ID#)		<input type="checkbox"/> (ID#)		<input type="checkbox"/> (ID#)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)											
HARWELL, DANIELLE											
3. PATIENT'S BIRTH DATE SEX MM / DD / YY 08 / 29 / 1980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
4. INSURED'S NAME (Last Name, First Name, Middle Initial) - same -											
5. PATIENT'S ADDRESS (No., Street)											
56 BIRRHAVEN DR											
CITY		STATE									
AMHERST		NY									
ZIP CODE		TELEPHONE (Include Area Code)									
14228		(716) 536-0951									
6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
7. INSURED'S ADDRESS (No., Street)											
CITY		STATE									
AMHERST		NY									
ZIP CODE		TELEPHONE (Include Area Code)									
14228		()									
8. RESERVED FOR NUCC USE											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
a. OTHER INSURED'S POLICY OR GROUP NUMBER											
b. RESERVED FOR NUCC USE											
c. RESERVED FOR NUCC USE											
d. INSURANCE PLAN NAME OR PROGRAM NAME											
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NY											
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
11. INSURED'S POLICY GROUP OR FICA NUMBER											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNED <u>— ON FILE</u> DATE 01-06-2016 SIGNED <u>— ON FILE</u>											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM / DD / YY) 15. OTHER DATE (MM / DD / YY)											
3-31-2015		DUAL		DUAL		MM : DD : YY		FROM MM : DD : YY		TO MM : DD : YY	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <u>SIDNEY GRABAU, PA</u> 17b. <u>NPI</u>											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-E to services line below (24E)) ICD Ind.											
A. <u>M79.1</u>		B. <u> </u>		C. <u> </u>		D. <u> </u>		E. <u> </u>		F. <u> </u>	
E. <u> </u>		F. <u> </u>		G. <u> </u>		H. <u> </u>		I. <u> </u>		J. <u> </u>	
22. RESUBMISSION CODE ORIGINAL REF NO											
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM / DD / YY To MM / DD / YY B. PLACE OF SERVICE EWS C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) D. CPT/HCPCS I. MODIFIER E. DIAGNOSIS CODE F. G. DAYS OF STAYS H. PAY TYPE I. J. RENDERING PROVIDER ID #											
1	03 / 05 / 18	03 / 05 / 18	11	97140				55 / 00	3	NPI	1144462011
2	03 / 09 / 18	03 / 09 / 18	11	97140				55 / 00	3	NPI	1144462011
3	03 / 12 / 18	03 / 12 / 18	11	97140				55 / 00	3	NPI	1144462011
4										NPI	
5										NPI	
6										NPI	
25. FEDERAL TAX ID NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. clients, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rcv'd for NUCC use	
47-0989449	<input type="checkbox"/> <input checked="" type="checkbox"/>	HARWELL, D		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		\$ 165.00		\$ 0.00		165.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)											
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043											
GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEN, NY 14043											
32. SERVICE FACILITY LOCATION INFORMATION											
33. BILLING PROVIDER INFO & PH# (716) 725-0264											
COLLEEN MARK, LMT 03-12-2018 DATE 3-12-2018 SIGNED 3-12-2018											

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a) If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency chosen. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, copayments and non-covered services. Copayments and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured" i.e., items 1a, 4, 6, 7, 8 and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds I certify that: 1) the information on this form is true, accurate and complete, 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor, 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision, 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section for services to be considered "incident to" a physician's professional services, 7) they must be rendered under the physician's direct supervision by her/his employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and CWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1852, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.8(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 30 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol 55 No. 177, page 37549, Wed Sept 12, 1990, or as updated and republished.

FOR CWCP CLAIMS: Department of Labor Privacy Act of 1974. Republishing of Notice of Systems of Records, Federal Register Vol 55 No. 40, Wed Feb 28, 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recompence claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLAIMERS: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, co-insurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1107. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer Mail Stop C4-26-05, Baltimore, Maryland 21244-1650. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0255

Client Name: Danielle Henrich Date: 3/5/18

Client Status: (Circle) Better Progressing Worse Same/No Change

First visit back since Fall Shoulder Surgery

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LBP still legs w/ tingling and spasms. Cervical myof tightness MB. Superficial tightness has returned.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat
Great Lakes

Practice: Therapeutic Massage Initials: mhr
NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14043

Office: (716) 725-0634

Fax: (716) 725-0255

Client Name: Danielle Henrich Date: 3/9/18

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

(Check All that Apply)

- Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

- Head Jaw Sinus/Eye Pressure
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliges ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) Glutes (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L)
 Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)

Specific: LBP still present. Some relief after massage. Sore throughout neck, MB. Superficial pressure due to surgery and being so stiff.

Actions Applied: (Check All that Apply)

- Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- ↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat
Great Lakes

Practice: Therapeutic Massage Initials: mhr
NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0634

Fax: (716) 725-0365

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0634

Fax: (716) 725-0365

Client Name: Danielle Hanwell Date: 3/12/18

Have you had an IME? Yes (date:) No X

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L) Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)
 Other Area (specify): _____

Specific: Client moving better today.

LBF hip soreness @ sleep on Q side

work glutes, hamstrings & quads
to lead hip and LBF tightness.

Action/s Applied: (Check All that Apply) Neck & MB mm

Heat Packs Cold Packs Sombra/Biofreeze hot as
 Light Pressure Massage Mod Pressure Massage tight.
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Practice: Great Lakes Initials: MCF
Therapeutic Massage Initials:
NYS Licensed Therapist

Client Name: _____ Date: _____

Have you had an IME? Yes (date:) No

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)

Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Area/s of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure Trigger Point Work
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 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L) Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)
 Other Area (specify): _____

Specific: _____

Action/s Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

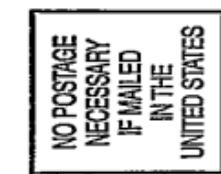
Plan/Recommendations: (check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice / Heat

Practice: _____ Initials: _____

03 19 18

03 19 18



GREAT LAKES
THERAPEUTIC MASSAGE
375 Dick Road, Suite #2
Depew, NY 14043

BUFFALO
NY 1420
12 AMERICAN
PH 54

BUSINESS REPLY MAIL

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GEICO[®]

NY PIP

PO BOX 9507

FREDERICKSBURG VA 22403-9527



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) #812

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

PICA □

NUCC Instruction Manual available at www.nucc.org

PLEASE PRINT OR TYPE

APPROVED GMB 0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from Federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) the claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employees under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's services, 3) they must be of funds commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5338). For Black Lung claims I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 434.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1802, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.21(a) and 424.3(g)(6), and 44 USC 3101-41 CFR 101 et seq and 10 USC 1079 and 1085-5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed, Sept. 12, 1990, as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S) To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

FOR TRICARE CLAIMS: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service private collection agencies, and consumer reporting agencies in connection with recoupment, claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DHS/OSI/HHS: Voluntary; however failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAO PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to except, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete the information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0624

Fax: (716) 725-4265

Client Name: Dawn M. Harwell Date: 3/20/18
 Have you had an IME? Yes (date:) No X

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 Q 6 8 10 (restricting/continuous pain)
 Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L) Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)
 Other Area (specify): _____

Specific: Client is still having H.As.
Slight ↓ pain/tightness @ Cervical
Region, LBP still present

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Mod Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat
 Great Lakes

Practitioner: Therapeutic Massage Initials: MH
 NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14204

Office: (716) 725-0624

Fax: (716) 725-0955

Client Name: Dawn M. Harwell Date: 3/23/18
 Have you had an IME? Yes (date:) No

Client Status: (Circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 Q 6 8 10 (restricting/continuous pain)
 Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumber Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L) Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)
 Other Area (specify): _____

Specific: Client states Jaw is a little less
sore since last session, S/NM tension
LB into B) Glutes, slight ↓ cervical
mm tension

Action's Applied: (Check All that Apply)

Heat Packs Cold Packs Sombra/Biofreeze
 Light Pressure Massage Moderate Pressure Massage
 Deep Tissue Massage Myofascial Release Friction
 Manual Traction Stretching Range-of-Motion
 Stripping Compression Lymph Drainage

Plan/Recommendations: (Check All that Apply)

↑ H2O Follow-Up w/ Chiro Follow-up w/ M.D.
 Follow-up w/ PT Stretches Con't Meds Ice/Heat
 Great Lakes

Practitioner: Therapeutic Massage Initials: MH
 NYS Licensed Therapist

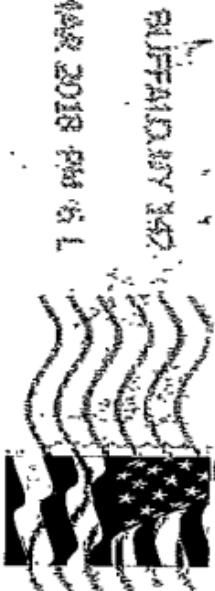
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03 26 18

GREAT LAKES
THERAPEUTIC MASSAGE

THE KAT-E-BOOZE
375 Dick Road, Suite
Depew, NY 14043

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GEICO INS CO of NY

P.O. BOX 9507

FREDRICKSBURG, VA 22403

22403-1992601



04 09 18

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

GEICO Ins Co NY
P.O. Box 9507
Fredericksburg, VA 22401

CARRIER

PICA										PIGA									
1. MEDICARE (Medicare #)	2. MEDICAID (Modicard #)	3. TRICARE (DA FORM)	4. CHAMPVA (Member ID#)	5. GROUP HEALTH PLAN (GHP) (GHP)	6. FED-A SILK LUNG (SLP) (SLP)	7. OTHER (Other)	8. X	9. X	10. X	11. INSURED'S I.D. NUMBER (For Programs In Item 1)	12. 013871940-01-01-059								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY				4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
HARWELL, DANIELLE				08 29 1980 M F				HARWELL, DANIELLE											
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)											
56 BEREBEAVEN DR																			
CITY AMHERST		STATE NY		CITY ZIP CODE		STATE NY													
14228		TELEPHONE (Include Area Code) (716) 536-0951		ZIP CODE		TELEPHONE (Include Area Code) ()													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FICA NUMBER								
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. INSURED'S DATE OF BIRTH MM DD YY	c. OTHER CLAIM ID (Designated by NUCC) M <input type="checkbox"/> F <input type="checkbox"/>							
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	d. INSURANCE PLAN NAME OR PROGRAM NAME								
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10e. CLAIM CODES (Designated by NUCC)	e. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO								
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										If yes, complete items 9, 1a, and 1b.									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED <u>ON FILE</u>										SIGNED <u>ON FILE</u>									
DATE 01-06-2016																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY				15. OTHER DATE QUAL				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
10-31-2015 QM1																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE SYDNEY GRABAT, PA				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LABS \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-H to service line below (24E) ICD Ind.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
A. <u>LN79-1</u>	B. <u> </u>	C. <u> </u>	D. <u> </u>	E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>	I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY Place of Service ENG 30 26 18 03 26 18										B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (English or Usual Description) CPT/HCPCS I 30214		E. DIAGNOSIS CODE Pointer	F. \$ CHARGES	G. DANS REPORT PER UNIT	H. I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
30 26 18 03 26 18										30214		55.00	3	NPI	13444462011				
30 29 18 03 29 18										30214		55.00	3	NPI	13444462011				
														NPI					
														NPI					
														NPI					
														NPI					
														NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Refd for NUCC to	
47-0989449										HARWELL, D		<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 110.00		\$ 0.00		110.00	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH. #		(716) 725-0264					
										GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043		GREAT LAKES THERAPEUTIC MASSAGE 375 DICK RD, SUITE #2 DEPEW, NY 14043							
COLLEEN MARX, LMT 03-31-2018																			

SIGNED DATE 7-14-04

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2013 | Page

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

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BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment, including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although modest part of a covered physician's service, 3) they must be of lands commonly furnished in physician's office, and 4) the services of non-physicians must be included on the physician's bills.

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NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 2051(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 421.5(b)(6), and 44 USC 3101-11 CFR 101 et seq and 10 USC 1079 and 1088; 5 USC 8101 et seq, and 30 USC 901 et seq; 38 USC 613, E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties pay to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosure are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 69-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Sept. 12, 1990, or as updated and republished.

FOR OWP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

DISCLOSURES: Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claim adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-603, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

NOTICE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0988-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1630. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office (716) 725-0264

Fax (716) 725-0265

Client Name: Danielle Harrell Date: 3/24/18Have you had an IME? Yes _____ (date: _____) No

Client Status: (circle) Better Progressing/Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L) Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)
 Other Area (specify): _____

Specific: Client has hypertonic mm in glutes & QL's. mild soreness in neck and m/s. Severe asthma attack that triggered mm. Due

Actions Applied: (Check All that Apply) MFB mm

- Heat Packs Cold Packs Sombra/Biofreeze
- Light Pressure Massage Mod Pressure Message
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Great Lakes

Practice: Therapeutic Massage Initials: mef
 NYS Licensed Therapist

Great Lakes Therapeutic Massage & Bodywork Practitioners

375 Dick Rd Depew, NY 14203

Office: (716) 725-0264 Fax: (716) 725-0265

Client Name: Danielle Harrell Date: 3/29/18Have you had an IME? Yes _____ (date: _____) No

Client Status: (circle) Better Progressing Worse Same/No Change

Pain Level: (no pain) 0 2 4 6 8 10 (restricting/continuous pain)
 Achy Anxiety Burning Depressed Fatigued
 Low Energy Pain Restlessness Restricted Sore
 Numbness Tingling ↓ Strength Inability to Sleep
 Headaches/Migraines Spasms Swelling

Observed Areas of Problem/Dysfunction: (Check All that Apply)

Head Jaw Sinus/Eye Pressure Trigger Point Work
 Cervical (Posterior) Cervical (Anterior)
 Upper Thoracic (Anterior) Upper Thoracic (Posterior)
 Mid/Thoracic Ribs Scapula (R) Scapula (L)
 Abdomen/Obliques ASIS PSIS
 Lumbar Sacrum Coccyx Hips Glutes (R) (L)
 IT Band Quads Hamstrings Knee (R) Knee (L)
 Calve Muscles (R) Calve Muscles (L)
 Ankle (R) Ankle (L) Foot (R) Foot (L)
 Shoulder (R) Shoulder (L) Upper Arm (R) Upper Arm (L)
 Forearm (R) Forearm (L) Hand (R) Hand (L)
 Other Area (specify): _____

Specific: Client was sore after last message but felt relief a day-3 day afterwards. CB legs & hypertonicity along w/ cervical mm. Client

Actions Applied: (Check All that Apply) moving better.
 Heat Packs Cold Packs Sombra/Biofreeze

- Light Pressure Massage Moderate Pressure Massage
- Deep Tissue Massage Myofascial Release Friction
- Manual Traction Stretching Range-of-Motion
- Stripping Compression Lymph Drainage

Plan/Recommendations: (check All that Apply)

- H2O Follow-Up w/ Chiro Follow-up w/ M.D.
- Follow-up w/ PT Stretches Con't Meds Ice / Heat

Great Lakes

Practice: Therapeutic Massage Initials: mef
 NYS Licensed Therapist

04 09 18

04 09 18

22400-952607

22400-952607

FREDERICKSBURG, VA 22403

P.O. BOX 9507

GEICO INS CO of NY



24 APR 2018 PM 11
"BLFRALD NY 42

GREAT LAKES
THERAPEUTIC MASSAGE
375 Dick Road, Suite #2
Depew, NY 14043



3980 Sheridan Drive
Amherst, NY 14226
Telephone (716) 250-2000

200 Sterling Drive
Orchard Park, NY 14217
Telephone (716) 250-2000

To: GEICO NY CLAIMS

1-856-294-5154

From: Dawn Crowley, AAS, CMBS

Dent Neurologic
dcrowley@dentinstitute.com

Tel: 716-250-2059 *Fax:* 716-250-2040

Regarding: CLAIM# 0138739400101059

BILLING AND NARRATIVE

ATTACHED



HARWELL_FAX.fax

Disclaimer: This transmittal contains PRIVILEGED AND CONFIDENTIAL information intended for the use by the recipient named above. This document and the information contained herein are confidential and protected from disclosure pursuant to Federal law. This message is intended only for the use of the Addressee(s) and may contain information that is PRIVILEGED and CONFIDENTIAL. If you are not the intended recipient, you are hereby notified that the use, dissemination, or copying of this information is strictly prohibited. If you have received this communication in error, please erase all copies of the message and its attachments and notify the sender immediately. You may notify the sender by telephone at (716) 250-3095.

GEICO INSURANCE - NF
NY PIP CLAIMS
POBOX 9507
FREDERICKSBURG VA 22403

XXX

XXX

X 0138739400101059

HARWELL, DANIELLE

08 29 1980

X HARWELL, DANIELLE

1131 CLEVELAND DR

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1131 CLEVELAND DR

CHEEKTOWAGA

NY

CHEEKTOWAGA

NY

14225-1257

14225-1257

DOI 10/31/15

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SIGNATURE ON FILE

02 09 16

SIGNATURE ON FILE

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716 2502010

HORACIO CAPOTE, MD

DENT TOWER 6TH FLR
3980 SHERIDAN DRIVE 6TH FLOOR
AMHERST NY 14226-1727

04 13 18

1497850911

DENT NEUROLOGIC GROUP LLP
PO BOX 8000 DEPT 057
BUFFALO NY 14267-0002

1497850911 EI161582336



DENT

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Abbey L. Burdick, PA-C

Re-Evaluation
Date: 04/05/2018

Patient Name: Harwell, Danielle
DOB: 08/29/1980 **Age:** 37 Y **Sex:** Female
PCP: James Panzarella, DO

Reason for Appointment

- NF- Requires Opinion
- Patient is here following up for migraines

History of Present Illness

General:

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle today in neurologic reevaluation regarding a motor vehicle accident and head injury. She was seen at DENT Neurologic Institute in Amherst, New York.

Danielle is a 37-year-old female with previous history of migraine headaches who initially presented to this office on 2/19/16 after a motor vehicle accident on 10/31/2015. The patient was the seat-belted driver in her vehicle and was rear-ended by another car. The patient hit her head against the headrest, then jolted forward. She was seen at urgent care the next day. Afterward, the patient struggled with dizziness, difficulty with attention and concentration, headaches, poor sleep. She had significant amount of pain in the left upper extremity and shoulder. Headaches were occurring 4 times per week at 3-7/10 on the pain scale.

The patient was evaluated by Dr. Pollina, a neurosurgeon, on 2/8/16. MRI L spine and C-spine 1/5/16 showed mild multilevel degenerative changes with disk extrusions seen at C4-C5 and C5-C6. She had an EMG 01/19/2016, but we do not have the results. Laboratory studies 3/24/16 were normal aside from a low MCV of 77.7, low MCH of 25.7 and elevated RDW 14.8.

Danielle has tried ibuprofen, Tylenol, Motrin, Lamictal, Nortriptyline, magnesium, Naproxen, Rizatriptan, and Topamax, Chiropractic care, massage therapy, vestibular therapy and physical therapy. Lamictal was not found to be helpful. Vestibular therapy and physical therapy have both proven helpful in symptom management, and she had since been discharged from both. Massage therapy and regular trigger point injections have been helpful with decreasing her cervical myofascial spasm.

MRI Brain completed 03/27/2017 was normal. MRI Cervical spine completed 03/27/2017 showed mild dextroscoliosis of the cervical spine, there were some bone spurs, but otherwise normal.

The patient has since been experiencing continued symptoms. She was started on Topamax and continued on Nortriptyline. Cambia has been effective as a rescue medication, however this unfortunately is not approved through her insurance. She continued with chiropractic therapy twice per week. At her last reevaluation on 10/19/17, dosing of both Nortriptyline and Topamax was increased. Cambia was recommended as a rescue medication due to GI upset caused by other NSAIDs. She continued with regular trigger point injections and occipital nerve blocks.

She was last seen for reevaluation on 1/11/18 reported continued headache activity, about 4 headaches per week with 2-3 migraines per month. She had not yet restarted physical or vestibular

		DIAGNOSTICS & SERVICES	
(716) 250-2000	www.dentinst.com	MRIs	Neuropsychology
		Arthrograms	Pneumography
		Breast	Sleep Studies
		Doppler/TCI	SPECT
		EKG	Ultrasound
		KMG	USG
		DaPACT	PNG
		Inflatus	

therapies. She had been undergoing regular lumbar facet injections, and continued with massage and chiropractic therapy. Dosing of Topamax was increased to 200 mg daily and Sumatriptan and Diclofenac were sent as alternative rescue medications. We also submitted for Botox.

The patient returns today with no change in frequency and severity of headaches. She did have to undergo a cholecystectomy on 2/9/18. She is hoping this will relieve some of her GI symptoms. She continues to take Topamax and is tolerating well. Botox was approved, however this has not yet been started. Upon reviewing recent appointments, she also stopped undergoing regular trigger point injections and occipital nerve blocks 4 months ago. She also reports temporomandibular joint pain. Rescue medications continue to be helpful, but can take a while to work.

Current Medications

- Taking nortriptyline 10 mg capsule 2 cap(s) orally QHS
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking magnesium oxide 250 mg tablet 1-2 tab(s) orally once a day
- Taking topiramate 100 mg tablet 1 tab(s) orally BID
- Taking Imitrex 100 mg tablet 1 tab(s) orally PRN Migraine; MDD = 2 MWD = 3
- Taking diclofenac potassium 50 mg tablet 1 tab(s) orally prn headache, MDD= 2, no more than 3 days per week
- Taking Vitamin D3 5000 Int'l units capsule 1 cap(s) orally once a day
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy
- Colonoscopy
- Cholecystectomy

Family History

Father: alive, Stroke
Mother: alive, Asthma
Siblings: alive
1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption: Patient does not drink alcohol.

