Dr. Charles Chapple
Chiropractic Physician

Advanced Chiropractic Health Center — 630-894-8778 — 360 E. Irving Park Road, Roselle, IL 60172
At Your Service Chiropractic House Calls — 1935 95th St, Unit 115, Naperville, IL 60564

BC/BS No. #0222 1909 | **IRS ID NO. 36-4210728** | **NPI: 1679696736** | **MEDICARE #269750**

New Patient Services

1. Examination, Problem Focused	99201	$175
1a. Exam, Separate From Care	99201	$175
2. Examination, Expanded Problem Focused	99202	$225
3. Examination, Detailed Problem Focused	99203	$275
4. Examination, Comprehensive E/M - 45 Min.	99204	$305
5. Examination, Comprehensive - 60 Min.	99205	$355

Established Patient Services

185. Orthotic Fitting/Training/Management	97763	$77
186. Check Out for Orthotic Usage/Wear	97762	$65
187. Handling/Conveyance of Specimen	99002	$38
178. Exam, E/M, Brief Exam	99212	$150
7. E/M, Expanded Problem Focused	99213	$175
8. E/M, Detailed Problem Focused	99214	$195
9. E/M, Comprehensive Re-Exam	99215	$225
163. Special Service / Narrative Report	99199	$325
162. Supplemental Report	99080	$85
158. Patient Education	99071	$1

Diagnostics

Range of Motion Measurement	95851	$50

Preventive Medicine (Chiro Health USA - cash only)

Initial Exam 99202 (Cash) $99 — Est. Patient Exam 99212 (Cash) $69

172. Preventative Maintenance	S8990-01	$30
174. Preventative Maintenance	S8990-02	$40
176. Preventative Maintenance	S8990-03	$50
177. Preventative Maintenance	S8990-04	$5

18CA Elect. Stim. 97014 (Cash) $15 — 17CA Atn. Stim. 97035 (Cash) $20

21CA Traction 97012 (Cash) $22 — 183CA Rehab (Cash) $22

200. Exam, Initial House Call		$149
201. Established Patient House Call		$40
132. Consultation/Counciling	99243	$100/15 minutes

Physical Medicine

17. Attd. Mus. Stim	Area 1	97035	$45
	Area 2		$90
18. Electrical Muscle Stim	Area 1	97014	$30
	Area 2		$60
168. Acupuncture		97810-CA	$40
20. Manual Therapy Technique		97140	$95
21. Traction		97012	$45
44. Manual Therapy/Attended		97140-59/-22	$45
17A. Light Therapy		97026	$40
Massage Therapy		97124	$20/15 minutes

Physical Medicine (cont.)

149. Therapeutic Activities	97530	$60
183. Therapeutic Procedures	97110	$55
179. Neuromuscular Re-education	97112	$55
23. Manipulation of Spine (1- 2 Areas)	98940	~~$45~~
24. Manipulation of Spine (3 - 4 Areas)	98941	~~$58~~
25. Manipulation of Spine (5 Areas)	98942	$65
157. Extra Spinal Manipulation	98943	~~$40~~

Pediatric Services

169. Pediatric Manipulation of Spine (1 -2 Areas)	98940	$45
170. Pediatric Manipulation of Spine (3 -4 Areas)	98941	$55
171. Pediatric Manipulation of Spine (5 Areas)	98942	$65

Ability's Rating

Since Your Last Visit

Standing — Worse — Same — Better — Details:

Sitting — Worse — Same — Better — Details:

Sleep — Worse — Same — Better — Details:

Lifting — Worse — Same — Better — Details:

Travel — Worse — Same — Better — Details:

Personal Care — Worse — Same — Better — Details:

Exercise — Worse — Same — Better — Details:

Recreational — Worse — Same — Better — Details:

STRESS LEVEL

None ——— Unbearable

Dx 1: _____ Dx 2: _____ Dx: 3 _____

Dx 4: _____ DX 5: _____ DX: 6 _____

(AT) MEDICARE (GA)

160. Medicare Manipulation (1 - 2 Areas)	98940	$45
161. Medicare Manipulation (3 - 4 Areas)	98941	$55
22. Medicare E STM	G0283	$30

Pain:	G8730	G8731	
Func:	G8539 (1ST)	G8942	G8542 (wellness)
BP:	G8783	G8950	

Chemistry / Lab (Chiro Health USA - cash only)

Gene SNP Analysis	$395
Neuro Screen Expanded	$325
Neuro Adrenal Expanded	$375
Hair Analysis: Food Intolerance	$125
Health Stat Initial $75/Follow Up $50	
Saliva Strip Nitric Oxide	$10 each
Urine Strip Adrenal or Free Radial or Calcium or Indicin	$10 each

Orthopedic Appliances

Lumber Support V10 40S 41SM 42M 43ML 44L 45XL	L0500	$60
V33 Lumbar Pillow	L0500	$40
V4 Cervical Pillow	E0943	$60
V39 Cold Packs, V285 K-Tape	99070	$10/$5
V290 Electrodes, 4 Pack	99070	$10
V32 Heal Lift	L3332	$8
V26 Orthotics	L3020	

Additional Charges

47. Broken Appt. W/O Adequate Notification	90049	$45
Service Outside of Office Hours	99050	$100

Nutritional Support

V _____ $ _____

V _____ $ _____

TAX $ _____

SUBTOTAL $ _____

A76 2% Convenience Fee $ _____

TOTAL _____

Today's Charge $ _____

Payment Made $ _____

☐ Cash ☐ Credit Card Visa/MC/Discover ☐ Personal Check

1 1/2 % Interest charge per month will be added on any unpaid balance over 30 days

Your Next Appointment Will Be

Date: _____

Time: _____ AM / PM

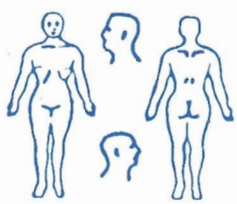
New and/or Chief Complaints today: _____

_____

PAIN RATING

None ——— Unbearable

Mark Areas of Pain



Increased Ability to: _____

Decreased Ability to: _____

IMPROVEMENT

None ——— 100%

I hereby authorize the above named Doctor or Clinic to furnish information concerning my present illness or injury and DIRECT the Insurer to pay, without equivocation, directly to the above named Doctor or Clinic, any and all benefits due them as a result of this claim at the time a properly assigned claim form is submitted. I am also aware that I am personally responsible for charges and/or balance not covered by my insurance. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy. Patient hereby agrees to Idemnify The Advanced Chiropractic Health Center and/or Charles Chapple, D.C., S.C. for all expenses it may incur to enforce collection of any amount due under this agreement and patient agrees to pay reasonable attorney's fees and court costs incurred in such Collection. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, e-mail correspondences, testimonials and coordination of care. Patient accepts responsibility to monitor their account balance and that credits older than thirty days will default to zero. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office. Patient requests and accepts above charged treatment and acknowledges informed consent, as well as agrees to pay in full at the time of service for all out of network services. Patient agrees to be completely responsible and immediate pay in full for any refunded amounts required by your insurance regardless of determined medical necessity. Patient agrees to pay % for any payment using credit card charge terminal.

Signed _____ Date _____

Assignment & Release