Illicit Drugs:

Using illicit drugs: Denies.

Resides with:

Spouse: Husband. Children: Yes, x3. Self: Yes.

Working:

Employed: Stay at home mom.

DIAGNOSTICS & SERVICES	
MRI	Neuropsychology
Arthrogram	Pneumography
Breast	Sleep Studies
Doppler/TCD	SPECT
EPO	Ultrasound
KMG	VMR
DaPAC/T	PNG
Inflatus	

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Orchard Park Office | Sterling Medical Park | 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

Marital Status:

Married: Yes.

Driving:

Does Patient Drive: Yes.

Exercise:

Daily: Yes, Walks.

Caffeine:

Other: Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Positive for headache, dizziness, weakness, unsteadiness, confusion, sleep problem, blurry vision, double vision, the years, earache, vertigo, joint pain and stiffness, neck and lower back pain, muscle aches, heartburn, anemia, easy bruising. No additional new neurological or physical deficits were reported outside of the patient's complaints upon the clinical review of systems for today's visit. The following systems were assessed: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 114/74, HR 88, RR 16, Ht 63, Wt 244.4, BMI 43.29, BSA 2.22.

Examination**General Examination:**

General Appearance: Well-nourished, well-developed, in mild distress, participated with the exam. Well groomed. Eyes: Disc margins clear, no vessel abnormalities, no papilledema. Neck: Supple. Range of motion limited with lateral flexion. Trigger points palpated within cervical musculature bilaterally.

Cardiovascular: peripheral pulses within normal limits. Extremities: Full range of motion of extremities x4. No edema.

Neurological:

Mental Status: Orientation to person, place, and time was normal. Attention span and concentration was appropriate. Speech: Speech content and production was normal. Memory: Memory for remote and recent events was intact. Fund of Knowledge: Appropriate for events and past history. Cognition was intact. Motor: 5/5 upper extremities bilaterally, 4/5 left lower extremity. Tone: Tone and bulk was within normal limits in the upper and lower extremities. No atrophy or fasciculations were noted. Reflexes: DTRs were +2 globally. Coordination: Test of coordination and fine motor skills were within normal limits. Gait and Station: Romberg positive.. Sensory: Decreased sensation left lower extremity.

Cranial Nerves:

Cranial Nerve II: Visual fields are full. Cranial Nerves III, IV, VI: Extraocular movements intact. PERRLA. Cranial Nerve V: Facial sensation and muscles of mastication were normal bilaterally. Cranial Nerve VII: Face was symmetric and strength was equal bilaterally. Cranial Nerve VIII: Hearing was intact to finger rub bilaterally. Cranial Nerves IX, X: Swallowing and palate elevation was within normal limits. Cranial Nerve XI: Sternocleidomastoid and shoulder shrug was within normal limits bilaterally. Cranial Nerve XII: Tongue was midline.

DIAGNOSTICS & SERVICES(716) 250-2000
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MR	Neuropsychology
Arthrograms	Pneumography
Breast	Sleep Studies
Doppler/TCG	SPECT
EKG	Ultrasound
KMG	USG
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Batavia Office | 35 Batavia City Center | Batavia, NY 14202 | Fax: (716) 250-2045

Assessments

- Posttraumatic headache - G44.309 (Primary)
- Myofascial pain - M79.1
- TMJ dysfunction - M26.609
- Migraine without aura - G43.009
- Vestibular dysfunction - H83.2X9
- Concussion, without loss of consciousness, sequela - S06.0X0S

Danielle is a 37-year-old female who returns today for reevaluation with continued headaches, myofascial pain, and back pain. She was advised to begin Botox injections for her chronic headaches. He will also resume trigger point injections and occipital nerve blocks. I would like to refer her to Dr. Goldberg for TMJ dysfunction. We will hold off on medication changes at this time, however we may elect to increase dosing of Topamax if needed. She will continue to follow with Dr. Siddiqui regarding lower back pain. We will have her return for Botox Injections at her earliest convenience, and for reevaluation in 3 months, sooner if needed.

This dictation was created with Dragon voice recognition system. Although efforts were made to ensure accuracy, voice recognition errors may be present.

Dr. Capote is the supervising physician on site.

Thank you for allowing us to participate in the care of this patient. If there are any questions please feel free to call anytime.

Treatment**1. Posttraumatic headache**

Refill magnesium oxide tablet, 250 mg, 2 tab(s), orally, once a day, 30 days, 60, Refills 5
Consultation1916491Burdick,Abbey L 04/05/2018 10:30:47 AM > Dr. Goldberg

2. Myofascial pain

MASSAGE Therapy1916465
Chiropractic therapy1916466

3. Migraine without aura

Continue nortriptyline capsule, 10 mg, 2 cap(s), orally, QHS
Continue topiramate tablet, 100 mg, 1 tab(s), orally, BID

Continue Imitrex tablet, 100 mg, 1 tab(s), orally, PRN Migraine; MDD = 2 MWD = 3

Continue diclofenac tablet, potassium 50 mg, 1 tab(s), orally, prn headache, MDD = 2, no more than 3 days per week

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle. 04/05/2018.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 04/05/2018.

Exercise: Patient counseled on importance of moderate physical activity daily. 04/05/2018.

Follow Up

3 Months



(716) 250-2000
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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14217 | Fax: (716) 250-0315
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DIAGNOSTICS & SERVICES	
MRI	Neuropsychology
Arthrograms	Pneumography
Breast	Sleep Studies
Doppler/TCG	SPECT
EPO	Ultrasound
KMG	EMG
DaPACT	PNG
Inflatus	

Electronically signed by Abbey Burdick , PA-C on 04/06/2018 at 07:12 PM EDT

Sign off status: Completed

(716) 250-2000
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Orchard Park Office | Sterling Medical Park • 200 Sterling Drive • Orchard Park, NY 14227 | Fax: (716) 250-0313
Batavia Office | 35 Batavia City Center • Batavia, NY 14020 | Fax: (716) 250-2045

DIAGNOSTICS & SERVICES	
MRI	Neuroangiography
Athrogram	Neurography
Bone	Sleep Studies
Doppler/TCD	SPECT
EEG	Ultrasound
KMG	TMS
InPACT	VNG
Deflation	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

01387394 0610 1059

CARRIER

(For Progress in Item 1) 01387394 0011-059-															
4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE															
5 PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE															
6 PATIENT'S BIRTH DATE MM DD YY SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> 08291980															
7 PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>															
8 INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT															
CITY CHEEKERTOWAGA		STATE NY		CITY AMHERST		STATE NY									
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951		ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951									
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)															
10 IS PATIENT'S CONDITION RELATED TO															
a OTHER INSURED'S POLICY OR GROUP NUMBER															
b RESERVED FOR NUCC USE															
c RESERVED FOR NUCC USE															
d INSURANCE PLAN NAME OR PROGRAM NAME															
10d CLAIM CODES (Designated by NUCC)															
11. INSURED'S POLICY GROUP OR FECA NUMBER															
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment before															
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below															
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 103115 15. OTHER DATE MM DD YY QUAL 431 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO MM DD YY QUAL 454 111215															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17b MM DD YY 17b NPI															
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO MM DD YY															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															
20. OUTSIDE LAB? CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-H to service line below (34E) ICD IND A M50.222 B M51.26 C M51.27 D M54.12 E I82.3 XXXA F M99.01 G M99.03 H M99.02 I M99.05 J M54.2 K M54.5 L M54.6															
22. REBIMBRESSION CODE		ORIGINAL REF NO													
23. PRIOR AUTHORIZATION NUMBER															
24. A. DATES(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE BMG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS		D. MODIFIER		E. DIAGNOSIS CODES		F. CHARGES		G. 0008 CH 04 UNIT\$	H. HOSP. TREAT. PAY.	I. ID CAR.	J. RENDERING PROVIDER ID #
1	03152018	03152018	11	98941				ABCD		32 28	1			NPI	1710014188
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6														NPI	
25. FEDERAL TAX ID NUMBER SSN ENR		26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE		29. AMOUNT PAID		30. Paid for NUCC Use					
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31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Notify that the statements on the reverse side of this form are true and accurate) PETER GOZINSKI DC															
32. SERVICE FACILITY/LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849															
33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849															
SIGNED 04072018 DATE 1235256546 1235256546															

Encounter dated 03/30/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/09/2018

improved from a 4 to 3 out of 10. *Prognosis:* Guarded. *Post-treatment analysis:* patient tolerated treatment without incident. *Set backs:* Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Visit# 1 of 4 planned treatments.* *Treatment schedule:* 1x every 2 weeks for 6 weeks; Re-examination for 6 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 16, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

Encounter dated 03/30/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/09/2018

End of note. Electronically signed by Peter Guzinski DC on 03/30/2018 at 9:38am

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

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Patent Pending



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FEDERALSBURG, MD 21636-9526

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

CARRIER

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN PECOA <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> DOD/DoD <input type="checkbox"/> Member ID# <input type="checkbox"/> (IV) <input type="checkbox"/> Billing <input type="checkbox"/> (OH) OTHER <input type="checkbox"/>												2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE			3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> X			4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT					
CITY CHEEKETOWAGA		STATE NY		8. RESERVED FOR NUCC USE		CITY AMHERST		STATE NY												
ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 536 0951				ZIP CODE 14228		TELEPHONE (Include Area Code) (716) 536 0951												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR PECOA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/> X 08291980					
b. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <u>NY</u>			b. OTHER CLAIM ID (Designated by NUCC)					
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO					
d. INSURANCE PLAN NAME OR PROGRAM NAME												10d. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete lines 5, 6a, and 6b					
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below								
SIGNED SIGNATURE ON FILE DATE												SIGNED SIGNATURE ON FILE								
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUA 103115				15. OTHER DATE MM DD YY 111215				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. <u> </u> 17b. NPI <u> </u>				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-L to service line below (NUC) A <u>M50.222</u> B <u>IM51.26</u> C <u>IM51.27</u> D <u>M54.12</u> E <u>IS23.3XXA</u> F <u>IM99.01</u> G <u>IM99.03</u> H <u>IM99.02</u> I <u>IM99.05</u> J <u>IM54.2</u> K <u>M54.5</u> L <u>M54.6</u>												22. RESUBMISSION CODE ORIGINAL REF NO								
24. A. DATES OF SERVICE From MM DD YY To MM DD YY Place of Service EMR B. PROCECDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS C. MODIFIER												E. DIAGNOSIS CODE F. CHARGES G. CHARGES OR UNITS H. PAYOR REF QUAL I. ID QUAL J. RENDERING PROVIDER ID #								
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2	03302018	03302018	11	97010			ABCD	10 53 1	NPI	1710014188										
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25. FEDERAL TAX ID NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO 343821273				27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. TOTAL CHARGE \$ 421.81	29. AMOUNT PAID \$ 0	30. Reserved for NUCC Use							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Orally state the statements on the reverse side to the bill and sign here) PETER GUZINSKI DC												32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			33. BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849					
SIGNED 04072018 DATE				34. 1235256546 ^a				35. 1235256546 ^b			APPROVED CMB-0938-1197 FORM 1500 (02-12)									

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 9, 2018

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Thursday March 15, 2018 Provider: Peter Guzinski DC RE-EXAM

Electronically signed by Peter Guzinski DC on 03/18/2018 at 4:06pm

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Accident Description: *Date of Accident:* October 31, 2015. *Time of Accident:* 4:55 PM. *Narrative Description of Accident:* Patient stated that she was stopped in traffic, while waiting for a truck to make a left hand turn into a driveway, when she was rear impacted. She stated that accident occurred while she was traveling South on Starin in the City of Buffalo, New York. Mrs Harwell, stated that this was a chain reaction accident. The vehicle that was behind her was also stopped and was pushed into her vehicle by an automobile that rear impacted them. *Patient Seatbelted?* Yes. *Position in vehicle driver.* *Patient Position at Impact:* looking straight ahead. *Impact Point of Patient's Car:* rear. *Brakes On At Time of Impact?* Yes. *Airbags Deployed?* No. *Did The Patient's Seat Break?* No. *Impact With Car Interior?* seatbelt left chest; headrest back head. *Patient's Vehicle Type:* Honda Odyssey 2007. *Type of Other Vehicle:* Honda CRV 2015. *Road Conditions At Time of Accident:* dry. *Was There Loss of Consciousness?* no. *What Symptoms Were Immediately Present?* Patient stated that she was experiencing head, neck, back and left shoulder and arm pain.

Cervical: Patient presented today with the continued chief complaint of neck pain. Due to the pain, she is unable to lift heavy weights off the floor, she has severe headaches which come frequently, she can do most of her usual work, but no more and her sleep has been moderately disturbed (1-2 hrs. sleepless). *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* improving, since last re-examination on December 29, 2017. *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 2->3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* "I still get headaches periodically, 2 to 3 a week. Headaches are more frontal today. She states that the duration varies, but they no longer last all day." Patient stated that she gets intermittent dizziness with the headaches but it has not been as severe. She states that does experience an irritation to bright lights with the headaches as well. *Cervical Disability Index:* 30%. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* Yes: Cholecystectomy performed on February 9, 2018.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving, since last re-examination on December 29, 2017. *Pain:* achy, dull, sharp, shooting. *Range:* 4->5/10. *Pain is*

Encounter dated 03/15/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 04/09/2018

frequent. *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none. *Oswestry score:* 58%.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain has been better since her last re-evaluation. Due to the pain, she is unable to lift heavy weights, she is unable to walk greater than 1 mile, she is unable to sit greater than 60 minutes, she is unable to stand greater than 60 minutes and she is unable to travel on journeys greater than 1 hour. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last re-examination on December 29, 2017. *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 4/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *OSWESTRY Disability Index:* 42%. *The Keele STaRT Back Screening Tool:* Low risk. *Recent medical treatment for this condition:* Massage therapy.

Activity of Daily Living Form Bathing/Showering: no impairment; Bending forward/backward: moderate impairment; Brushing teeth: no impairment; Buttoning shirt: no impairment; Driving: mild impairment; Drying Hair: mild impairment; Household chores: mild impairment; Laundry: moderate impairment; Lifting less than 10 lbs: mild impairment; Lifting more than 10 lbs: moderate impairment; Kneeling: mild impairment; Making Meals: mild impairment; Prolonged Sitting more than 30 minutes: moderate impairment; Putting pants on: mild impairment; Putting shoes/socks on: mild impairment; Reaching above the shoulders: no impairment; Restful night's sleep: mild impairment; Seated to standing position: mild impairment; Sexual activity: moderate impairment; Standing: mild impairment; Squatting: mild impairment; Taking out the trash: not performed; Tying shoes: mild impairment; Using lavatory: mild impairment; Walking: mild impairment.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain right neck; extension: WNL 60/60 with no pain; left rotation: WNL 80/80 with no pain; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain right neck; right lateral bending: WNL 45/45 with no pain left neck. *Posture:* rounded shoulders. *Strength:* all upper extremity musculature (C5-T1) were WNL and graded 5/5. *Sensation:* all upper extremity sensory exams (C5-T1) were WNL to Pin prick. *Hypertonicity & Tenderness* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Reflexes:* bilateral upper extremity reflexes (C5, C6, C7) 2+. *Orthopedic tests:* left lateral compression: Positive left lower neck pain; right lateral compression: Negative; maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative; Spinal Percussion C1-C7: Negative; left shoulder depression: Positive for left lower neck pain; right shoulder depression: Negative; neutral cervical compression: Negative; hyperextension cervical compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Orthopedic tests:* Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Encounter dated 03/15/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/09/2018

Lumbar/Sacral/Pelvis: Range of motion: flexion: 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. Gait pattern: normal. Strength: all lower extremity motor exams (L1-S1) were WNL bilaterally and graded 5/5. Sensation: left S1 dermatomes had decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderess & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. **Tenderess on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Reflexes:** bilateral lower extremity reflexes (L4 and S1) 2+. **Orthopedic tests:** Patrick's Fabere: Negative bilateral; Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral; Minor's sign: Negative; Femoral nerve stretch test: Negative bilateral; Dejerine's sign: Positive for lower back pain on a cough or sneeze. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-examination on December 29, 2017, Mrs. Harwell's neck condition has improved. Her Neck Disability Index score improved from 42% to 30% and her pain is no longer constant but now frequent. In addition, her active cervical extension and left rotation are now WNL and without pain. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL, improve active cervical ROM to WNL and to decrease the frequency and intensity of headaches. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 99212, 97124.

Thoracic assessment: Mrs. Harwell's middle back condition improved since her last re-evaluation on December 29, 2018. Her pain is no longer constant but now frequent. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last re-evaluation on December 29, 2018. Her VAS score improved from a 5 to 6 to 4 out of 10 and her Oswestry Disability Index score improved from 58% to 42%. She is now able to walk 1/2 of a mile farther and sit 30 minutes longer with less pain. Her active lumbar flexion improved from 40 to 60 degrees, extension improved from 5 to 15 degrees and left rotation is WNL. In addition, her left SLR improved from 45 to 60 degrees and her left tibialis anterior muscle is now stronger and graded 5/5 from a 4/5. Further treatment is medically necessary to help improve her active lumbar ROM to WNL and improve her ability to sit, stand, walk, bend, perform household chores and lift with 50% less pain. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation)

Encounter dated 03/15/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/09/2018

with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. *Treatment schedule:* 1x every 2 weeks for 8 weeks; Re-examination for 8 weeks. *Subluxations found on assessment and adjusted:* C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (blocking maneuver). *Physical Modalities:* bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. *Patient given:* home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. *Home care:* ice: neck / lower back prn for 20 minutes. *Additional instructions:* Advised patient to monitor for any changes in their symptoms. *Short term goals:* decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. *Long term goals:* decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. *Disability status:* Temporary partial starting on November 12, 2015 to May 16, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 03/18/2018 at 4:06pm

Abbreviations:
ADL: activities of daily living
MVA: motor vehicle accident

Encounter dated 03/15/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 04/09/2018

ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
April 9, 2018

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday March 30, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 03/30/2018 at 9:38am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit.* *Pain:* achy, dull, sharp, tingling, shooting, numb. *Range:* 2->3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* "I still get headaches periodically, 2 to 3 a week. I think my headaches are coming from my jaw". *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, sharp, shooting. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain has been better since last visit. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving. *since last visit.* *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain right neck; extension: WNL 60/60 with no pain; left rotation: WNL 80/80 with no pain; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain right neck; right lateral bending: WNL 45/45 with no pain left neck. *Posture:* rounded shoulders.

Encounter dated 03/30/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 04/09/2018

Hypertonicity & Tenderness Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild; cervical paraspinal musculature Right Mild. **Trigger points:** left levator scapulae, bilateral upper trapezius. **Orthopedic tests:** maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative. **X-ray findings:** Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. **Spinal subluxation level(s):** C5, C6, left first rib. **Subluxations detected by:** motion and static palpation.

Thoracic: **Hypertonicity & Tenderness** Thoracic paraspinal musculature Bilateral Moderate. **Trigger points:** bilateral rhomboids. **Orthopedic tests:** Spinal percussion T1-T12: Negative; Sheppleman's: Negative bilateral. **Spinal subluxation level(s):** T2, T3, T6, T7, T8, T9. **Subluxations detected by:** motion and static palpation.

Lumbar/Sacral/Pelvis: **Range of motion:** flexion: 60/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with no pain; right rotation: WNL 30/30 with no pain; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: WNL 25/25 with pain lower back. **Gait pattern:** normal. **Strength:** left extensor hallucis longus: 4/5; right extensor hallucis longus: 5/5. **Sensation:** left L5 and S1 dermatomes had decreased sensation Pin prick; all other lower extremity dermatomes WNL to Pin prick. **Tenderness & Hypertonicity** lumbar paraspinal left moderate; TFL / ITB left moderate; lumbar paraspinal right mild. **Tenderness on palpation:** left SI: moderate. **Trigger points:** left gluteus maximus. **Orthopedic tests:** Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. **Spinal subluxation level(s):** L4, L5, Left SI. **Subluxations detected by:** motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-examination on December 29, 2017, Mrs. Harwell's neck condition has improved. Her Neck Disability Index score improved from 42% to 30% and her pain is no longer constant but now frequent. In addition, her active cervical extension and left rotation are now WNL and without pain. Further chiropractic treatment is medically necessary to decrease pain and improve function especially with her ability to perform her ADL, improve active cervical ROM to WNL and to decrease the frequency and intensity of headaches. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition improved since her last visit. Her VAS score improved from a 4 to 5 to 3 out of 10. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last visit. Her VAS score



Jeffrey I. Goldberg DDS PLLC

**FACIAL PAIN &
APNEA APPLIANCE
THERAPY**

**FAX
Cover Sheet**

To: Cara Fiolino

Fax #: 856-294-5154

From: Rachel B. @ Dr. Jeffrey I. Goldberg DDS PLLC

Date: 4/23/18 Cover Plus Pages

Re: D Harwell

Claim # 0138739400/0101069

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, Danielle Harwell ("Assignor") hereby assign to Jeffrey I. Goldberg, D.O., P.C. ("Assignee")

(Print patient's name) (Print hospital or health care provider name)
all rights, privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault Statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on 10/13/11, not withstanding any other agreement.
(Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Danielle Harwell
(Print name of Patient)

Danielle Harwell
(Signature of Patient)

1131 Cleveland Dr.

4/23/18
(Date of signature)

Cheektowaga, NY 14225
(Address of Patient)

Jeffrey I. Goldberg
(Print name of Provider)


(Signature of Provider)

3980 Sheridan Dr., STE 401

(Date of signature)

Amherst, NY 14226-1727
(Address of Provider)

Insurance Claim # 0138739400101059

Insurance Carrier Geico

Insurance Address P.O. Box 9507
Fredrick Ksheng, VA 224



Geico Insurance

PO Box 9507

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Fredericksburg, VA 22405

CARRIER

PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FEDERAL <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (None) (Medicare) (Medicaid) (VAD) (DOD) (Part B) (DGA) (Other)											
1a. INSURED'S I.D. NUMBER (For Programs in Item 1) 0138739400101059											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle											
3. PATIENT'S BIRTH DATE SEX 03 29 1980 N <input type="checkbox"/> M <input checked="" type="checkbox"/>											
4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell, Danielle											
5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive											
6. PATIENT'S RELATIONSHIP TO INSURED Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive											
CITY Cheektowaga ZIP CODE 14225		STATE NY		CITY Cheektowaga ZIP CODE 14225		STATE NY					
8. RESERVED FOR NUCC USE											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
d. INSURANCE PLAN NAME OR PROGRAM NAME 10e. CLAIM CODES (Designated by NUCC)											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I acknowledge the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
SIGNATURE ON FILE SIGNED						DATE 4/23/2018 SIGNATURE ON FILE SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) 15. OTHER DATE (MM DD YY) QUAL: _____											
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR Jennifer McVice MD											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer A-L to service line below (S4E) ICD-9-CM A. M79.1 B. L C. L D. L E. L F. L G. L H. L I. L J. L K. L L. L											
22. RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Useless Circumstances) D. MODIFIER OPT/EPCS											
E. DIAGNOSIS CODE F. CHARGES G. DEBS OR AMTS H. PAYMENT I. ID. QM J. RENDERING PROVIDER ID. # ZZ 1223G0001X NPI 1760405088											
1	04 20 18	04 20 18	11	99204		A	220.00	1	NPI	1760405088	
2	04 20 18	04 20 18	11	70330		AB	140.00	1	NPI	1760405088	
3	04 20 18	04 20 18	11	70355		AB	120.00	1	NPI	1760405088	
4									NPI		
5									NPI		
6									NPI		
25. FEDERAL TAX I.D. NUMBER SSN EN <input checked="" type="checkbox"/> 26. PATIENT'S ACCOUNT NO. 27. ADJUSTED ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
26. TOTAL CHARGE 28. AMOUNT PAID 29. FUND FOR NUCC USE 6 480.00 \$ 0.00 480.00											
30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and am made a part thereof)											
Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226											
32. SERVICE FACILITY LOCATION INFORMATION Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226											
33. BILLING PROVIDER INFO & PH# (716) 6362222 Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226											
Jeffrey I. Goldberg DDS 4/27/2018 1760405088 <input type="checkbox"/> ZZ 1223G0001X * 1760405088 <input type="checkbox"/> ZZ 1223G0001X											



April 23, 2018

Patient: Danielle Harwell

DOB: August 29, 1980

Exam date: April 23, 2018

Referring Physician: Dr. Jennifer McVige

SUBJECTIVE

Patient presents for evaluation of a possible temporomandibular joint (TMJ) disorder following motor vehicle accident.

Mrs. Harwell's chief complaints included jaw locking, sensation of malocclusion (patient indicates "bite feels off"), limited mouth opening, jaw pain, headaches, TMJ clicking and ear pain.

Additional description of chief complaint: Jaw pain, popping, occasional open locking since MVA. Ear pain. Referred by neurology for TMJ assessment. Headaches. No prior history of TMJ issues. History of current condition: MVA 10/31/2015. Patient was stopped n Kenmore Avenue behind a truck. 4 car accident occurred, with 3 cars in a row rear-ended behind her. Struck from behind, did not hit anything in front of her. Did not lose consciousness. Went to Immediate Care (Delaware Avenue) the following day, x-rays taken, diagnosed as whiplash. Was later told by physicians she had two herniated discs in neck, two herniated discs in lower back, concussion. Developed headaches, jaw pain. Subsequent treatment has included botox, trigger point injections, and other headache care at Dent. Chiropractic care and massage. Injections and epidurals for pain management. Primary pain location: right. Patient indicates (pointing with finger) that pain is centered at TMJ. Joint sounds: Constant popping on right. Very rare popping on left. Temporal pattern: None. Condition is worse with stress.: Yes. Previous treatment: No prior history of TMJ issues. Was seen one time by another TMJ specialist, ordered MRI, pt did not wish to continue with him,. Patient is aware of parafunctional activity consisting of Grinding - Nocturnal. Eccentric jaw posture at times. History of head and neck surgery: None. Trauma history: MVA 10/31/15 - no other history of significant facial, head or neck trauma. Recent dental work includes None. Additional headache notes: Rare minor headaches prior to accident, did not require treatment.

Mrs. Harwell has symptoms since 10/31/2015. Patient reports that the problem appears to have started with car accident. Activities which make the condition worse include talking, eating. Massage appears to improve the condition. Progression is described as getting worse over time. Quality of pain is described by patient as Aching. The pain typically lasts "Variable". The patient indicates a pattern wherein the condition is best described as Steady throughout day. Jaw is painful with opening (bilateral), painful with chewing (bilateral). Current pain level is 5 out of ten. Average pain level for the past six months is 5 out of ten. Worst pain level in the past six months is 7 out of ten. The patient is aware of joint clicking on both sides. There is pain associated with the jaw

clicking. The patient reports the sensation of a recent occlusal change. The patient reports a limited or restricted jaw opening. Lateral mandibular movement feels limited or reduced. The patient has experienced an open lock.

The headaches affect the following areas of the head: temples (bilateral), the entire head, vertex of the head, occipital region. The patient indicates a history of migraines. The migraines were formally diagnosed by Dr Peter Guzinski. Additional headache information provided by the patient: "Dr Jennifer McVige." The patient typically sees a dentist Emergencies only. At this time, the patient reports that her teeth are sensitive to temperature. The patient reports xerostomia. Orthodontia history includes None. The patient reports ear pain (bilateral), tinnitus (bilateral), ear fullness (bilateral), dizziness or vertigo, eye pain (bilateral), blurred vision (bilateral). There is a feeling of a foreign object in the throat. Neck pain is reported by the patient. The patient reports back pain. There is numbness reported in the hands or fingers. There is a sensation of tingling in the hands or fingers. The patient states the following about his or her posture: "good." Overall sleep quality is described as 3 out of ten. Patient snores. The pain causes waking during the night.

To the question, How often are you tense, aggravated, or frustrated during a usual day? patient responded Half the time. The patient reports feeling depressed Seldom. To the question, Do you have thoughts of hurting yourself or committing suicide? the patient responded: No.

OBJECTIVE

Cranial nerve screening revealed a possible deficit in the following nerves: #11 (spinal accessory) - Right shoulder weakness..Otherwise all cranial nerves within normal limits. The patient is alert, attentive, and oriented. Speech is clear and fluent. Patient is able to detect and identify odor in both nostrils. Pupils are normal, equal, and reactive to light. At primary gaze, there is no eye deviation. Normal and coordinated tracking through six cardinal positions. No signs of diplopia. No evident nystagmus or ptosis. Facial sensation is intact to cotton in all three divisions of trigeminal nerve bilaterally. Face is symmetric with normal eye closure and facial expression. No evident facial weakness. Hearing is normal to rubbing sticks. Palate elevates symmetrically. Phonation is normal. Gag reflex is normal. Head turning and shoulder shrug with resistance are intact. Tongue protrudes in midline with normal movements and no atrophy. and No tenderness was elicited upon palpation of the Trapezius bilaterally, sternocleidomastoid bilaterally, lateral TMJ capsule on the left, Lateral Pterygoid bilaterally, posterior joint space bilaterally, middle temporalis bilaterally, anterior temporalis bilaterally, posterior temporalis bilaterally, Mastoid process bilaterally and Splenius Capitis / Cervical Insertions bilaterally. Mild tenderness was elicited upon palpation of the Masseter - Insertion bilaterally, Masseter - Enthesis bilaterally, lateral TMJ capsule on the right, temporal tendon bilaterally, stylomandibular ligament on the left and Masseter - Origin bilaterally. Severe tenderness was elicited upon palpation of the stylomandibular ligament on the right.

Comprehensive orofacial examination revealed:

Blood Pressure: 122/62.

Heart rate: 92 BPM.

Facial appearance: Normocephalic / symmetric.

Opening click observed on the right.

Opening pattern: Deviates Left, with correction.

The opening pattern is consistent.: Yes

Pain free opening: 44 mm.

Maximum unassisted opening: 50 mm.

Maximum assisted opening: 51 mm.

End feel of assisted opening: Normal.

Wide opening produces pain at Right TMJ.

Right lateral excursion: 4 mm.

Left lateral excursion: 8 mm.

Protrusion: 1 mm.

Mandibular midline 3 mm deviated from maxillary. (To the right)

Maxillary midline consistent with facial midline

All oral soft tissue within normal limits, including buccal mucosa, floor of mouth, and lateral tongue.

Tongue: Class 3: average to large, above occlusal plane.

Tori: none.

Palate: Hard and soft palate normal.

Mallampati throat form: 4.

Symmetrical rise of soft palate observed.

Periodontal condition: Fair.

Signs of dental wear: none.

Dental prosthesis present: None.

Occlusal class II.

Overjet of 4 mm.

Overbite of 3 mm.

Missing teeth 1,2,32.

Fractures of teeth 18,19,20,30 observed.

Cervical range of motion measurements indicated normal range of motion with pain free rotation, extension, flexion and side bend, with the following exceptions: pain on rotation to both side, pain on side bend to both shoulder.

Panoramic and bilateral TMJ radiographs at initial visit reveal: Compressed joint space (bilateral). Pronounced antegonial notching (bilateral). Pt aware of several fractured lower teeth requiring extraction. MRI 5/5/16 reviewed - indicates disc displacement with reduction on right, normal on left.

The patient reported allergic reactions to clindamycin, Environmental allergies, biaxin, Food allergies, latex, soma, penicillin, cipro, Other antibiotics:, ranidin, sulfa drugs, codeine and Keflex. She is currently taking claritin, magnesium, pantoprazole and vitamin d3.

SIGNIFICANT MEDICAL HISTORY: Past: Anxiety, low blood pressure, heart murmur, current pregnancy, sinus problems, Ulcers and Recent weight loss. Current: acid reflux, anemia, arthritis, asthma, autoimmune disorder, bruising easily, chronic pain, Digestive issues, dizziness, Headaches and osteoarthritis.

Past surgical procedures include dnc, gallbladder, nasal and tonsillectomy.

Family History: cancer, heart disease, diabetes, high blood pressure and stroke.

Social History: Occupation: homemaker. Cigarettes: The patient denies ever smoking. Alcohol: None. Caffeine: None. Reported weight: 200 pounds, Weight change in past two years: Gain of more than 10 pounds, Ethnic background: Caucasian / white.

ASSESSMENT

My working diagnosis is Disc displacement with reduction (right side) (ICD M26.631), myofascial pain / myalgia (right side) (ICD M79.1). Based on history and examination, the patient's condition appears to be attributable to the motor vehicle accident.

PLAN

Procedures performed: New patient exam level 3

(Patient was referred for evaluation. Office visit consisting of detailed history, detailed examination, and medical decision making of low complexity; presenting problem is of moderate severity; at least 40 minutes engaged in face-to-face examination, history taking, and counseling; counseling and/or coordination of care account for more than 50% of this time). Panoramic radiograph, TMJ lateral radiographs (bilateral, open and closed),

Recommendation of a soft diet, application of heat to painful area, hydrate, avoid chewing gum, minimize caffeine.

Instruction provided in therapeutic exercise (classic 5x5)

Provided patient with a copy of "Blue Book" outlining progressive therapy approach, instructions for care and maintenance of orthotic, and home care.

Immediate oral orthotic for parafunctional control (NTI type)

The treatment plan consists of Complete Biometric evaluation and review (including jaw tracking, facial EMG, joint vibration analysis). Immediate occlusal orthotic / deprogramer (NTI type), Lower occlusal appliance (Gelb anterior positioning type) and Upper occlusal orthotic (Farrar anterior positioning type).

We would like to see the patient in 4 weeks.

This patient has symptoms for which proper evaluation and therapy are medically necessary.



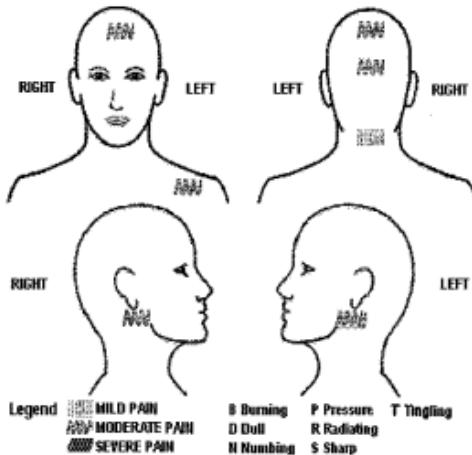
Jeffrey I. Goldberg DDS MS MBA

TMD and Orofacial Pain Diagnostic Report

Jeffrey I. Goldberg DDS MS MBA

Patient: Danielle Harwell

Examination Date: 4/20/2018



Pain pattern described
by patient

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

<input type="checkbox"/> HCA												
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FEDA EXCLUDING (DM)	OTHER	1a. INSURED'S ID. NUMBER		(For Program In Item 1)			
<input type="checkbox"/>	<input type="checkbox"/> Medicaid	<input type="checkbox"/> VA(DSDF)	<input type="checkbox"/> Member ID#	<input type="checkbox"/> (DM)	<input checked="" type="checkbox"/>	<input type="checkbox"/> (DSF)	0138739400101059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
HARWELL, DANIELLE		MM	DD	YY	<input type="checkbox"/> M	<input checked="" type="checkbox"/> F	HARWELL, DANIELLE					
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)								
1131 CLEVELAND DRIVE		<input checked="" type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	1131 CLEVELAND DRIVE							
CITY	STATE			CITY	STATE							
CHEERBTOWAGA	NY			CHEERBTOWAGA	NY							
ZIP CODE	TELEPHONE (Include Area Code)			ZIP CODE	TELEPHONE (Include Area Code)							
14225	()			14225	()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FEDA NUMBER								
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		0138739400101059								
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. EMPLOYMENT? (Current or Previous)		c. INSURED'S DATE OF BIRTH		d. OTHER CLAIM ID (Designated by NUCC)						
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		MM	DD	YY	<input type="checkbox"/> Y4 <input checked="" type="checkbox"/> 0138739400101059					
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?		PLACE (State)		e. INSURANCE PLAN NAME OR PROGRAM NAME						
		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> NY			Geico						
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?						
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If yes, complete items 9, 9a, and 9d.					
d. INSURANCE PLAN NAME OR PROGRAM NAME		105. CLAIM CODES (Designated by NUCC)		115. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						
SIGNED Signature On File		DATE 4/27/2018		116. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		121. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY State A-L to service line below (84E) ICD Ind. 0						
				MM	DO	YY	FROM MM DD YY	TO MM DD YY				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE		MM	DO	YY	14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)	15. OTHER DATE				
MM	DO	YY	MM	DO	YY	MM	DO	YY	FROM MM DD YY	TO MM DD YY		
10	31	15	QUAL	454	01	19	10	31	15	QUAL	454	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		17b.		17c.		17d.		17e.		
DN PETER GUZINSKI DC				NPI 1710014188								
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY State A-L to service line below (84E) ICD Ind. 0												
A. <u>S33.5XXA</u>	B. <u>M51.26</u>	C. <u>I M48.06</u>	D. <u>M79.609</u>	22. RESUBMISSION CODE		ORIGINAL REF. NO.						
E. <u>R20.1</u>	F. <u>R20.2</u>	G. <u>I</u>	H. <u>L</u>									
I. <u>J.</u>	K. <u>L</u>	23. PRIOR AUTHORIZATION NUMBER		NOT REQUIRED								
24. A. DATES(S) OF SERVICE												
From MM DD YY	To MM DD YY	PLACE OF SERVICE EMB	C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	E. DIAGNOSIS PCMASTER MODIFER	F. \$ CHARGES	G. DATES ON UNITS	H. PAYOR/PAYER	I. ID CODE	J. RENDERING PROVIDER ID. #			
04 25 18	04 25 18	11	95903	ABCD	349	84	4	OB 007938	NPI 1942397245			
04 25 18	04 25 18	11	95904	ABCD	223	76	4	OB 007938	NPI 1942397245			
04 25 18	04 25 18	11	95934	ABCD	126	10	2	OB 007938	NPI 1942397245			
04 25 18	04 25 18	11	95860	ABCD	97	59	1	OB 007938	NPI 1942397245			
04 25 18	04 25 18	11	99212	ABCD	20	29	1	OB 007938	NPI 1942397245			
25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENTS (For part b, check one box)												
22-3830040	<input checked="" type="checkbox"/>	531622Z	531622Z	<input checked="" type="checkbox"/> X	ND	\$ 817.58	\$ 0.00					
28. TOTAL CHARGE 29. AMOUNT PAID 30. Refd for NUCC Use												
\$ 817.58 \$ 0.00												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)												
Gary R. Smith												
32. SERVICE FACILITY LOCATION INFORMATION General Diagnostic Associates 5660 Clinton Street Suite 4 Elma, NY 14059												
33. BILLING PROVIDER INFO & PHR (716) 686-0868 General Diagnostic Associates 5660 Clinton Street Suite 4 Elma, NY 14059												
SIGNED 4/27/2018 DATE a. 0 b. 007938 c. 1942397245												

Organization Manifest

CLINICAL PRACTICE MANAGEMENT PLAN(21)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
03223949501010461		RAEESI, QAIS	04/11/2018	04/11/2018
03018730401010461		HAYES, KEVIN	04/21/2018	04/21/2018
06000707101010121		WOOLSEY, HEATHER	04/22/2018	04/22/2018
03018730401010461		HAYES, KEVIN	04/22/2018	04/22/2018
01239937101017652		GAMBALE, LORRAINE	04/15/2018	04/15/2018
03018730401010461		HAYES, KEVIN	04/22/2018	04/22/2018
00039348301011405		ALTOMARE, JACQUELINE	04/12/2018	04/12/2018
03892483801010361		RYAN, SARAH	04/03/2018	04/03/2018
06072971301010161		PLANK, JUSTIN	04/23/2018	04/23/2018
00423130501013581		MCDONNEL, WILDA	02/17/2018	02/17/2018
06000707101010123		WOOLSEY, HEATHER	04/19/2018	04/19/2018
00918381201011608		GALLO, MARYANN	03/20/2018	03/20/2018
06000707101010121		WOOLSEY, HEATHER	04/21/2018	04/21/2018
00423130501013581		MCDONNEL, WILDA	02/17/2018	02/17/2018
06250184301010113		BERENZY, CHRISTINA	04/12/2018	04/12/2018
03899484801010891		MCCUNN, JACOB	04/16/2018	04/16/2018
06000707101010121		WOOLSEY, HEATHER	04/22/2018	04/22/2018
00353471301011101		FISHMAN, NATALIE	04/15/2018	04/15/2018
06250184301010112		BERENZY, CHRISTINA	04/12/2018	04/12/2018
01239937101017651		GAMBALE, RICHARD	04/15/2018	04/15/2018
05433810501010601		TRENHOLM, CHARLES	04/19/2018	04/19/2018

05 03 18



PRIORITY MAIL
POSTAGE REQUIRED



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**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**
(This form is not for verification of hospital treatment.)

GEICO NY PIP OFFICE
PO Box 9507
Fredericksburg VA 22403-9526

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
04/26/18	Danielle Harwell	0138739400101059	10/31/2015	0138739400101059

GDA CHIROPRACTIC PC dba/ General Diagnostic Associates

Gary Smith DC
3660 Clinton Street
Elma, NY 14059-9494

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

Danielle Harwell 1131 Cleveland Drive Cheektowaga, NY 14225

2. DATE OF BIRTH 3. SEX 4. OCCUPATION (IF KNOWN)
08/29/1980 F

5. DIAGNOSIS AND CONCURRENT CONDITIONS

933.5XXA sprain of ligaments of lumbar sp M51.26 Other intervertebral disc displacement,
M48.06 Spinal stenosis, lumbar region M79.609 Pain in unspecified limb

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: 10/31/2015 7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS
CONDITION? DATE: 01/19/2016

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES NO

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES NO

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES NO

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES NO NOT DETERMINABLE AT THIS TIME
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)
#12 AND #13 PLEASE CONSULT TREATING DOCTOR'S NOTES
FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE
ABLE TO RETURN TO WORK ON: _____
(DATE) _____

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

PAGE 2

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES NO

IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED - ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEESCHEDULE TREATMENT CODE	CHARGES
04/25/2018	see below*	Motor NCV w/ F-wave Global Billing	95903	349.84
04/25/2018	see below*	Sensory NCV Global Billing	95904	223.76
04/25/2018	see below*	H-reflex Solitus Global Billing	95934	126.10
04/25/2018	see below*	Needle EMG 1 extremity w/ or w/o ** see attached **	95860	97.59

*5660 Clinton Street Elma, NY 14545-9494

TOTAL CHARGES TO DATE \$

817.58

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)
Smith Gary	D.C.	X007938	*****	** OWNER **	*****

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

GARY SMITH DC JEFFREY ROSS DC

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
-
- YES
-
- NO
-

19. ESTIMATED DURATION OF FUTURE TREATMENT:

N/A

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (Authorization to Pay Benefits) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in Item 20 of this form.

20. (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____
 PATIENT _____ PATIENT _____ DATE _____

CONTINUE ON PAGE 3

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. XX (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS:

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR.

PRINT NAME	<u>Danielle Harwell</u>	SIGNED	PATIENT	DATE
------------	-------------------------	--------	---------	------

PATIENT (Assignor)

PRINT NAME	<u>Gary Smith DC</u>	SIGNED	PATIENT	DATE
------------	----------------------	--------	---------	------

PARTNER OF HEALTH CARE SERVICE (Assignee)

PATIENT

DATE

******* SEE ATTACHED NF-AOB *******

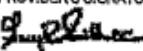
HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY
BEEN EXECUTED?

YES NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE?

YES NO

ANY PERSON WHO KNOWLINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWLINGLY MAKES OR KNOWLINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCS RATING CODE IF NONE, SPECIALTY
04/27/2018		22-3830040	D.C.

Organization Manifest

excelsior orthopaedics, llp(6)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
04081689801010452		ATKINSON, NIAMA	04/14/2018	04/14/2018
04081689801010452		ATKINSON, NIAMA	04/10/2018	04/10/2018
03366532601010102		ORMOND, KRISTEN	04/16/2018	04/16/2018
05033174201010161		HUDSON, SANDRA	04/05/2018	04/05/2018
03445818601011082		WASILEWSKI, GLORIA	04/11/2018	04/11/2018
05435305801010121		MATURSKI, MARK	04/13/2018	04/13/2018

Organization Manifest

University Orthopaedic Services, Inc. (6)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
02738239601010661		KUMRO, KATHLEEN	04/23/2018	04/23/2018
03693527701011374		BOWEN, SHELLY	04/20/2018	04/20/2018
02262555601010551		SHEEHAN, TAYLOR	04/02/2018	04/02/2018
05368937401010282		TARDI, LISA	04/18/2018	04/18/2018
01237948401011091		MORGAN, BRANDON	04/24/2018	04/24/2018
04693092701010572		NOWAK, LEEANN	04/18/2018	04/18/2018

Organization Manifest

FLH Medical, PC(2)

<u>Claim #</u>	<u>Services</u>	<u>Patient Name</u>	<u>DOS Start</u>	<u>DOS End</u>
05732367501010132		GLOVER, CONSTANCE	04/20/2018	04/20/2018
05732367501010131		GLOVER, CONSTANCE	04/20/2018	04/20/2018

Carrier Manifest

Geico

P O BOX 9507

Fredericksburg, VA 22403-9526

NOTICE: PLEASE DO NOT MAIL CORRESPONDENCE TO IHCFa. ALL CORRESPONDENCE SHOULD BE DIRECTED TO THE BILLING PROVIDER LISTED ON EACH CLAIM FORM.

Total Claims: 219
Claims per Organization:

Advantum Health Prog : 87
Brain and Spine Center : 1
CareMount Medical, P.C. : 12
CLINICAL PRACTICE MANAGEMENT PLAN : 21
Crouse Medical Practice, PLLC : 2
DAVID J.WEISSBERG, MD,PC : 16
excelsior orthopaedics, Ilp : 6
FLH Medical, PC : 2
General Diagnostic Associates : 2
Medical Pain Management Services, PLLC : 7
MONMOUTH MEDICAL IMAGING P.A. : 1
NEW ROCHELLE RADIOLOGY ASSOCIATES : 3
PROSPECT HILL RADIOLOGY GROUP : 2
Ramapo Imaging Assoc PC : 3
Syracuse Orthopedic Specialists, PC : 5
The Lattimore 6 : 8
Timothy D Groth MD PC : 1
Total Orthopedics, Spine & Sports Medicine : 25
UB Neurosurgery, Inc : 1
University Orthopaedic Services, Inc. : 6

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IHCFa.com, LLC PO Box 2016, Morristown, NJ 07962; 973-795-1641 ext 4000 ** DATE GENERATED: 4/30/2018 **

Carrier Manifest

Geico

P O BOX 9507

Fredericksburg, VA 22403-9526

NOTICE: PLEASE DO NOT MAIL CORRESPONDENCE TO IHCFA. ALL
CORRESPONDENCE SHOULD BE DIRECTED TO THE BILLING PROVIDER LISTED ON
EACH CLAIM FORM.

Total Claims: 219
Claims per Organization:

Upstate Anesthesiology : 1

Upstate Emergency Medicine Inc : 2

Upstate University Medical Assoc at Syr : 4

Vasilios Kountis DO : 1

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IHCFA.com, LLC PO Box 2016, Morristown, NJ 07962; 973-795-1641 ext 4000 ** DATE GENERATED: 4/30/2018 **

Fredericksburg, VA 22403-9526

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIONISM CLAIM COMMITTEE (NUCC) 08/13

PICA											
1. MEDICARE <input type="checkbox"/> Medicare	2. MEDICAID <input type="checkbox"/> Medicaid	3. TRIAGE <input type="checkbox"/>	4. CHAMPVA <input type="checkbox"/>	5. GROUP HEALTH PLAN <input type="checkbox"/> Member (M) <input type="checkbox"/> Non-Member (NM)	6. FECA BUILDING <input type="checkbox"/> Bldg <input type="checkbox"/> (NM)	7. OTHER <input type="checkbox"/> Other (O)	8a. INSURED'S I.D. NUMBER 0138739400101059 (For Program in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)											
BARWELL, DANIELLE											
3. PATIENT'S BIRTH DATE MM DD YY 08 29 80 M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
4. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE											
6. RESERVED FOR NUCC USE											
7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE											
CITY CHEERTONAGA STATE NY											
ZIP CODE 14225 TELEPHONE (Include Area Code) ()											
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)											
9. OTHER INSURED'S POLICY OR GROUP NUMBER											
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO NY PLACE (State)											
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
d. INSURANCE PLAN NAME OR PROGRAM NAME Geico											
10. IS PATIENT'S CONDITION RELATED TO: 10d. CLAIM CODES (Designated by NUCC)											
11. INSURED'S POLICY GROUP OR FECA NUMBER											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
Signature On File 4/23/2018											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.											
Signature On File											
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 10 31 15 QUAL 431											
15. OTHER DATE MM DD YY QUAL 439 10 31 15											
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DM J PETER GUZINSKI											
17a. NPI 1710014166											
17b. NPI											
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LABS \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to services line below (24E) ICD Ind. <input type="checkbox"/> 0											
A. <u>M51.26</u>	B. <u>M47.26</u>	C. <u>M51.36</u>	D. <u> </u>								
E. <u> </u>	F. <u> </u>	G. <u> </u>	H. <u> </u>								
I. <u> </u>	J. <u> </u>	K. <u> </u>	L. <u> </u>								
22. RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER NOT REQUIRED											
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 04 11 18 04 11 18 11											
B. PLACE OF SERVICE ENG											
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances) CPT/HCPCS 99214											
E. DIAGNOSIS \$ CHARGE ABC 74 79 1											
F. G. H. I. J. DAYS OR UNITS GRANT Party Pay ID OB 248830 NPI 1023202355											
G. RENDEZ PROVIDER ID. # NPI NPI NPI NPI NPI NPI											
25. FEDERAL TAX ID. NUMBER SSN/EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 030445678 <input checked="" type="checkbox"/> 102251 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (\$ For gross estimate, see Item 1)											
28. TOTAL CHARGE 29. AMOUNT PAID 30. Rev'd for NUCC Use \$ 74 79 5 0 00											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this Bill and are made a part thereof.) Jafar Siddiqui											
32. SERVICE FACILITY LOCATION INFORMATION UB Neurosurgery, Inc 180 Park Club Lane, STE 250 Williamsburg, NY 14221											
33. BILLING PROVIDER INFO & PAY (716) 218-1030 UB Neurosurgery, Inc PO Box 8000 DEPT 883											
SIGNED 4/23/2018 DATE a 1306896220 a 248830 a 1306896220 a											



UNIVERSITY AT BUFFALO
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Neurosurgeons

Badri L. Levy, MD, MBA, FRCR, FAJR
Gregory J. Castiglia, MD, FRCR
Arian M. Barles, MD, PhD
John G. Fabrizio IV, MD
Kevin J. Gibbs, MD, FRCR, FAANS
William J. MD
Douglas B. Meiland, MD, FRCR
Robert J. Plautz, MD
John Pollina, MD, FRCR
Kenton Reynolds, MD, FRCR, FAANS
Jonathan Riley, MD

Adham H. Siddiqui, MD, FRCR, FAJR

Kenneth V. Snyder, MD, PhD, FAANS
Michael R. Stoffman, MD, FRCR, FAANS

Interventional Pain Management

John W. Siddiqui, MD, FAAPMR, DABPM
Andrea C. Wong, MD, DABR, DABPM, MRSE

Chiropractors

Jonathan P. Beck, DC
Surjeet Kapoor, DC

3980-A Sheridan Drive
Amherst, NY 14226
716/219-1000
EMR Fax: 716/659-2991

Buffalo General Medical Center
100 High Street - Section B4
Buffalo, NY 14203
716/219-1000
EMR Fax: 716/659-7489

5059 Big Tree Road - Suite 103
Orchard Park, NY 14215
716/219-1000
EMR Fax: 716/657-4938

Robert Children's Outpatient Center
Convalescent Building
1001 Main Street • 3rd Floor
Buffalo, NY 14203
716/219-1040
EMR Fax: 716/343-2535

The Park Center
100 Park Club Lane
Williamsville, NY 14221
716/839-9402
EMR Fax: 716/659-3579

6050 Williams Road - Suite 3000
(Dr. Michael Stoffman)
Magnus Eds., RT 14394
716/219-1000
EMR Fax: 716/205-8388

Interventional Pain Management

Dr. John Siddiqui, Dr. Jonathan Wong
180 Park Club Lane
Suite 250
Williamsville, NY 14221
716/219-1000
EMR Fax: 716/580-7877

April 11, 2018

James Panzarella DO
1208 Niagara Falls Boulevard
Tonawanda, NY 14150

Patient Name: Danielle Harwell
Date of Birth: 08/29/1980
No-Fault Carrier: NF Geico
CL#: 0138739400101059
Date of Injury: 10/31/15

Psychiatry Re-evaluation: April 11, 2018

Chief Complaint(s): Low back pain, left greater than right lower extremity pain/weakness.

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle Harwell in our Park Club Lane office for re-evaluation on April 11, 2018.

HISTORY/CHIEF COMPLAINT

The patient is a 37-year-old female. We saw the patient last on January 31, 2018. At that time we were speaking with the patient regarding increased pain and weakness in the left leg, which she felt following an epidural steroid injection she had with Dr. Siddiqui in early December. The patient is pleased to report she has had some improvement in her pain. She was scheduled to come back to our office a week after our last appointment, but, unfortunately, had to undergo an urgent cholecystectomy with a complicated course. At this time she is feeling much better from this standpoint. She states that the left leg pain she was experiencing has also improved. She is still experiencing weakness, but it is also improved. An updated MRI of the lumbar spine will be reviewed below. We initiated the patient on gabapentin at her last appointment, which she is now taking and finding good relief with. She was given small supply of hydrocodone, which she states she has exhausted, but did feel it helped in times when her pain was very severe. She is also utilizing ibuprofen 800 mg. Her pain score today is 5/10 on the visual analog scale. She is unable to stand, walk or sit for any length of time and has to make frequent position changes. She notes occasional electric-shock sensations in the back, as well as down the leg, more so on the left-hand side. Her right leg is doing quite well.

Review of systems is notable for joint pain, numbness, tingling, muscle weakness and headaches, otherwise noncontributory to chief complaint.

PHYSICAL EXAMINATION

Resp: 16 **Ht:** 63" **Wt:** 200lb **BMI:** 35.4

General: This is a 37-year-old female, in no acute distress. She is awake, alert and appropriate. Speech is fluent and coherent.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are pink and moist.

Cardiovascular: Normal S1, S2.

Abdomen: Soft, non-distended, obese.

Neuromusculoskeletal: The patient has decreased strength throughout multiple muscle groups of the left lower extremity, most notable in left hip flexion. However, this is improved when compared to the significant weakness she exhibited in January. Sensory examination continues to be decreased in multiple dermatomal distributions of the left leg, most pronounced in the lateral aspect of the calf. Straight leg raise sign is negative. She is able to stand without assistance. Gait is mildly antalgic. She utilizes a straight cane for assistance in ambulation.

Psychiatric: Judgement and cognition are within normal limits.

REVIEW OF DIAGNOSTIC STUDIES

MRI of the lumbar spine without contrast from Buffalo MRI dated February 2, 2018, report was reviewed. There is disc space narrowing present at L3-4, L4-5 and L5-S1. This is severe at L3-4. There is mild central canal narrowing with no foraminal stenosis at L3-4. At L4-5 there is a broad-based annular bulge with mild canal stenosis similar to previous study in 2016. There is no significant foraminal stenosis. At L5-S1 there is disc space narrowing with a central broad-based disc protrusion and increased epidural fat noted. There is mild bilateral foraminal stenosis and mild central stenosis. This is unchanged compared to the 2016 study.

ASSESSMENT

M51.26 - Other intervertebral disc displacement, lumbar region, M47.26 - Other spondylosis with radiculopathy, lumbar region, M51.36 - Other intervertebral disc degeneration, lumbar region

IMPRESSION/RECOMMENDATIONS:

This is a 37-year-old female with low back pain and improved left lower extremity pain, paresthesias and weakness. Due to the ongoing symptoms she has, although they are markedly improved when compared to our last appointment, and in reviewing her MRI from February with no significant explanation of the weakness and numbness she is experiencing, I am recommending a bilateral lower extremity EMG/nerve conduction study. She will continue with chiropractic care and massage therapy. I will continue her on gabapentin 300 mg, and I have encouraged her to take this twice a day if capable. She will receive a refill of hydrocodone 7.5/325, a quantity of #15 tablets to be used sparingly. She will continue with ibuprofen for anti-inflammatory relief. The patient expressed understanding and agreement with today's plan of care. I will see her back following her EMG to review further treatment options.

The patient was advised today regarding treatment with the above named controlled substance(s). The risk, benefits, common side effects and alternative treatments were discussed with the patient. Risks discussed include, but are not limited to: physical and/or psychological dependence, medication tolerance, drowsiness/sleepiness, balance or coordination problems, confusion, allergic reaction or other abnormal symptoms. The patient has been advised and agrees to use the medication only as prescribed and not to drive or operate heavy machinery or equipment. The patient understood and consented to under a narcotic/opiate regimen and has agreed to sign and comply with the University at Buffalo Neurosurgery controlled substance contract/agreement. The patient verbalized understanding and was told to call with any concerns.

Danielle Harwell DD 04/11/2018

Page #3

The patient was advised today regarding treatment with the above named medication(s). The risks, benefits, common side effects and alternative treatments were discussed with the patient. The patient verbalized understanding and was told to call with any concerns.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

Sincerely,



Electronically signed by Sarah O'mara, PA-C on 04/16/2018 at 12:12 pm
Sarah O'mara, PA-C



Electronically signed by Jafar Siddiqui, M.D. on 04/16/2018
Jafar Siddiqui, M.D.

SO/abb

cc: Peter Guzinski DC

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200 Sterling Drive
Orchard Park, NY 14217
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To: GEICO NY CLAIMS

1-856-294-5154

From: Dawn Crowley, AAS, CMBS

Dent Neurologic
dcrowley@dentinstitute.com

Tel: 716-250-2059 Fax: 716-250-2040

Regarding: CLAIM # 0138739400101059 BILLING AND NARRATIVE ATTACHED



HARWELL_FAX.fax

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XXX

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X 0138739400101059

HARWELL, DANIELLE

08 29 1980

X HARWELL, DANIELLE

1131 CLEVELAND DR

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1131 CLEVELAND DR

CHEEKTOWAGA

NY

CHEEKTOWAGA

NY

14225-1257

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SIGNATURE ON FILE

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JENNIFER W MCVIGE, MD		DENT TOWER 6TH FLR 3980 SHERIDAN DRIVE 6TH FLOOR AMHERST NY 14226-1727		DENT NEUROLOGIC GROUP LLP PO BOX 8000 DEPT 057 BUFFALO NY 14267-0002	
05 10 18		1497850911		1497850911	EI161582336



DENT

NEUROLOGIC INSTITUTE

Venice Rates, MD	Sanjay Gupta, MD	Bennett Myers, MD
Refa Ajai, MD	Tomas Hainline, MD	Mohammed M. Qasimzada, MD
Alfred Batan III, MD	J. Manasco Houserland, MD	Michelle M. Rainko, PharmD
Hernio Capeto, MD	Amparo M. Kalo, MD	Luis Rojas, MD
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J. Aubrey Betens, PhD	Leandro Mechler, MD	Joseph V. Irlitz, PhD, CBO
Mire S. Pena, MD	Jennifer W. McVige, MD	
Francis M. Genglo, PharmD	Kenneth R. Murray, MD	

Abbey L. Burdick, PA-C

Procedure Note

Date: 05/08/2018

Patient Name: Harwell, Danielle

DOB: 08/29/1980 Age: 37 Y Sex: Female

PCP: James Panzarella, DO

Reason for Appointment

- NF- Requires Opinion
- Patient is here for Trigger Point injections . Patient presents for treatment of headache

History of Present Illness

General:

The patient is here today for trigger point injections. The patient denies any history of allergies to lidocaine, bupivacaine or dexamethasone. The patient denies any history of bleeding disorders. The patient is not on any anticoagulant medications. Prior to the procedure the risks and benefits were discussed with the patient and a written informed consent was signed. The patient has elected to have the procedure performed today. Patient reports good results with her trigger point injections. She unfortunately had to cancel her initial Botox appointment due to coming down with the stomach flu. We will resubmit for Botox authorization.

Current Medications

- Taking magnesium oxide 250 mg tablet 2 tab(s) orally once a day
- Taking nortriptyline 10 mg capsule 2 cap(s) orally QHS
- Taking topiramate 100 mg tablet 1 tab(s) orally BID
- Taking Imitrex 100 mg tablet 1 tab(s) orally PRN Migraine; MDD = 2 MWD = 3
- Taking diclofenac potassium 50 mg tablet 1 tab(s) orally prn headache, MDD= 2, no more than 3 days per week
- Taking Melatonin 3 mg tablet 1 tab(s) orally once (at bedtime)
- Taking Vitamin D3 5000 int'l units capsule 1 cap(s) orally once a day
- Taking pantoprazole 40 mg delayed release tablet 1 tab(s) orally once a day
- Taking loratadine 10 mg capsule 1 cap(s) orally once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

- Asthma
- Esophageal reflux

Surgical History

- T & A
- D&C
- Endoscopy

DIAGNOSTICS & SERVICES

(716) 250-2000	MRI	Neuropsychology
www.dentinstitute.com	Angiogram	Pneumography
	Breast	Sleep Studies
	Doppler/TCI	SPECT
	EKG	Ultrasound
	KMG	VMR
	DaPCT	PNG
	Inflatus	

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- Colonoscopy
- Cholecystectomy

Family History

Father: alive, Stroke
Mother: alive, Asthma
Siblings: alive
1 brother(s) - healthy.

Social History

Tobacco Use:

Smoking Patient is a: non smoker .

Fall History:

Have you fallen: No . Do you feel unsteady when: No .

Alcohol use:

Alcohol Consumption Patient does not drink alcohol.

Resides with:

Spouse: Husband . Children: Yes x3. Self: Yes .

Working:

Employed Stay at home mom.

Marital Status:

Married: Yes .

Driving:

Does Patient Drive: Yes .

Exercise:

Daily: Yes Walks.

Caffeine:

Other Patient does not consume caffeine.

Allergies

- Keflex
- codeine
- penicillin
- Biaxin
- Cipro
- Soma

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Neck pain and headaches. No additional new neurological or physical deficits reported outside of the patient's complaints as compared to the previous visit, and upon review of clinical systems for today's visit. This assessing the following systems: neurologic, constitutional, eyes, ears, nose and throat, cardiovascular, respiratory, gastrointestinal, genitourinary, skin, musculoskeletal, psychiatric, endocrine, hematologic, and allergy.

Vital Signs

BP sitting 126/82, HR 80, RR 16, Ht 63, Wt 242.4, BMI 42.93, BSA 2.21.

Examination

Neurological:

The patient was seated comfortably on a chair and appeared to be well dressed, well nourished and without distress. The speech was clear and fluent. Affect was positive.

DIAGNOSTICS & SERVICES	
MRI	Neuropsychology
Angiogram	Pneumography
Breast	Sleep Study
Doppler/TCG	SPECT
EKG	Ultrasound
KMG	VMR
DaPACT	PNG
Inflatus	

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Muscular exam reveals 5/5 strength in the upper and lower extremities bilaterally. Prominent trigger points were palpated throughout the cervical and thoracic musculature, including the bilateral trapezius and latissimus dorsi muscles. These focal areas of tenderness are associated with distinct patterns of referred pain. Stimulation of these trigger points reproduces patterns of pain. There is no evidence of muscle deconditioning or wasting. Range of motion about the cervical spine is moderately limited in all directions.

Assessments

1. Myofascial pain - M79.1

Continue all previously prescribed medicines at the current doses.

Return for repeat trigger point injections in 1 month.

Avoid migraine triggers such as MSG and nitrates, obtain good sleep, avoid skipping meals and exercise regularly.

Thank you for allowing to participate in the care of this patient. If there are any questions please feel free to call anytime.

Dr. McVige is the supervising physician on site.

Procedures

Injections:

Trigger Point (w) The risks and benefits of this procedure were explained to the patient, and the patient agreed to the procedure. The patient denied any allergy to the agents used prior to administration. There is no history of bleeding disorder. Trigger point areas were palpated and cleansed with isopropyl alcohol in sterile fashion while the patient was in a seated position within the exam room. I then provided the patient with trigger point injections with equal volumes of 1% lidocaine and 0.5% marcaine (5 cc each). A total of 10 cc was injected with a 25-gauge needle without complication into 10 areas in the back within the trapezius and latissimus dorsi bilaterally. The patient tolerated the procedure well and complete hemostasis was maintained throughout. The patient was instructed to refrain from strenuous exercise, and to apply warm compresses with gentle massage to the area of injection for the next 2-3 days to address any local tenderness.

Preventive Medicine

COUNSELING: Healthy Living: Patient counseled on the importance of healthy lifestyle 05/08/2018.

Diet: Patient counseled on importance of lowering sugar intake, sodium and fats. 05/08/2018.

Exercise: Patient counseled on importance of moderate physical activity daily. 05/08/2018.

Follow Up

4 Weeks

Electronically signed by Abbey Burdick , PA-C on 05/08/2018 at 10:32 AM EDT

Sign off status: Completed

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DIAGNOSTICS & SERVICES	
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EEG	Posturography
EMG	Sleep Studies
Breath	SPECT
Doppler/TCD	Ultrasound
EEG	TMS
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DIAGNOSTICS & SERVICES

<i>MRI</i>	<i>Neuropsychology</i>
<i>Arthrograms</i>	<i>Positronigraphy</i>
<i>Breast</i>	<i>Sleep Studies</i>
<i>Doppler/TCD</i>	<i>SPECT</i>
<i>EEG</i>	<i>Transcranial</i>
<i>EMG</i>	<i>TMS</i>
<i>ImPACT</i>	<i>PNG</i>
<i>Inflators</i>	



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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CARRIER

0138739400101059

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1 MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA SICKLE CELL		OTHER		1a INSURED'S ID NUMBER		(For Program in Item 1)							
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2 PATIENT'S NAME (Last Name, First Name, Middle Initial)								3 PATIENT'S BIRTH DATE		MM DD YY		SEX		4 INSURED'S NAME (Last Name, First Name, Middle Initial)									
HARWELL DANIELLE								08291980		M <input type="checkbox"/> F <input checked="" type="checkbox"/>		HARWELL DANIELLE											
5 PATIENT'S ADDRESS (No., Street)								6 PATIENT RELATIONSHIP TO INSURED															
1131 CLEVELAND DRIVE								Spouse <input checked="" type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>															
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CHEEKTOWAGA		NY		56 BEREHAVEN DR, LEFT																			
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9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)								10 IS PATIENT'S CONDITION RELATED TO															
a OTHER INSURED'S POLICY OR GROUP NUMBER								a EMPLOYMENT? (Current or Previous)															
b RESERVED FOR NUCC USE								b AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
c RESERVED FOR NUCC USE								c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
d INSURANCE PLAN NAME OR PROGRAM NAME								d 10d CLAIM CODES (Designated by NUCC)															
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12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								f OTHER CLAIM ID (Designated by NUCC) 08291980 M <input type="checkbox"/> F <input checked="" type="checkbox"/>															
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14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 103115 QUA 431								h IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO # year, complete items 9, 9a, and 1d															
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a 17b NPI								i INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below															
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								j SIGNATURE ON FILE															
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer A-L to service lines below (24E))								k SIGNATURE ON FILE															
a M50.22		b M51.26		c M51.27		d M54.12		l ICD 9-CM CODE 0															
e E82.3_XXXA		f M99.01		g M99.03		h M99.02		m RESUBMISSION CODE															
i M99.05		j M54.2		k M54.5		l M54.6		n ORIGINAL REF NO															
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25 FEDERAL TAX ID NUMBER SSN EN 364500165								26 PATIENT'S ACCOUNT NO 343821275								27 ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse side of this bill are true and correct. PETER GUZINSKI DC								28 TOTAL CHARGE 42 81 5								29 AMOUNT PAID							
32 SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849								30 RPD for NUCC Use															
33 BILLING PROVIDER INFO & PH # (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849								34 APPROVED OMB-0938-1197 FORM 1500 (02-12)															
SIGNED 05042018 DATE 1235256546								PLEASE PRINT OR TYPE 1235256546								APPROVED OMB-0938-1197 FORM 1500 (02-12)							

Encounter dated 05/01/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/04/2018

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits



Item# 43568
Patent Pending



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FULL TIME
345 Dick Rd.
Depew, NY 14043

Geno
P.O. Box 9567
Fredericksburg, VA

22403-9526



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare) (Medicaid) (DOD/DGA) (Member ID#) (DOD) (DOD) (DOD)												1a. INSURED'S ID NUMBER 013873940011059			(For Progress in Item 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE												3. PATIENT'S BIRTH DATE MM DD YY 08291980			SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE	
5. PATIENT'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE												6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 56 BEREHAVEN DR, LEFT			
CITY CHEEKERTOWAGA		STATE NY		8. RESERVED FOR NUCC USE			CITY AMHERST		STATE NY		ZIP CODE 14228 TELEPHONE (Include Area Code) (716) 536 0951							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)												10. IS PATIENT'S CONDITION RELATED TO a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER 08291980			
												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> NY			c. INSURANCE PLAN NAME OR PROGRAM NAME GEICO			
												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d			
d. INSURANCE PLAN NAME OR PROGRAM NAME												12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below			
SIGNED SIGNATURE ON FILE												DATE			SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 103115		15. OTHER DATE QUAL 454		MM DD YY 111215		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY												
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE GUAL 431		17a NPI		17b NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY												
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			21. CHARGES			
												22. RESUBMISSION CODE ORIGINAL REF. NO.						
23. PRIOR AUTHORIZATION NUMBER																		
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25. FEDERAL TAX ID NUMBER 364500165		SSN/EIN X		26. PATIENT'S ACCOUNT NO. 343871274		27. ACCEPT ASSIGNMENTS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 42.81		29. AMOUNT PAID \$		30. Reserved for NUCC Use						
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to the bill and are made in good faith. PETER GOZINSKI DC												32. SERVICE FACILITY LOCATION INFORMATION CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849			33. BILLING PROVIDER INFO & PH.# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW, NY 140431849			
SIGNED 04292018 DATE 1235256546												34. b			35. b			

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
May 4, 2018

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Friday April 27, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 04/27/2018 at 10:00am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving; lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* "I still get headaches periodically, 2 to 3 a week." Patient saw Dr. Golberg and a mouth guard was made to help with her TMJ. Follow up on May 21, 2018 for Bio testing. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change, since last visit. *Pain:* achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient presented today stating that her lower back pain continues. She stated that the electrodiagnostic testing "really aggravated her left lower back and both lower extremity. It just feels weird." Patient had the electrodiagnostic testing performed on Wednesday. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* improving, since last visit. *Pain:* achy, dull, sharp, shooting, tingling, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right buttock, left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain right neck; extension: WNL 60/60 with no pain; left

Encounter dated 04/27/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 05/04/2018

rotation: WNL 80/80 with no pain; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45 with no pain right neck; right lateral bending: WNL 45/45 with no pain left neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: *Range of motion:* flexion: 45/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: 20/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: 15/25 with pain lower back. *Gait pattern:* normal. *Strength:* left extensor hallucis longus: 4/5; right extensor hallucis longus: 5/5; left tibialis anterior: 4/5; right tibialis anterior: 5/5. *Tenderness & Hypertonicity:* lumbar paraspinal bilateral moderate; TFL / ITB left moderate. *Tenderness on palpation:* left SI: moderate; right SI: moderate. *Trigger points:* left gluteus maximus, right gluteus maximus. *Orthopedic tests:* Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Since her last re-examination on December 29, 2017, Mrs. Harwell's neck condition has remained similar to her last visit. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained similar to her last visit. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has improved since her last visit. Her VAS score improved from a 6 to 3 out of 10. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet

Encounter dated 04/27/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/04/2018

arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to: relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. Visit# 1 of 4 planned treatments. Treatment schedule: 1x/week for 3 weeks; Re-examination for 3 weeks. Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (no treatment rendered); C6 left lateral flexion restriction (no treatment rendered); T2 left rotation restriction (diversified prone); T3 left rotation restriction (diversified prone); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (prone mobilization). Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. Home care: ice: neck / lower back prn for 20 minutes. Additional instructions: Advised patient to monitor for any changes in their symptoms. Short term goals: decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. Long term goals: decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. Disability status: Temporary partial starting on November 12, 2015 to May 16, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 04/27/2018 at 10:00am

Encounter dated 04/27/2018 for Danielle Harwell #3438
DOB:08/29/1980 Today's date: 05/04/2018

Abbreviations

ADL: activities of daily living
MVA: motor vehicle accident
ROM: range of motion
VAS: Visual Analog Scale
WNL: within normal limits

Cichocki & Cichocki LLP (TIN#: xx-xx00165)
345 Dick Road
Depew, NY 140431849
716-681-3333
May 4, 2018

Patient: Danielle Harwell #3438 DOB: 08/29/1980
Policy ID: 013873940011059

Tuesday May 1, 2018 Provider: Peter Guzinski DC

Electronically signed by Peter Guzinski DC on 05/01/2018 at 10:44am

Patient presented for initial evaluation on November 12, 2015 for injuries sustained in a MVA on October 31, 2015.

Subjective

Cervical: Patient presented today with the continued chief complaint of neck pain. Patient stated that she has been experiencing numbness in her right thumb and index. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior neck pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, tingling, shooting, numb; level: 3/10. *Pain is frequent.* *Pain radiates to:* right shoulder, left upper extremity. *Exacerbates symptoms:* movement of neck; driving, lifting; any kind of physical activity; reaching; activities of daily living; performing household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* right hand. *Weakness:* left upper extremity. *Recent infection or fever:* No. *Night sweats or pain:* No. *Headaches:* "I still get headaches periodically, 2 to 3 a week." Patient saw Dr. Golberg and a mouth guard was made to help with her TMI. Follow up on May 21, 2018 for Bio testing. *Recent medical treatment for this condition:* Massage therapy. *Changes in past medical history:* None.

Thoracic: Patient presented today with the continued chief complaint of middle back pain. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior thoracic pain:* none. *Changes in this condition:* no change. *since last visit:* Pain: achy, dull, sharp, shooting; level: 3/10. *Pain is frequent.* *Exacerbates symptoms:* movement; bending; lifting; reaching; activities of daily living. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* none. *Weakness:* none.

Lumbar/Sacral/Pelvis: Patient stated that her lower back pain continues to remain the same. *Onset:* October 31, 2015. *Cause of symptoms:* MVA, rear impact. *Prior low back pain:* none. *Changes in this condition:* slightly worse. *since last visit:* Pain: achy, dull, sharp, shooting, tingling, numb. *Pain is frequent.* *Pain radiates to:* right buttock, left posterior thigh and leg. *Exacerbates symptoms:* driving; lifting; sitting; standing; bending; sit to stand; performing ADL; squatting; tying shoes; putting pants, socks and shoes on; household chores. *Alleviates symptoms:* chiropractic care; massage. *Numbness:* left foot. *Weakness:* none. *Bowel or bladder incontinence:* No. *Recent infection or fever:* No. *Night sweats or pain:* No. *Recent medical treatment for this condition:* Massage therapy.

Objective

Cervical: *Range of motion:* flexion: WNL 50/50 with pain right neck; extension: WNL 60/60 with no pain; left rotation: WNL 80/80 with no pain; right rotation: WNL 80/80 with no pain; left lateral bending: WNL 45/45

Encounter dated 05/01/2018 for Danielle Harwell #3438
 DOB:08/29/1980 Today's date: 05/04/2018

with no pain right neck; right lateral bending: WNL 45/45 with no pain left neck. *Posture:* rounded shoulders. *Hypertonicity & Tenderness:* Sub-occipital musculature Left Mild to Moderate; cervical paraspinal musculature Left Mild to Moderate; scalene Left Mild to Moderate; sternocleidomastoid Left Mild to Moderate; pectoralis minor Left Mild; cervical paraspinal musculature Right Mild. *Trigger points:* left levator scapulae, bilateral upper trapezius. *Orthopedic tests:* maximum left lateral compression: Positive left lower neck pain; maximum right lateral compression: Negative. *X-ray findings:* Reviewed X-ray results of the chest and cervical spine from Immediate Care performed on November 1, 2015 with the patient. According to the cervical report, there was mild disc space narrowing at C5-C6 with loss of lordosis. The chest film was read as normal. *Spinal subluxation level(s):* C5, C6, left first rib. *Subluxations detected by:* motion and static palpation.

Thoracic: *Hypertonicity & Tenderness:* Thoracic paraspinal musculature Bilateral Moderate. *Trigger points:* bilateral rhomboids. *Spinal subluxation level(s):* T2, T3, T6, T7, T8, T9. *Subluxations detected by:* motion and static palpation.

Lumbar/Sacral/Pelvis: Reviewed electrodiagnostic testing of the lower extremity which was performed by General Diagnostic Associates on April 25, 2018. According to Dr. Smith, no electrophysiological evidence of an active or chronic lumbar radiculopathy, lumbosacral plexopathy, focal lower extremity entrapment neuropathy, lower extremity peripheral polyneuropathy, or myopathy was observed. *Range of motion:* flexion: 45/60 with pain lower back; extension: 15/25 with pain lower back; left rotation: WNL 30/30 with pain lower back; right rotation: 20/30 with pain lower back; left lateral bending: WNL 25/25 with pain lower back; right lateral bending: 15/25 with pain lower back. *Gait pattern:* normal. *Strength:* left extensor hallucis longus: 4/5; right extensor hallucis longus: 5/5; left tibialis anterior: 5/5; right tibialis anterior: 5/5. *Tenderness & Hypertonicity:* lumbar paraspinal bilateral moderate; TFL / ITB left moderate. *Tenderness on palpation:* left SI: moderate; right SI: moderate. *Trigger points:* left gluteus maximus, right gluteus maximus. *Orthopedic tests:* Straight leg raise: Negative left at 60 degrees; Well leg raise: Negative right at 60 degrees; Bechterew: Negative bilateral. *Spinal subluxation level(s):* L4, L5, Left SI. *Subluxations detected by:* motion and static palpation.

Assessment

Cervical assessment: Based on the current history and examination results, I professionally feel that their current symptoms are causally related to the MVA sustained on October 31, 2015. Mrs. Harwell's neck condition has remained similar to her last visit. **Diagnosis:** M50.222 (other cervical disc displacement at C5-C6 level), M51.26 (Other intervertebral disc displacement, lumbar region), M51.27 (Other intervertebral disc displacement, lumbosacral reg), M54.12 (Radiculopathy, cervical region), S23.3XXA (Sprain of ligaments of thoracic spine, initial encounter), M99.01 (Segmental and somatic dysfunction of cervical region), M99.03 (Segmental and somatic dysfunction of lumbar region), M99.02 (Segmental and somatic dysfunction of thoracic region), M99.05 (Segmental and somatic dysfunction of pelvic region), M54.2 (Cervicalgia), M54.5 (Low back pain), M54.6 (Pain in thoracic spine). **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Cervical MRI performed on 01/04/2016 at Buffalo MRI revealed according to the radiologist a C4-C5 shallow central disc extrusion with disc space narrowing and at C5-C6 shallow central disc extrusion which barely flattens the thecal sac. **CPT code(s):** 98941, 97010.

Thoracic assessment: Mrs. Harwell's middle back condition has remained similar to her last visit. **Differential diagnosis:** Thoracic disc herniation. **Post-treatment analysis:** patient tolerated treatment without incident.

Lumbar assessment: Mrs. Harwell's lower back condition has been slightly worse since her last visit. Her VAS score increased from a 3 to 4 to 5 out of 10. **Prognosis:** Guarded. **Post-treatment analysis:** patient tolerated treatment without incident. **Set backs:** Lumbar MRI performed at Buffalo MRI on 01/04/2016 revealed

Encounter dated 05/01/2018 for Danielle Harwell #3438

DOB:08/29/1980 Today's date: 05/04/2018

according to the radiologist a L1-L2 shallow disc bulge, at L3-L4 desiccated disc and disc space narrowing with facet arthropathy and a shallow disc bulge which results in mild canal narrowing, at L4-L5 desiccated disc with central disc protrusion (herniation) with annular tear which impresses upon the thecal sac with ligamentum flavum prominence which results in mild canal stenosis along with bilateral facet arthropathy and underlying annular bulge which results in mild bilateral recess and neural foraminal narrowing as well and at L5-S1 hypertrophic facet changes with desiccated disc and central to left paracentral disc protrusion (herniation) and annular tear which results in mild to moderate left recess and neural foraminal narrowing and mild right neural foraminal and recess narrowing.

Treatment & Plan

Patient treated to relieve pain, improve ADL, improve function, improve ROM, increase spinal mobility, centralize pain, decrease muscular hypertonicity and tenderness, reduce frequency and intensity of headaches. Visit# 2 of 4 planned treatments. Treatment schedule: 1x/week for 2 weeks; Re-examination for 2 weeks.

Subluxations found on assessment and adjusted: C5 left lateral flexion restriction (Instrument adjustment Arthrostim); C6 left lateral flexion restriction (Instrument adjustment Arthrostim); T2 left rotation restriction (diversified prone, thumb move); T3 left rotation restriction (diversified prone, thumb move); T6 extension restriction (diversified prone); T7 extension restriction (diversified prone); T8 extension restriction (diversified prone); T9 extension restriction (diversified prone); L4 extension restriction (manual traction); L5 extension restriction (manual traction); SI left PI (gentle diversified side posture). Physical Modalities: bilateral cervical heat therapy (15 minutes); bilateral lumbar electric muscle stimulation (15 minutes); bilateral lumbar heat therapy (15 minutes); bilateral cervical paraspinal soft tissue massage; left sternocleidomastoid soft tissue massage; left scalene soft tissue massage; left suboccipital soft tissue massage; left thoracic paraspinal soft tissue massage; bilateral lumbar paraspinal soft tissue massage; left TFL / ITB soft tissue massage; bilateral upper trapezius trigger point therapy; left levator scapula trigger point therapy; left rhomboid trigger point therapy. Patient given: home exercise program: advised patient to perform active cervical rotation exercises 3 sets of 10 daily; home exercise program: advised patient to perform nerve glide exercises 3 sets of 10 daily; home exercise program: advised patient to perform chin tucks 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform standing extension exercises 3 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform CAT / Camel stretches 2 sets of 10 daily hold 5 sec; home exercise program: advised patient to perform single knee to chest exercises 3 sets of 10 daily hold 10 sec; home exercise program: advised patient to perform dog leg stretches 2 sets of 10 daily. Home care: ice: neck / lower back prn for 20 minutes. Additional instructions: Advised patient to monitor for any changes in their symptoms. Short term goals: decrease pain; decreased tenderness; decrease hypertonicity; improved ADL; centralize pain; increase ROM; increase spinal mobility; improve the ability to sit, stand and walk longer with less pain; decrease frequency and intensity of headaches; improve the ability to bend with less pain; improve the ability to lift with less pain; improve the ability to sleep longer with less pain; improve the ability to go from a seated to standing position with less pain. Long term goals: decrease pain; able to perform functional activities with less difficulty; educate the patient to be able to perform home exercises to help relieve and or control pain. Disability status: Temporary partial starting on November 12, 2015 to May 16, 2018 with the restrictions of no lifting greater than 15lbs and no repetitive bending or lifting. In addition, she has been advised to refrain from reaching above the shoulder.

Postscript This report was generated using an electronic medical record system. Despite our diligent efforts, misspelling may be part of this report. Please feel free to contact our office at 716-681-3333 if you need further clarification.

End of note. Electronically signed by Peter Guzinski DC on 05/01/2018 at 10:44am



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO
PO BOX 9507
FREDERICKSBURG VA 22403-9526

CARRIER

PICA

013-873-940-0101-059

PIGA

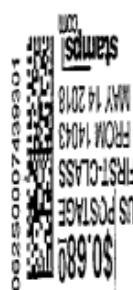
1 MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FED GOV'T	OTHER (ID#)	1a INSURED'S ID NUMBER 013873940011059	(For Program in Item 1)	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TRICARE	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> Group Health Plan	<input type="checkbox"/> FED Gov't	<input type="checkbox"/> Other (ID#)			
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)			3 PATIENT'S BIRTH DATE MM DD YY		SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		4 INSURED'S NAME (Last Name, First Name, Middle Initial) HARWELL DANIELLE		
HARWELL DANIELLE			08291980						
5 PATIENT'S ADDRESS (No., Street)			6 PATIENT RELATIONSHIP TO INSURED				7 INSURED'S ADDRESS (No., Street)		
1131 CLEVELAND DRIVE			<input checked="" type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	56 BEREHAVEN DR., LEFT			
CITY CHEEKETOWAGA	STATE NY	8 RESERVED FOR NUCC USE		CITY AMHERST	STATE NY	9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO	
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 536 0951			ZIP CODE 14228	TELEPHONE (Include Area Code) (716) 536 0951			a EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b RESERVED FOR NUCC USE			b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		PLACE (State) NY		a INSURED'S DATE OF BIRTH MM DD YY 08291980		
c RESERVED FOR NUCC USE			c OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				b OTHER CLAIM ID (Designated by NUCC)		
d INSURANCE PLAN NAME OR PROGRAM NAME			10d CLAIM CODES (Designated by NUCC)				c INSURANCE PLAN NAME OR PROGRAM NAME GEICO		
11 INSURED'S POLICY GROUP OR FECA NUMBER									
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below									
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15 OTHER DATE MM DD YY DUAL 431 MM DD YY 103115 DUAL 439 103115									
16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM TO									
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a NPI 17b NPI									
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO									
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
20 OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to A-L to service line below (24d)) ICD IND A I50.222 B IM51.26 C IM51.27 D IM54.12 E IS23.3XXA F IM99.01 G IM99.03 H IM99.02 I IM99.05 J IM54.2 K IM54.5 L IM54.6									
22 RESUBMISSION CODE ORIGINAL REF NO									
23 PRIOR AUTHORIZATION NUMBER									
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY C PLACE OF SERVICE EMR B PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS D MODIFIER E DIAGNOSIS PCNT/PER F CHARGES G DAYS OF UNITS H CHARGE PER UNIT I ID QMUL J RENDERING PROVIDER ID #									
1	05112018	05112018	11	98941		ABCD	32 28	1	NPI 1710014188
2	05112018	05112018	11	97010		ABCD	10 53	1	NPI 1710014188
3	05112018	05112018	11	99212	25	ABCD	20 29	1	NPI 1710014188
4									NPI
5									NPI
6									NPI
25 FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO 27. ACCEPT ASSIGNMENT? 364500165 <input type="checkbox"/> * 343821276 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									28 TOTAL CHARGE 29 AMOUNT PAID 30 Reserved for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse side of this form are true and correct. PETER GOZINSKI DC									33 BILLING PROVIDER INFO & PH# (716) 681-3333 CICHOCKI & CICHOCKI LLP 345 DICK ROAD DEPEW NY 140431849
32 SERVICE FACILITY LOCATION INFORMATION									
34 SIGNED 05122018 DATE * 1235256546* PLEASE PRINT OR TYPE * 1235256546*									

05.21.18

CICCHOCKI & CICCHOCKI, LLP
346 DICK RD
DEPew, NY 14043

53

FEDERAL BOX 9507
FREDERICKSBURG VA 22403-9526
GEICO



5 21 18

Jeffrey I. Goldberg DDS PLLC



**FACIAL PAIN &
APNEA APPLIANCE
THERAPY**

**FAX
Cover Sheet**

To: Geilo

Fax #: 856-294-5154

From: Rachel B. @ Dr. Jeffrey I. Goldberg DDS PLLC

Date: 5/24/18 Cover Plus _____ Pages _____

Re: D. Harwell Claim# 013873940010101059



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Geico Insurance
PO Box 9507

Fredericksburg, VA 22405

1. MEDICARE	MEDICAD	TRICARE	CHAMPVA	GROUP	FECA	OTHER	1a. INSURED'S ID NUMBER (For Program in Item 1)	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> CHAMPUS	<input type="checkbox"/> CHAMPVA	<input type="checkbox"/> GROUP ID#	<input type="checkbox"/> FECA ID#	<input checked="" type="checkbox"/> OTHER ID#	0138739400101059	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTHDATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Harwell Danielle				MM DD YY	SEX		Harwell Danielle	
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT'S RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No. Street)	
1131 Cleveland Drive				<input checked="" type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	1131 Cleveland Drive	
6. CITY	CHEEKTOWAGA	STATE	NY	8. RESERVED FOR NUCC USE	CITY	CHEEKTOWAGA	STATE	
ZIP CODE	14225	TELEPHONE (Include Area Code)	(716) 773979		ZIP CODE	14225	TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER	
				a. EMPLOYMENT? (Current or previous)	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO		
				b. AUTO ACCIDENT	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	c. OTHER ACCIDENT	
							d. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAM CODES (Designated by NUCC)			e. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
							<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (If yes, complete items 6, 8a and 8d)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.								
SIGNED <input checked="" type="checkbox"/> SIGNATURE ON FILE				DATE 5/23/2018				
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	MM DD YY	15. OTHER DATE	MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	MM DD YY	FROM	TO	
QUAL		QUAL		MM DD YY		MM DD YY		
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. MM DD YY	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	MM DD YY	TO	
DN Jennifer McVige MD				17b. NPI	MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								
20. OUTSIDE LAB? \$ CHARGES								
<input type="checkbox"/> YES <input type="checkbox"/> NO								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Rate A-L to service line below (24E) ICD-9 C: 0								
A: M79.1	B: _____	C: _____	D: _____	E: _____	F: _____	G: _____	H: _____	
I: _____	J: _____	K: _____	L: _____	22. RESUBMISSION CODE ORIGINAL REF. NO.				
23. PRIOR AUTHORIZATION NUMBER								
24. A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE BMO	C. D. PROCEDURES, SERVICES OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS	E. MODIFIER	F. DIAGNOSIS POINTER	G. DATES OR UNITS	H. EXPRT FEE/PCP	I. ID # QUAL	J. RENDERING PROVIDER ID #
05 21 18 05 21 18	11	96000		A	500.00	1	ZZ 1223G0001X	NPI 1760405088
							ZZ 1223G0001X	NPI 1760405088
05 21 18 05 21 18	11	96002		A	350.00	1	ZZ 1223G0001X	NPI 1760405088
05 21 18 05 21 18	11	96004		A	100.00	1	ZZ 1223G0001X	NPI 1760405088
							ZZ 1223G0001X	NPI 1760405088
							ZZ 1223G0001X	NPI 1760405088
							ZZ 1223G0001X	NPI 1760405088
							ZZ 1223G0001X	NPI 1760405088
							ZZ 1223G0001X	NPI 1760405088
25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If yes, checkmark both)				28. TOTAL CHARGE	29. AMOUNT PAID	30. PAYD FOR NUCC US		
264112009	<input checked="" type="checkbox"/>	56947	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	950.00	0.00			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH # (716) 6362222 Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226	
Jeffrey I. Goldberg DDS							Amherst, NY 14226	
SIGNED	DATE 5/23/2018	a. NPI 1760405088	b. ZZ 1223G0001X	c. NPI 1760405088	d. ZZ 1223G0001X	e. ZZ 1223G0001X		



Jeffrey I. Goldberg DDS PLLC

FACIAL PAIN &
APNEA/APPLIANCE
THERAPY

May 21, 2018

Patient: Danielle Harwell

DOB: August 29, 1980

Exam date: May 21, 2018

Patient presents Complete biometric assessment of mandibular function, including jaw tracking, joint vibration analysis, and surface EMG. This test is medically necessary.

Mrs. Harwell's chief complaints included jaw locking, sensation of malocclusion (patient indicates "bite feels off"), limited mouth opening, jaw pain, headaches, TMJ clicking and ear pain.

The patient reported allergic reactions to clindamycin, Environmental allergies, biaxin, Food allergies, latex, soma, penicillin, cipro, Other antibiotics:, ranidin, sulfa drugs, codeine and Keflex. She is currently taking claritin, magnesium, pantoprazole and vitamin d3. **SIGNIFICANT MEDICAL HISTORY:** Past Anxiety, low blood pressure, heart murmur, current pregnancy, sinus problems, Ulcers and Recent weight loss. Current acid reflux, anemia, arthritis, asthma, autoimmune disorder, bruising easily, chronic pain, Digestive issues, dizziness, Headaches and osteoarthritis.

Past surgical procedures include hnc, gallbladder, nasal and tonsillectomy.

Family History: cancer, heart disease, diabetes, high blood pressure and stroke.

Patient's data on use of the orthotic:

No change, medical history

Current pain = 5 out of ten.

Average pain = 6 out of ten, over the past (since last visit)

Pain Free Opening = 42 mm

Maximum Unassisted Opening = 52 mm

Areas tender to palpation: R TMJ, R mastoid process, R Stylomandibular ligament

Patient is using upper appliance without problems

Condition of appliances: Not present today

Fit and feel of lower appliance: Good

Current appliance use protocol: wearing NTI at night

Overall effect on facial / TMJ pain: No change

Overall effect on headaches: No change

Overall effect on jaw function: No change

Effect on TMJ clicking: No change

Alginate impressions taken for fabrication of orthotic. Plan for fabrication and delivery of Lower Gelb, Upper Farrar (Completed chairside. Posture derived bite).

EMG AT REST, All muscles normal (less than 2 microvolts) with the exception of hyperactive muscles: Temporalis (left), Masseter (left). Hyperactive temporalis & masseter unilaterally indicative of unilateral overclosure.

EMG PLAIN CLENCH, All muscles demonstrate weakness (force less than 100 microvolts). All muscles demonstrate normal clenching force (greater than 100 microvolts) with the following exceptions: Notably weak muscle force. Temporalis muscle exerting more force than the masseter muscle on both sides;

indicative of imbalance and retrusive force on mandible. Delayed muscle recruitment evident: Yes, Muscle fatigue evident: Yes. Prolonged silent period of approximately 30 ms milliseconds observed, indicative of chronic muscle dysfunction, often associated with excessive clenching.

EMG POSTERIOR CLENCH, Muscle force generally weaker than plain clench. Weak muscles: All masticatory muscles less than 100 mv. Weakness in plain clench and with posterior support indicative of truly weak muscles, not just central inhibition due to pain. Muscle force symmetry worse than plain clench. Dominance of temporalis muscle over masseter improved. Temporalis muscle exerts significantly more force than masseter on the left. Improvement in muscle fatigue over plain clench: No, Improvement in after spiking over plain clench: No, Improvement in silent period duration over plain clench: Yes, Comments: right masseter dominant over left.

EMG POSTERIOR CLENCH WITH POSTURE CORRECTION, Muscle force generally greater than posterior clench with uncorrected posture. Muscle symmetry generally better than posterior clench with uncorrected posture. Dominance of temporalis muscle over masseter improved, relative to posterior clench with uncorrected posture. Improvement in muscle fatigue, relative to posterior clench with uncorrected posture: Yes, Improvement in EMG after spiking, relative to posterior clench with uncorrected posture: No,

EMG ANTERIOR CLENCH, Muscle force generally weaker than plain clench. Muscle force generally weaker than posterior clench. Weak muscles: All masticatory muscles below 100 mv. Muscle symmetry improved relative to plain clench and posterior clench. Masseters dominant over temporalis muscles.

EMG MASTICATION, RIGHT SIDE, Muscle force during chewing: Right temporalis >> left temporalis >> right masseter >> left masseter. Deviates from normal healthy pattern, indicating muscle incoordination.

EMG MASTICATION, LEFT SIDE, Muscle force during chewing: Left temporalis >> right temporalis >> left masseter >> right masseter. Deviates from normal healthy pattern, indicating muscle incoordination.

JVA / JT METERED, Impression of opening and closing pattern: Opening and closing initially smooth but deteriorate over time. Condition of right joint per BioPak flowchart: Chronic Disc Displacement with advanced Degenerative Joint Disease (Piper 4b, 5a). Condition of left joint per BioPak flowchart: Chronic Disc Displacement Adapted (Piper 4b). Comments on right side using FFT chart: Suggestive of multiple pronounced clicks with significant degenerative joint disease. Comments on left side using FFT chart: Distinct sharp click, mild evident degenerative disease.

JVA / JT PHONATION, Range of motion: Normal opening while speaking of approximately 16 mm. Patient has a tendency to speak mostly on the left side. Patient maintains normal range of motion while speaking relative to occlusion. Comments: Left joint noise evident.

JT RANGE OF MOTION / VELOCITY, Maximum opening 31.6 mm. Deflection of 1 mm. (To the right, less than 3 mm, normal). Right excursion 8.6 mm. Left excursion 5 mm. Asymmetry noted in right and left excursions. Velocity: Distinct drop in velocity at mid opening, consistent with reducing disc.

JT MASTICATION, RIGHT, General impression of frontal chewing pattern, right side: Narrow "banana" pattern with upper portion on right side and majority of chewing, including turning point, on left, suggesting acute disc displacement without reduction on left side. General pattern of mandibular velocity while chewing on right: Concavity midway on opening indicative of internal derangement.

JT MASTICATION, LEFT, General impression of frontal chewing pattern, left side: Notably restricted (laterally) pattern with nearly all chewing limited to left side, suggesting disc displacement on right side. General pattern of mandibular velocity while chewing on left: Concavity midway on opening indicative of internal derangement.

Most notable findings of biometric testing: Weakness and incoordination in clenching, significant improvement with posture and posterior support. Temporalis dominance in chewing. Significant degeneration in right joint, disc displacement in both joints. Testing confirms a muscle and joint based TMJ disorder.

Jeffrey I. Goldberg DDS PLLC



FACIAL PAIN &
APNEA/APPLIANCE
THERAPY

**FAX
Cover Sheet**

To: GEICO

Fax #: 856-294-5154

From: Rachel B. @ Dr. Jeffrey I. Goldberg DDS PLLC

Date: 10/11/18 Cover Plus 3 Pages

Re: Claim #0138 T39400101059



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 03/12

Geico Insurance
PO Box 9507

Fredericksburg, VA 22405

1. MEDICARE [Medicare]	2. MEDICAID [Medicaid]	3. TRICARE CHAMPUS [CHAMPUS] [CHAMPUS]	4. CHAMPVA [CHAMPVA]	5. GROUP HEALTH PLAN [GHP]	6. FECA [FECA]	7. OTHER [OTHER]	8. INSURED'S ID NUMBER 0138739400101059 (For Program in Item 1)										
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell Danielle			3. PATIENT'S BIRTHDATE MM DD YY 08 29 1980			4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell Danielle											
5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive			6. PATIENT'S RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive											
CITY Cheektowaga		STATE NY		CITY Cheektowaga		STATE NY											
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 773979		ZIP CODE 14225		TELEPHONE (Include Area Code) (716) 773979												
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER											
b. OTHER INSURED'S POLICY OR GROUP NUMBER			b. AUTO ACCIDENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. INSURE DATE OF BIRTH MM DD YY 08 29 1980											
c. RESERVED FOR NUCC USE			c. OTHER ACCIDENT <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. OTHER CLAIM ID (Designated by NUCC)											
d. RESERVED FOR NUCC USE			10b. CLAIM CODES (Designated by NUCC)			d. INSURANCE PLAN NAME OR PROGRAM NAME											
e. INSURANCE PLAN NAME OR PROGRAM NAME			10c. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete item 9, 9a and 9d											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM																	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment of my claim.																	
SIGNED <input checked="" type="checkbox"/> SIGNATURE ON FILE		DATE 6/21/2018		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorized payment of medical benefits to the undersigned physician or supplier for services described below.													
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY MM DD YY 06 20 18		15. OTHER DATE QUAL MM DD YY 06 20 18		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY													
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DN: Jennifer McVige MD		17a. <input type="checkbox"/> <input type="checkbox"/> 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY													
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																	
20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (34E) ICD-10: D																	
A. M79.1	B. <input type="checkbox"/>	C. <input type="checkbox"/>	D. <input type="checkbox"/>	22. RESUBMISSION CODE													
E. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	23. PRIOR AUTHORIZATION NUMBER													
I. <input type="checkbox"/>	J. <input type="checkbox"/>	K. <input type="checkbox"/>	L. <input type="checkbox"/>	F. <input type="checkbox"/>	G. <input type="checkbox"/>	H. <input type="checkbox"/>	I. <input type="checkbox"/>										
24. A. DATES OF SERVICE MM DD YY MM DD YY 06 20 18 06 20 18								B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS PICKLIST pointer		F. G. H. I. J. \$ CHARGES DAYS OR UNITS EXCPT Per Unit ID QUAL RENDERING PROVIDER ID #			
												2Z 1223G0001X					
												NPI 1760405088					
												2Z 1223G0001X					
												NPI					
												NPI					
												NPI					
												NPI					
												NPI					
												NPI					
												NPI					
25. FEDERAL TAX ID NUMBER SSN EIN 264112009 <input checked="" type="checkbox"/>								26. PATIENT'S ACCOUNT NO 56947		27. ACCEPT ASSIGNMENT? For government fee back <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. TOTAL CHARGE 1800.00		29. AMOUNT PAID 0.00		30. Rcvd by NUCC up	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made in part thereof.) Jeffrey I. Goldberg DDS PLLC Date 6/21/2018								32. SERVICE FACILITY LOCATION INFORMATION Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226		33. BILLING PROVIDER INFO & PH # (716) 6362222 Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226							
								a. NPI 1760405088 b. 2Z 1223G0001X		e. NPI 1760405088 f. 2Z 1223G0001X							



Jeffrey I. Goldberg DDS MS MBA

FACIAL PAIN &
APNEA/APPLIANCE
THERAPY

June 20, 2018

Patient: Danielle Harwell
DOB: August 29, 1980
Exam date: June 20, 2018

Patient presents for delivery of an orthotic.

Mrs. Harwell's chief complaints included jaw locking, sensation of malocclusion (patient indicates "bite feels off"), limited mouth opening, jaw pain, headaches, TMJ clicking and ear pain.

The patient reported allergic reactions to clindamycin, Environmental allergies, biaxin, Food allergies, latex, soma, penicillin, cipro, Other antibiotics:, ranidin, sulfa drugs, codeine and Keflex. She is currently taking claritin, magnesium, pantoprazole and vitamin d3. **SIGNIFICANT MEDICAL HISTORY:** Past: Anxiety, low blood pressure, heart murmur, current pregnancy, sinus problems, Ulcers and Recent weight loss. Current: acid reflux, anemia, arthritis, asthma, autoimmune disorder, bruising easily, chronic pain, Digestive issues, dizziness, Headaches and osteoarthritis.

Past surgical procedures include dnc, gallbladder, nasal and tonsillectomy.

Family History: cancer, heart disease, diabetes, high blood pressure and stroke.

Orthotic Delivery: Delivery date: 06/20/2018, orthotic design: Definitive orthopedic appliance, medically necessary. Changes since previous visit: Pt in another Car accident 5/22/18. Provided patient with a copy of "Blue Book" outlining therapy plan, instructions for care and maintenance of orthotic, and home care instructions. Reviewed relevant information. Orthotic care and instructions provided. Upper orthotic design: Farrar. Upper instructions: wear at night. Lower orthotic design: Gelb. Lower instructions: Wear during day as much as possible. Fabricated chairside. Next appointment: Two weeks.

Patient was in another MVA 5/22/18: Was driving on Cleveland Drive, stopped at red light, proceeded when light turned green. Hit on right by another car which was running the red light. Car was pushed into another car. Patient hit head and lost consciousness. Pt was driving. Three people in car were taken by ambulance to ECMC. Did ultrasound and MRI of neck and back. Being evaluated currently for spine. Loss of right side peripheral vision. Concussion diagnosed by Dr. McVige, possible other brain injuries. Waiting on additional MRI. No change in jaw pain.

Jeffrey I. Goldberg DDS MS MBA

Jeffrey I. Goldberg DDS PLLC



**FACIAL PAIN &
APNEA APPLIANCE
THERAPY.**

**FAX
Cover Sheet**

To: Geico

Fax #: 856-294-5154

From: Rachel B. @ Dr. Jeffrey I. Goldberg DDS PLLC

Date: 7/9/18 Cover Plus 3 Pages

Re: Claim # 013873940101059

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 09/12

Geico Insurance
PO Box 9507

Fredericksburg, VA 22405

1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP	FECA	OTHER	1a. INSURED'S ID NUMBER	(For Progress in Item 1)				
<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> CHAMPUS	<input type="checkbox"/> ID/DIR	<input type="checkbox"/> HEALTH PLAN	<input type="checkbox"/> BULK BLDG	<input checked="" type="checkbox"/> ID#	0138739400101059					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTHDATE			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
Harwell Danielle				08	125	1980	<input type="checkbox"/> M	<input checked="" type="checkbox"/> F	Harwell Danielle			
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT'S RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No. Street)					
1131 Cleveland Drive				<input checked="" type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	1131 Cleveland Drive					
CITY Cheektowaga	STATE NY	8. RESERVED FOR NUCC USE			CITY Cheektowaga	STATE NY	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 773979				ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 773979	10. IS PATIENT'S CONDITION RELATED TO:					
a. OTHER INSURED'S POLICY OR GROUP NUMBER				b. EMPLOYMENT? (Current or previous)			11. INSURED'S POLICY GROUP OR FECA NUMBER					
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT			MM	DD	SEX			
				<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	PLACE (State)	08	29	W			
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT			<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	b. OTHER CLAIM ID (Designated by NUCC)			
									c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)			12. IS THERE ANOTHER HEALTH BENEFIT PLAN?					
							<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	If yes, complete lines 9, 9a and 9c			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM									13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorized payment of medical benefits to the undersigned physician or supplier for services described below.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									SIGNED <input checked="" type="checkbox"/> SIGNATURE ON FILE			
SIGNED <input checked="" type="checkbox"/> SIGNATURE ON FILE DATE 7/9/2018									SIGNED <input checked="" type="checkbox"/> SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY MM DD YY			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE DN Jennifer McVige MD			17a. NPI			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY						
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (See A-E to service line below (34e)) ICD-9-CM A. M79.1 B. C. D. E. F. G. H. L. J. K. L.									22. RESUBMISSION ORIGINAL REF. NO. CODE			
23. PRIOR AUTHORIZATION NUMBER												
24. A. DATES OF SERVICE From MM DD YY To MM DD YY			B. PLACE OF SERVICE EMR	C. D. PROCEDURES, SERVICES OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS			E. DIAGNOSIS MODIFIER	F. \$ CHARGES	G. DAYS OR UNITS	H. EXPDT/PMT PER UNIT	I. ID QWL	J. RENDERING PROVIDER ID #
07 02 18 07 02 18				99213			R	45.00	1		3Z 1223G0001X	
									NPI			
									NPI			
									NPI			
									NPI			
									NPI			
									NPI			
									NPI			
25. FEDERAL TAX ID. NUMBER SBN EN									26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov't claims see back) 56947 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28. TOTAL CHARGE 45.00	29. AMOUNT PAID 0.00	30. Paid for NUCC us
264112009 <input type="checkbox"/> X												
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jeffrey I. Goldberg DDS SIGNED DATE 7/9/2018									32. SERVICE FACILITY LOCATION INFORMATION Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226	33. BILLING PROVIDER INFO & PH # (716) 6362222 Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226		
									a. NPI 1760405088 b. ZZ 1223G0001X	a. NPI 1760405088 b. ZZ 1223G0001X		



July 02, 2018

Patient: Danielle Harwell

DOB: August 29, 1980

Exam date: July 02, 2018

Patient presents for follow-up visit after orthotic delivery.

Mrs. Harwell's chief complaints included jaw locking, sensation of malocclusion (patient indicates "bite feels off"), limited mouth opening, jaw pain, headaches, TMJ clicking and ear pain.

The patient reported allergic reactions to clindamycin, Environmental allergies, biaxin, Food allergies, latex, soma, penicillin, cipro, Other antibiotics:, ranidin, sulfa drugs, codeine and Keflex. She is currently taking claritin, magnesium, pantoprazole and vitamin d3. **SIGNIFICANT MEDICAL HISTORY:** Past: Anxiety, low blood pressure, heart murmur, current pregnancy, sinus problems, Ulcers and Recent weight loss. Current: acid reflux, anemia, arthritis, asthma, autoimmune disorder, bruising easily, chronic pain, Digestive issues, dizziness, Headaches and osteoarthritis.

Past surgical procedures include dnc, gallbladder, nasal and tonsillectomy.

Family History: cancer, heart disease, diabetes, high blood pressure and stroke.

Patient's data on use of the orthotic:

No change, medical history

Current pain = 4 out of ten.

Average pain = 6 out of ten, over the past (two weeks)

Pain Free Opening = 37 mm

Maximum Unassisted Opening = 51 mm

Mild tenderness was elicited upon palpation of the Masseter - Insertion bilaterally, Masseter - Origin on the right, lateral TMJ capsule bilaterally, Lateral Pterygoid bilaterally, posterior joint space bilaterally, anterior temporalis bilaterally, temporal tendon on the left, middle temporalis bilaterally, Mastoid process bilaterally and posterior temporalis bilaterally. Moderate tenderness was elicited upon palpation of the stylomandibular ligament bilaterally and temporal tendon on the right.

Patient is using upper appliance without problems

Patient is using lower appliance without problems

Condition of appliances: Good

Fit and feel of upper appliance: Fair

Fit and feel of lower appliance: Fair - lower right slightly loose

Changes / adjustments made to appliance: Tightened lower

Current appliance use protocol: Wearing Farrar appliance at night routinely, Gelb during the day

Overall effect on facial / TMJ pain: No change

Overall effect on headaches: No change

Comments on headaches: Less frequent and less intense

Overall effect on jaw function: Somewhat more limited

Effect on TMJ clicking: No change

Comments on joint sounds: Clicking bilaterally but more prominent on right side.

Improvement in headaches – still significant pain similar to pre-treatment. Pt pleased with progress so far.

Next visit: One month

Follow up evaluation level 3

(Office visit consisting of expanded problem focused history or expanded problem focused examination, and medical decision making of low complexity; presenting problem of low to moderate severity; approximately 15 minutes face-to-face with patient) (CPT 99213).

Maintenance and periodic evaluation are medically necessary in the long term management of facial pain.

Jeffrey I. Goldberg DDS MS MBA



Jeffrey I. Goldberg DDS PLLC

FACIAL PAIN &
APNEA APPLIANCE
THERAPY

FAX
Cover Sheet

To: Geico Claims

Fax #: (856) 294-5154

From: Rachel B. @ Dr. Jeffrey I. Goldberg DDS PLLC

Date: 7/19/18 Cover Plus 8 Pages

Re: Claim #01387394D0101059

Danielle Hanwell

Corrected claims

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, Danielle Harwell ("Assignor") hereby assign to Jeffrey I. Goldberg MD ("Assignee")

(Print patient's name) (Print hospital or health care provider name)
all rights, privileges and remedies to payment for health care services provided by assignee to which I am
entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and
shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained
due to the motor vehicle accident which occurred on 10/3/18, notwithstanding any other agreement

(Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack
of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON
FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR
PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE
PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO,
IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS,
SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR
CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR
VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND
SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF
THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Danielle Harwell
(Print name of Patient)

Danielle Harwell
(Signature of Patient)

1131 Cleveland Dr.

6/20/18
(Date of signature)

Cheektowaga, NY 14225
(Address of Patient)

Jeffrey I. Goldberg
(Print name of Provider)

6/20/18
(Signature of Provider)

3980 Sheridan Dr. STE 401

6/20/18
(Date of signature)

Amherst, NY 14226-1727
(Address of Provider)

Insurance Claim # 01387394D0101059

NYS FORM NF-40B (Rev 1/2004)

Insurance Carrier Geico

Insurance Address P.O. Box 9507

Fredricksburg, VA

22403



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

Geico Insurance

PO Box 9507

Fredericksburg, VA 22405

CARRIER

PICA										RICA																									
1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FED. CLLNG (ROM)		OTHER (ROM)																							
<input type="checkbox"/> (Medicare)		<input type="checkbox"/> (Medicaid)		<input type="checkbox"/> (TRICARE)		<input type="checkbox"/> (CHAMPVA)		<input type="checkbox"/> (Group Health Plan)		<input type="checkbox"/> (FED. CLLNG ROM)		<input type="checkbox"/> (Other ROM)																							
12. INSURED'S S.I.D. NUMBER (For Program in Item 1) 0138739400101059																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Harwell Danielle						3. PATIENT'S BIRTH DATE (MM DD YY) SEX 08 29 1980 M						4. INSURED'S NAME (Last Name, First Name, Middle Initial) Harwell Danielle																							
5. PATIENT'S ADDRESS (No., Street) 1131 Cleveland Drive						6. PATIENT RELATIONSHIP TO INSURED <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						7. INSURED'S ADDRESS (No., Street) 1131 Cleveland Drive																							
CITY Cheektowaga			STATE NY			CITY Cheektowaga			STATE NY																										
ZIP CODE 14225			TELEPHONE (Include Area Code) (716) 773979			ZIP CODE 14225			TELEPHONE (Include Area Code) (716) 773979																										
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER												10. IS PATIENT'S CONDITION RELATED TO: b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
9. RESERVED FOR NUCC USE												b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
c. RESERVED FOR NUCC USE												c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
d. INSURANCE PLAN NAME OR PROGRAM NAME												12. CLAIM CODES (Designated by NUCC) d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, d.a. and d.b.																							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																							
SIGNATURE ON FILE												SIGNATURE ON FILE																							
SIGNED _____ DATE 7/19/2018												SIGNED _____ DATE																							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM DD YY) QUAL:						15. OTHER DATE (MM DD YY) QUAL:						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM: _____ TO: _____																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN: Jennifer McVige MD						17b. 17c.						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM: _____ TO: _____																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)												20. OUTSIDE LABS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A/I to service line below (ZHE) ICD-9-CM A. M79.1 B. K26.631 C. L D. L E F G H J K L												22. REFERRAL/ADMISSION CODE ORIGINAL REF. NO.																							
24. DATE(S) OF SERVICE (MM DD YY) From: To: PAYER: THRU: EMB:												25. PROCEDURES, SERVICES, OR SUPPLIES (Refer to Usual Circumstances) ICD-9-CM CPT/HCPCS MODIFIER																							
1 04 23 18 04 23 16 11 D0160												E. DIAGNOSIS DIAGNOSTIC CODE \$ CHARGES AB 220.00 1																							
2 04 23 18 04 23 18 11 D0321												F. DATE OR TIME AB 140.00 1																							
3 04 23 18 04 23 18 11 D0330												G. H. APPT PERIOD QUAL AB 120.00 1																							
4												I. RENDERING PROVIDER ID. # ZZ 1223G0001X																							
5												J. NPI NPI 1760405088																							
6												K. NPI NPI 1760405088																							
28. FEDERAL TAX ID. NUMBER 264112009						29. PATIENT'S ACCOUNT NO. 56947						30. ACCEPT ASSIGNMENT? (For Non-Participating Providers) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						31. TOTAL CHARGE \$ 480.00						32. AMOUNT PAID \$ 0.00						33. REB. FOR NUCC USE \$ 480.00					
34. SIGNATURE OF PHYSICIAN OR SUPPLIER DR. JENNIFER MC VIGE MD												35. OFFICE/CLINIC/INSTITUTION/AMBULATORY 1131 CLEVELAND DRIVE CHEEKETOWAGA NY 14225												36. BILLING SERVICES INDICATOR Z 71161-5352222											

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)



April 23, 2018

Patient: Danielle Harwell

DOB: August 29, 1980

Exam date: April 23, 2018

Referring Physician: Dr. Jennifer McVige

SUBJECTIVE

Patient presents for evaluation of a possible temporomandibular joint (TMJ) disorder following motor vehicle accident.

Mrs. Harwell's chief complaints included jaw locking, sensation of malocclusion (patient indicates "bite feels off"), limited mouth opening, jaw pain, headaches, TMJ clicking and ear pain.

Additional description of chief complaint: Jaw pain, popping, occasional open locking since MVA. Ear pain. Referred by neurology for TMJ assessment. Headaches. No prior history of TMJ issues. History of current condition: MVA 10/31/2015. Patient was stopped n Kenmore Avenue behind a truck. 4 car accident occurred, with 3 cars in a row rear-ended behind her. Struck from behind, did not hit anything in front of her. Did not lose consciousness. Went to Immediate Care (Delaware Avenue) the following day, x-rays taken, diagnosed as whiplash. Was later told by physicians she had two herniated discs in neck, two herniated discs in lower back, concussion. Developed headaches, jaw pain. Subsequent treatment has included botox, trigger point injections, and other headache care at Dent. Chiropractic care and massage. Injections and epidurals for pain management. Primary pain location: right. Patient indicates (pointing with finger) that pain is centered at TMJ. Joint sounds: Constant popping on right. Very rare popping on left. Temporal pattern: None. Condition is worse with stress: Yes. Previous treatment: No prior history of TMJ issues. Was seen one time by another TMJ specialist, ordered MRI, pt did not wish to continue with him,. Patient is aware of parafunctional activity consisting of Grinding - Nocturnal. Eccentric jaw posture at times. History of head and neck surgery: None. Trauma history: MVA 10/31/15 - no other history of significant facial, head or neck trauma. Recent dental work includes None. Additional headache notes: Rare minor headaches prior to accident, did not require treatment.

Mrs. Harwell has symptoms since 10/31/2015. Patient reports that the problem appears to have started with car accident. Activities which make the condition worse include talking, eating. Massage appears to improve the condition. Progression is described as getting worse over time. Quality of pain is described by patient as Aching. The pain typically lasts "Variable". The patient indicates a pattern wherein the condition is best described as Steady throughout day. Jaw is painful with opening (bilateral), painful with chewing (bilateral). Current pain level is 5 out of ten. Average pain level for the past six months is 5 out of ten. Worst pain level in the past six months is 7 out of ten. The patient is aware of joint clicking on both sides. There is pain associated with the jaw clicking. The patient reports the sensation of a recent occlusal change. The patient reports a limited or restricted jaw opening. Lateral mandibular movement feels limited or reduced. The patient has experienced an open lock.

The headaches affect the following areas of the head: temples (bilateral), the entire head, vertex of the head, occipital region. The patient indicates a history of migraines. The migraines were formally diagnosed by Dr Peter Guzinski. Additional headache information provided by the patient: "Dr Jennifer McVige." The patient typically sees a dentist Emergencies only. At this time, the patient reports that her teeth are sensitive to temperature. The patient reports xerostomia. Orthodontia history includes None. The patient reports ear pain (bilateral), tinnitus (bilateral), ear fullness (bilateral), dizziness or vertigo, eye pain (bilateral), blurred vision (bilateral). There is a feeling of a foreign object in the throat. Neck pain is reported by the patient. The patient reports back pain. There is numbness reported in the hands or fingers. There is a sensation of tingling in the hands or fingers. The patient states the following about his or her posture: "good." Overall sleep quality is described as 3 out of ten. Patient snores. The pain causes waking during the night.

To the question, How often are you tense, aggravated, or frustrated during a usual day? patient responded Half the time. The patient reports feeling depressed Seldom. To the question, Do you have thoughts of hurting yourself or committing suicide? the patient responded: No.

OBJECTIVE

Cranial nerve screening revealed a possible deficit in the following nerves: #11 (spinal accessory) - Right shoulder weakness.. Otherwise all cranial nerves within normal limits. The patient is alert, attentive, and oriented. Speech is clear and fluent. Patient is able to detect and identify odor in both nostrils. Pupils are normal, equal, and reactive to light. At primary gaze, there is no eye deviation. Normal and coordinated tracking through six cardinal positions. No signs of diplopia.. No evident nystagmus or ptosis. Facial sensation is intact to cotton in all three divisions of trigeminal nerve bilaterally. Face is symmetric with normal eye closure and facial expression. No evident facial weakness. Hearing is normal to rubbing sticks. Palate elevates symmetrically. Phonation is normal. Gag reflex is normal. Head turning and shoulder shrug with resistance are intact. Tongue protrudes in midline with normal movements and no atrophy. and

No tenderness was elicited upon palpation of the Trapezius bilaterally, sternocleidomastoid bilaterally, lateral TMJ capsule on the left, Lateral Pterygoid bilaterally, posterior joint space bilaterally, middle temporalis bilaterally, anterior temporalis bilaterally, posterior temporalis bilaterally, Mastoid process bilaterally and Splenius Capitis / Cervical Insertions bilaterally. Mild tenderness was elicited upon palpation of the Masseter - Insertion bilaterally, Masseter - Enthesis bilaterally, lateral TMJ capsule on the right, temporal tendon bilaterally, stylomandibular ligament on the left and Masseter - Origin bilaterally. Severe tenderness was elicited upon palpation of the stylomandibular ligament on the right.

Comprehensive orofacial examination revealed:

Blood Pressure: 122/62.
Heart rate: 92 BPM.
Facial appearance: Normocephalic / symmetric.
Opening click observed on the right.
Opening pattern: Deviates Left, with correction.
The opening pattern is consistent: Yes
Pain free opening: 44 mm.
Maximum unassisted opening: 50 mm.
Maximum assisted opening: 51 mm.
End feel of assisted opening: Normal.
Wide opening produces pain at Right TMJ.
Right lateral excursion: 4 mm.
Left lateral excursion: 8 mm.
Protrusion: 1 mm.
Mandibular midline 3 mm deviated from maxillary. (To the right)
Maxillary midline consistent with facial midline
All oral soft tissue within normal limits, including buccal mucosa, floor of mouth, and lateral tongue.
Tongue: Class 3: average to large, above occlusal plane.
Tori: none.
Palate: Hard and soft palate normal.
Mallemptati throat form: 4.
Symmetrical rise of soft palate observed.
Periodontal condition: Fair.
Signs of dental wear: none.
Dental prosthesis present: None.
Occlusal class II.
Overjet of 4 mm.
Overbite of 3 mm.
Missing teeth 1,2,32.
Fractures of teeth 18,19,20,30 observed.

Cervical range of motion measurements indicated normal range of motion with pain free rotation, extension, flexion and side bend, with the following exceptions: pain on rotation to both side. pain on side bend to both shoulder.

Panoramic and bilateral TMJ radiographs at initial visit reveal: Compressed joint space (bilateral). Pronounced antegonial notching (bilateral). Pt aware of several fractured lower teeth requiring extraction. MRI 5/5/16 reviewed - indicates disc displacement with reduction on right, normal on left.

The patient reported allergic reactions to clindamycin, Environmental allergies, biaxin, Food allergies, latex, soma, penicillin, cipro, Other antibiotics; ranidin, sulfa drugs, codeine and Keflex. She is currently taking claritin, magnesium, pantoprazole and vitamin d3.

SIGNIFICANT MEDICAL HISTORY: Past: Anxiety, low blood pressure, heart murmur, current pregnancy, sinus problems, Ulcers and Recent weight loss. Current: acid reflux, anemia, arthritis, asthma, autoimmune disorder, bruising easily, chronic pain, Digestive issues, dizziness, Headaches and osteoarthritis.

Past surgical procedures include doc, gallbladder, nasal and tonsillectomy.

Family History: cancer, heart disease, diabetes, high blood pressure and stroke.

Social History: Occupation: homemaker. Cigarettes: The patient denies ever smoking. Alcohol: None. Caffeine: None. Reported weight: 200 pounds, Weight change in past two years: Gain of more than 10 pounds, Ethnic background: Caucasian / white.

ASSESSMENT

My working diagnosis is Disc displacement with reduction (right side) (ICD M26.631), myofascial pain / myalgia (right side) (ICD M79.1). Based on history and examination, the patient's condition appears to be attributable to the motor vehicle accident.

PLAN

Procedures performed: New patient exam level 3

(Patient was referred for evaluation. Office visit consisting of detailed history, detailed examination, and medical decision making of low complexity; presenting problem is of moderate severity; at least 40 minutes engaged in face-to-face examination, history taking, and counseling; counseling and/or coordination of care account for more than 50% of this time). Panoramic radiograph, TMJ lateral radiographs (bilateral, open and closed),

Recommendation of a soft diet, application of heat to painful area, hydrate, avoid chewing gum, minimize caffeine.

Instruction provided in therapeutic exercise (classic 5x5)

Provided patient with a copy of "Blue Book" outlining progressive therapy approach, instructions for care and maintenance of orthotic, and home care.

Immediate oral orthotic for parafunctional control (NTI type)

The treatment plan consists of Complete Biometric evaluation and review (including jaw tracking, facial EMG, joint vibration analysis). Immediate occlusal orthotic / deprogramer (NTI type), Lower occlusal appliance (Gelb anterior positioning type) and Upper occlusal orthotic (Farrar anterior positioning type).

We would like to see the patient in 4 weeks.

This patient has symptoms for which proper evaluation and therapy are medically necessary.

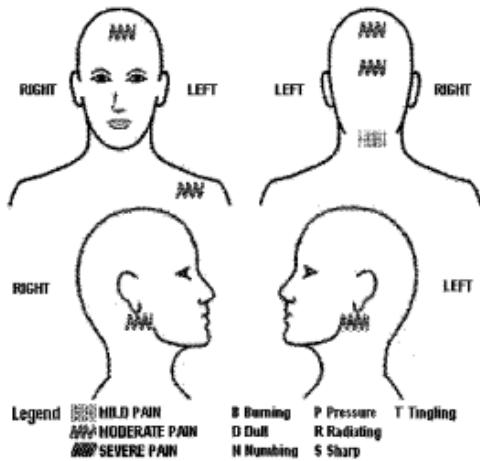
Jeffrey I. Goldberg DDS MS MBA

TMD and Orofacial Pain Diagnostic Report

Jeffrey I. Goldberg DDS MS MBA

Patient: Danielle Harwell

Examination Date: 4/20/2018



Pain pattern described
by patient



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 2012

Geico Insurance

PO Box 9507

Fredericksburg, VA 22405

CARRIER

PICA												PICA		
1. MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FED EXCLNG	OTHER	1a. INSURED'S ID. NUMBER	(For Program in Item 1)						
<input type="checkbox"/> (Medicare)	<input type="checkbox"/> (Medicaid)	<input type="checkbox"/> (DOD Only)	<input type="checkbox"/> (Member/ID#)	<input type="checkbox"/> (ADM)	<input type="checkbox"/> (DM)	<input type="checkbox"/> (Other)	0138739400101059							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE			SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
Harwell Danielle			08 29 1980			<input type="checkbox"/> M <input checked="" type="checkbox"/> F	Harwell Danielle							
5. PATIENT'S ADDRESS (No. Street)			6. PATIENT'S RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No. Street)								
1131 Cleveland Drive			<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			1131 Cleveland Drive								
CITY Cheektowaga	STATE NY	8. RESERVED FOR NUCC USE			CITY Cheektowaga	STATE NY	9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				
ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 773979				ZIP CODE 14225	TELEPHONE (Include Area Code) (716) 773979				a. EMPLOYMENT? (Current or Previous)	b. OTHER CLAIM ID (Designated by NUCC)			
d. RESERVED FOR NUCC USE			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			a. EMPLOYMENT? (Current or Previous)	b. OTHER CLAIM ID (Designated by NUCC)				
e. RESERVED FOR NUCC USE			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						a. EMPLOYMENT? (Current or Previous)	b. OTHER CLAIM ID (Designated by NUCC)				
f. INSURANCE PLAN NAME OR PROGRAM NAME			10d. CLAIM CODES (Designated by NUCC)			g. IS THERE ANOTHER HEALTH BENEFIT PLAN?			11. INSURED'S POLICY GROUP OR FICA NUMBER					
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
HEAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												If yes, complete items 9, 10, and 11.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
SIGNATURE ON FILE			DATE 7/19/2018			SIGNATURE ON FILE			SIGNATURE ON FILE					
SIGNED						SIGNED			SIGNED					
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM DD YY) QUAL:			15. OTHER DATE QUAL:			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Jennifer McVige MD			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		
17a.			17b.			18a.			18b.			19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Enter A-L to describe the below) ICD Ind. 10			22. RESUBMISSION CODE ORIGINAL REF. NO.			23. PRIOR AUTHORIZATION NUMBER			24. a. DATES OF SERVICE From MM DD YY To MM DD YY PLACE OF SERVICE E/M&G b. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS c. MODIFIER d. DIAGNOSIS FINDER e. CHARGES f. DAYS OR UNITS g. AMT PER h. I. ID. i. QTY j. RENDING PROVIDER ID #					
1 06 20 18	06 20 18	11	D7880			AB	900 00	1	ZZ	1223G0001X				
2 06 20 18	06 20 18	11	D7880			AB	900 00	1	NPI	1760405086				
3									ZZ	1223G0001X				
4									NPI					
5									NPI					
6									NPI					
25. FEDERAL TAX ID. NUMBER 264112009	SSN MM <input checked="" type="checkbox"/>	26. PATIENT'S ACCOUNT NO. 56947	27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$ 1800 00	29. AMOUNT PAID \$ 0 00	30. Basis for NUCC Use 1800 00								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Jeffrey I. Goldberg DDS Amherst, NY 14226 SIGNED 7/19/2018 DATE			32. SERVICE FACILITY LOCATION INFORMATION Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226 * 1760405086			33. BILLING PROVIDER NPI & PHS (716) 6362222 Jeffrey I. Goldberg DDS PLLC 3980 Sheridan Drive #401 Amherst, NY 14226-1727 * 1760405086			34. APPROVED OMB-0938-1197 FORM 1500 (02-12)					



June 20, 2018

Patient: Danielle Harwell
DOB: August 29, 1980
Exam date: June 20, 2018

Patient presents for delivery of an orthotic (D7880 x 2, UPPER AND LOWER)

Mrs. Harwell's chief complaints included jaw locking, sensation of malocclusion (patient indicates "bite feels off"), limited mouth opening, jaw pain, headaches, TMJ clicking and ear pain.

The patient reported allergic reactions to clindamycin, Environmental allergies, biaxin, Food allergies, latex, soma, penicillin, cipro, Other antibiotics: ranidin, sulfa drugs, codeine and Keflex. She is currently taking claritin, magnesium, pantoprazole and vitamin d3. **SIGNIFICANT MEDICAL HISTORY:** Past: Anxiety, low blood pressure, heart murmur, current pregnancy, sinus problems, Ulcers and Recent weight loss. Current: acid reflux, anemia, arthritis, asthma, autoimmune disorder, bruising easily, chronic pain, Digestive issues, dizziness, Headaches and osteoarthritis.

Past surgical procedures include dnc, gallbladder, nasal and tonsillectomy.

Family History: cancer, heart disease, diabetes, high blood pressure and stroke.

Orthotic Delivery: Delivery date: 06/20/2018.

Orthotic design: Definitive orthopedic appliance, medically necessary. Changes since previous visit: Pt in another Car accident 5/22/18. Provided patient with a copy of "Blue Book" outlining therapy plan, instructions for care and maintenance of orthotic, and home care instructions. Reviewed relevant information. Orthotic care and instructions provided.

Upper orthotic design: Farrar. Upper instructions: wear at night.

Lower orthotic design: Gelb. Lower instructions: Wear during day as much as possible. Fabricated chairside. Next appointment: Two weeks.

Patient was in another MVA 5/22/18: Was driving on Cleveland Drive, stopped at red light, proceeded when light turned green. Hit on right by another car which was running the red light. Car was pushed into another car. Patient hit head and lost consciousness. Pt was driving. Three people in car were taken by ambulance to ECMC. Did ultrasound and MRI of neck and back. Being evaluated currently for spine. Loss of right side peripheral vision. Concussion diagnosed by Dr. McVige, possible other brain injuries. Waiting on additional MRI. No change in jaw pain.

Jeffrey I. Goldberg DDS MS MBA



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO

Attn: NEW YORK PIP
PO BOX 9507
FREDERICKSBURG, VA 22403-9526

CARRIER →

PICA		Invoice Date: 08/03/2018				PICA						
1 MEDICARE		MEDICAID		TRICARE		CHAMPVA	GROUP	COUP	FEIN	OTHER	To INSURED'S ID NUMBER	(For Program in Box 1)
<input type="checkbox"/> Medicare #		<input type="checkbox"/> Medicaid #		<input type="checkbox"/> DOD/COM		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	0138739400101059	
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)		3 PATIENT'S BIRTH DATE				SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)					
HARWELL, DANIELLE		MM	DD	YY		M						
08 29 80		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	F						
5 PATIENT'S ADDRESS (No. & Street)		6 PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No. & Street)						
1111 CLEVELAND DR		<input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other										
CITY CHEERTONAGA		STATE NY		8 RESERVED FOR NUCC USE 5110215		CITY		STATE				
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()						ZIP CODE		TELEPHONE (Include Area Code) ()		
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO				11 INSURED'S POLICY GROUP OR PICA NUMBER						
a OTHER INSURED'S POLICY OR GROUP NUMBER		a EMPLOYMENT? (Current or Previous)				a INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>						
		<input type="checkbox"/> YES <input type="checkbox"/> NO										
b RESERVED FOR NUCC USE		b AUTO ACCIDENT?				b OTHER CLAIM ID (Designated by NUCC)						
		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										
c RESERVED FOR NUCC USE		c OTHER ADVICE?				c INSURANCE PLAN NAME OR PROGRAM NAME						
		<input type="checkbox"/> YES <input type="checkbox"/> NO										
d INSURANCE PLAN NAME OR PROGRAM NAME		10d CLAIM CODES (Designated by NUCC)				11d IS THERE ANOTHER HEALTH BENEFIT PLAN?						
						<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete item 9, 1a, and 9d						
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM												
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim I also request payment of government benefits either to myself or to the party who accepts assignment below												
SIGNED AVAILABLE UPON REQUEST DATE _____												
14 DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/YY)		15 OTHER DATE Q1 Q2 Q3 Q4		MM	DD	YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY		17 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY			
MM DD YY 05 22 18							FROM TO		FROM TO			
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE CAPOTE, HORACIO		17a MM DD YY 1053475939		17b		17c		17d				
18 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18 OUTSIDE LAB TEST CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to services listed below (240) ICD IND												
A 1749.9XXA	B <input type="checkbox"/>	C <input type="checkbox"/>	D <input type="checkbox"/>	22 RESUBMISSION CODE ORIGINAL REF. NO.								
E <input type="checkbox"/>	F <input type="checkbox"/>	G <input type="checkbox"/>	H <input type="checkbox"/>	23 PRIOR AUTHORIZATION NUMBER								
I <input type="checkbox"/>	J <input type="checkbox"/>	K <input type="checkbox"/>	L <input type="checkbox"/>									
24 A. DATES(S) OF SERVICE From MM DD YY To MM DD YY 07 26 18		B. PLACE OF ENG. 43547038003	C. PROCESES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPTR2PCB H308ER	D. DIAGNOSIS CODE PTN	E. DIAGNOSIS PINTER	F. CHARGES	G. DATES OR UNITS	H. DATES OR UNITS	I. D. DATES OR UNITS	J. RENDERING PROVIDER ID #		
1 466033			DULOXETINE CAP 30MG	A	d:7, 48 91 c:7	NPI						
2						NPI						
3						NPI						
4						NPI						
5						NPI						
6						NPI						
25 FEDERAL TAX ID NUMBER 36-1924025		SSN SSI <input checked="" type="checkbox"/>	26 PATIENT'S ACCOUNT NO 4674581	27 ACCEPT ASSESSMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	28 TOTAL CHARGE \$ 48 91 5	29 AMOUNT PAID 0 00	30 Revd for NUCC Use 48 91					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32 SURFACE LOCATION INFORMATION Walgreens 09753 (NY) 5305 Main St Williamsville, NY 14221-5329 TIN: 36-1924025				33 BILLING PROVIDER INFO & PH# (866) 428-8679 Walgreens PO Box 271589 Salt Lake City, UT 84127-1589 36-1924025						
On File		34 BILLING PROVIDER INFO & PH# 1124952202				35 APPROVED OMB-0938-1197 FORM 1500 (02-12)						



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO

Attn: NEW YORK PIP
PO BOX 9507
FREDERICKSBURG, VA 22403-9526

CARRIER

PICA		Invoice Date: 08/03/2018		PICA
<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP LIFE PLAN <input type="checkbox"/> FEES FOR SERVICE <input type="checkbox"/> OTHER		1a INSURED'S ID NUMBER 0138739400101059		(For Program Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial) HARWELL, DANIELLE		3 PATIENT'S BIRTH DATE MM DD YY 08 29 80		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F
5 PATIENT'S ADDRESS (No. Street) 1131 CLEVELAND DR		6 PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7 INSURED'S ADDRESS (No. Street)
CITY CHEEKTONAGA		STATE NY		CITY
ZIP CODE 14225-1257		TELEPHONE (Include Area Code) ()		STATE
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 		10 IS PATIENT'S CONDITION RELATED TO 		11 INSURED'S POLICY GROUP OR PICA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER 		b EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY M 08 29 80
b RESERVED FOR NUCC USE 		b AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)
c RESERVED FOR NUCC USE 		c OTHER ADVENTURE? <input type="checkbox"/> YES <input type="checkbox"/> NO		c INSURANCE PLAN NAME OR PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME 		16 CLAIM CODES (Designated by NUCC) 		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>N/A: Yes, complete items 9, 10, and 11.</small>
<small>READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM</small> 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim I also request payment of government benefits either to myself or to the party who accepts assignment below				
SIGNED AVAILABLE UPON REQUEST DATE _____				
14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/DD/YY) 05 22 18		15 OTHER DATE QM/L MM DD YY		16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE CAPOTE, HORACIO		17a 17b HPI		18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC) a V4.9.9XXA b _____ c _____ d _____ e _____ f _____ g _____ h _____ i _____ j _____ k _____ l _____				
24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY		B PLACE OF SERVICE Eng. CPT/HCPCS		D PROCEDURES, SERVICES, OR SUPPLIES <small>(Specify Unusual Circumstances)</small> DULOXETINE CAP 60MG
07 26 18		01		E DIAGNOSIS <small>ICD-9-CM</small> 466039
				F CHARGES <small>\$ CHARGES OR UNIT PRICE PER PAYOR</small> d:30
				G DATES OF SERVICES <small>WEEK BY WEEK</small> 193 19
				H PAYOR <small>ID #</small> NPI
				I REMARKS <small>REMARKS</small> PROVIDER ID #
				J NPI
				K NPI
				L NPI
				M NPI
				N NPI
25 FEDERAL TAX ID NUMBER 36-1924025		SSN SSN 36-1924025		26 PATIENT'S ACCOUNT NO 4674582
				27 ACCEPT ASSIGNMENT? <small>(Except cases on back)</small> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
				28 TOTAL CHARGE \$ 193 19
				29 AMOUNT PAID \$ 0 00
				30 Revd for NUCC Use 193 19
31 SIGNATURE OF PHYSICIAN OR SUPPLIER <small>INCLUDES DEGREES OR CREDENTIALS</small> <small>If certify that the statements on the reverse apply to this bill and are made a part thereof)</small>				
32 SERVICE FACILITY LOCATION INFORMATION Walgreens 09759 (NY) 5305 Main St. Williamsburg, NY 14221-5329 TIN 36-1924025				
33 BILLING PROVIDER INFO & PH# Walgreens PO Box 271589 Salt Lake City, UT 84127-1589 36-1924025				
On File		DATE 1124152202		34 PICA FPI

08 09 18

AUTO RX
480 E WINCHESTER ST STE 210
SALT LAKE CITY UT 84107-7518

Flat - Box - 7 - 88
GEICO
ATTN NEW YORK PIP
PO BOX 9507
FREDERICKSBURG VA 22403-9526



00000000000000000000000000000000

Rev. Rev. T. 88

08 09 18

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FEOA BUILDING <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (DME)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE SEX HARWELL, DANIELLE MM DD YY SEX M <input checked="" type="checkbox"/>											
4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT RELATIONSHIP TO INSURED HARWELL, DANIELLE Son <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>											
6. PATIENT ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 1131 CLEVELAND DRIVE 1131 CLEVELAND DRIVE											
CITY CHEEKERTOWAGA		STATE NY		CITY CHEEKERTOWAGA		STATE NY					
ZIP CODE 14225		TELEPHONE (Include Area Code) ()		ZIP CODE 14225		TELEPHONE (Include Area Code) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. OTHER INSURED'S POLICY OR GROUP NUMBER b. EMPLOYMENT? (Current or Previous) c. AUTO ACCIDENT? d. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
e. RESERVED FOR NUCC USE f. RESERVED FOR NUCC USE g. RESERVED FOR NUCC USE h. INSURED'S POLICY GROUP OR FECA NUMBER i. INSURED'S DATE OF BIRTH SEX MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>											
j. INSURANCE PLAN NAME OR PROGRAM NAME Geico											
k. IS THERE ANOTHER HEALTH BENEFIT PLAN? l. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete Items g, h, and i.											
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
Signature On File SIGNED		DATE 8/1/2018		Signature On File SIGNED							
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) 15. OTHER DATE 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD YY FROM MM DD YY TO MM DD YY 10 31 15 QUAL: 431 QUAL: 439 10 31 15											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES DN J PETER GUZINSKI FROM MM DD YY TO MM DD YY 17a. NPI: 1710014188											
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB \$ CHARGES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer A-L to service line below (24E)) 22. RESUBMISSION CODE ORIGINAL REF. NO. A. M47.26 B. M51.26 C. M51.36 D. L E. L F. L G. L H. L I. L J. L K. L L. L M. L N. L O. L P. L Q. L R. L S. L T. L U. L V. L W. L X. L Y. L Z. L											
23. PRIOR AUTHORIZATION NUMBER NOT REQUIRED											
24. A. DATE(S) OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES E. DIAGNOSIS F. G. H. I. J. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. From MM DD YY To MM DD YY PLACE OF SERVICE BMG EXPLAIN UNUSUAL CIRCUMSTANCES MODIFIER DIAGNOSIS POINTER CHARGES AMOUNT PAID RENDERING PROVIDER ID. # 07 18 18 07 18 18 11 99213 ABC 51 54 1 DB 248830 NPI 1023202355											
25. FEDERAL TAX I.D. NUMBER SSN EN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. Rev'd for NUCC Use 030445678 <input checked="" type="checkbox"/> 102251 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO \$ 51 54 \$ 0 00											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# I certify that the statements on the reverse apply to this bill and am made a part thereof.) UB Neurosurgery, Inc (716) 218-1030 Jafar Siddiqui 180 Park Club Lane, STE 250 UB Neurosurgery, Inc Williamsville, NY 14221 PO Box 8000 DEPT 883 Buffalo, NY 14267											
SIGNED 8/1/2018 DATE * 1306896220 # 248830 & 1306896220 b											



UNIVERSITY AT BUFFALO
NEUROSURGERY
UBNS.COM

Neurosurgery

Brett Levy, MD, MBA, FACS, FAHS
Gregory J. Cosca, MD, FRCR
Aaron M. Davies, MD, PhD
John G. Eshleman, MD
Steven J. Gibbons, MD, FRCR, FAANS
Vernon K. Mofield
Douglas K. Moreland, MD, FRCR
Jeffrey P. Molin, MD, FRCR
Robert J. Marotta, MD
John Phillips, MD, FRCR
David Reynolds, MD, FRCR
Jonathan Riley, MD

Adam R. Sacks, MD, FRCR, FAHS

Kenneth V. Snyder, MD, FRCR, FAHS

Michael R. Stellman, MD, FRCR, FAHS

Interventional Pain Management

John W. Schildknecht, MD, FRCR, FAHS
Andres C. Wong, MD, DABR, DABRPA, MPH

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Jonathan P. Beck, DC,
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3980-A Sheridan Drive
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716/218-1998
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Governors Building
1801 Main Street • 4th Floor
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716/218-1048
EMR Fax: 716/632-2525

The Park Center
180 Park Lab Lane
Williamsville, NY 14221
716/639-0482
EMR Fax: 716/639-3570

6230 Williams Road • Suite 3200
[Dr. Michael Stefford]
Maywood Park, NY 14204
716/218-1000
EMR Fax: 716/603-9336

Interventional Pain Management

[Dr. John Schildknecht, Dr. Andrew Wong]
110 Park Club Lane
Suite 250
Williamsville, NY 14221
716/218-1099
EMR Fax: 716/320-1677

July 18, 2018

James Panzarella DO
1208 Niagara Falls Boulevard
Tonawanda, NY 14150

Patient Name: Danielle Harwell
Date of Birth: 08/29/1980
No-Fault Carrier: NF Geico
CL#: 0138739400101059
Date of Injury: 10/31/15

Psychiatry Re-evaluation: July 18, 2018

Chief Complaint(s): Low back pain.

Dear Dr. Panzarella:

I had the pleasure of seeing Danielle in our Park Club office for re-evaluation on July 18, 2018.

HISTORY/CHIEF COMPLAINT

This is a 37-year-old female presenting today for re-evaluation. She was last evaluated on April 11, 2018. At that time we reviewed an MRI of the lumbar spine due to the patient's pain, weakness and numbness encompassing the left leg. At that point she was initiated on gabapentin 300 mg, which she is now taking twice daily. She does tolerate this medication and feels that it provides relief. A small supply of hydrocodone was given at that appointment; however, she is no longer using this. She is also utilizing ibuprofen with some benefit. The patient states she was doing fairly well, noting improvement in her left leg numbness, until a subsequent car accident. She will not be seen for the symptoms related to this, as it is out of the scope of today's evaluation. She rates her pain score today 6/10 on the visual analog scale. Coughing, standing, lifting, lying down and walking worsen her pain. She states that any position or any activity for any length of time causes her increased pain, so she has to switch positions and activities often. Other than as noted above, there are no changes to her health history or reported medications. Results of an EMG/nerve conduction study will be reviewed below.

REVIEW OF SYSTEMS

Notable for joint pain and headaches. She reports neck pain since her most recent motor vehicle accident.

PHYSICAL EXAMINATION

BP: 145/89 Pulse: 106 Resp: 16 Ht: 63" Wt: 215lb BMI: 38.1

General: A 37-year-old female, in no acute distress. She is awake, alert and appropriate. Speech is fluent and coherent.

HEENT: Normocephalic, atraumatic. Lips, tongue and mucous membranes are pink and moist.

Cardiovascular: Normal S1, S2.

Abdomen: Soft, non-distended, obese.

Neuromusculoskeletal: The patient has tenderness to palpation of the cervical paraspinal muscles, trapezius and lumbar paraspinal muscles bilaterally. Range of motion of the cervical spine does create pain in all movements. Her lower extremity strength is relatively well maintained with improvement in sensation through the left leg when compared to her previous evaluation. Straight leg raise sign is positive in the seated position bilaterally. Gait is mildly antalgic.

Psychiatric: Judgement and cognition appear to be within normal limits.

REVIEW OF DIAGNOSTIC STUDIES

An EMG/nerve conduction study completed at General Diagnostic Associates dated April 25, 2018, report reviewed showing no electrophysiologic evidence of active or chronic lumbar radiculopathy. No evidence of lumbosacral plexopathy, focal lower extremity entrapment neuropathy or lower extremity polyneuropathy.

ASSESSMENT

M47.26 - Other spondylosis with radiculopathy, lumbar region, M51.26 - Other intervertebral disc displacement, lumbar region, M51.36 - Other intervertebral disc degeneration, lumbar region

IMPRESSION/RECOMMENDATIONS:

This is a 37-year-old female with low back pain and left greater than right lower extremity symptoms in the setting of lumbar disc bulging/herniations L3-4 through L5-S1, lumbar disc space narrowing and disc desiccation L3-4 and mild central stenosis L3-4 through L5-S1. Her symptoms are causally related to a motor vehicle accident on October 31, 2015. The patient informs me at today's evaluation that she was involved in a more recent motor vehicle accident. This was not discussed in depth, as it is out of the scope of today's evaluation. At this time we advised the patient she may no longer be a candidate for interventional procedures, as she had poor results with her most recent procedure. She was given a referral to alternative physiatry practices should she wish to establish with them. The patient would like to think about this and contact our office for further recommendations as needed. We will continue gabapentin at this time; however, in the future, this should be taken over by whomever moves forward with this patient's care. She will continue with ibuprofen at this time. The patient expressed understanding and agreement with today's plan of care.

The material risks, benefits, side effects and alternatives with the above named procedure were discussed with the patient today. These include, but are not limited to, injection site pain, bleeding, bruising, infections, damage to targeted or non-targeted tissue, increased pain, nerve injury or other reaction. In rare cases potentially serious reactions such as a CVA, arrhythmia, or death may occur. The patient was given procedure instructions for this specific purpose at the time of the visit.

Thank you for allowing me to participate in Danielle's care. If you have any questions or concerns regarding this patient, please do not hesitate to contact me at your earliest convenience.

Danielle Harwell DD 07/18/2018

Page #3

Sincerely,



Electronically signed by Sarah O'mara, PA-C on 08/06/2018 at 3:12 pm
Sarah O'mara, PA-C



Electronically signed by Jafar Siddiqui, M.D. on 08/06/2018
Jafar Siddiqui, M.D.

SO/abb

cc: Peter Guzinski DC

