VITA CHIROPRACTIC

Patient Name: _____ Date of Birth: ____/_____/_____

BODILY INJURY INSURANCE CLAIM INFORMATION FORM

Thank you for providing the necessary information for your insurance claim. In accordance with Kansas state law, we require your auto insurance details due to the Kansas Personal Injury Protection (PIP) law. PIP coverage is mandatory in Kansas and provides coverage for medical expenses regardless of fault in an accident. This ensures that your chiropractic care is properly billed and processed. Please complete the following:

YOUR AUTO INSURANCE COMPANY (Required due to Kansas PIP Law)

Auto Insurance Company: _____
Insurance Adjuster Name: _____
Policy #: _____
Insurance Adjuster Phone #: _____
Primary Policy Holder: _____
Injury Claim #: _____

AT FAULT INSURANCE COMPANY INFORMATION

Driver of Vehicle at Fault: _____
Insurance Company Name: _____
Insurance Adjuster Name: _____
Insurance Adjuster Phone #: _____
Injury Claim #: _____
Policy #: _____
Primary Policy Holder: _____

IF YOU HAVE RETAINED AN ATTORNEY

Attorney's Name: _____
Attorney's Phone Number: _____
Office Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Any Other Claim Information that may be applicable, please provide below:

_____
_____
_____
_____
_____

Thank you for allowing us to support your chiropractic care and recovery!

VITA CHIROPRACTIC

VITA CHIROPRACTIC AUTOMOBILE/PERSONAL INJURY/WORKMANS COMP PROFILE

Patient Name: _____ Date of Birth: _____ /_____ /_____ Sex: Male / Female Age: _____

Address: _____ Employer / School: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Cell phone: _____ Spouse's Name:_____

Email Address: _____ Children Names & ages: _____

Circle: Single / Married / Divorced / Widowed / Partnered IN CASE OF EMERGENCY: NAME:_____

Pregnant: Yes / No / N/A Relationship:_____ Phone#:_____

NATURE OF ACCIDENT:

1. Date of Accident: _____ Time of Day: _____
2. Where you were in the vehicle: DRIVER or PASSENGER
   FRONT—BACK SEAT DRIVER SIDE—CENTER—BACK SEAT PASSENGER SIDE
3. Does your car have a headrest? YES or NO
   If yes, what were the settings? Bottom of Neck / Bottom of Head / Middle of Head
4. Number of people in vehicle: _____ Were you wearing a seatbelt: YES or NO
5. Were you struck from: Behind / Front / Left Side / Right Side / _____
6. Speed of your car? _____ mph / Other Car: _____mph
7. Were the police notified? YES or NO If yes, Police Report #: _____
8. Kind of Car you were driving: Model: _____ Make: _____ Year: _____
9. How much damage to your car: $_____ / Unsure / Totaled

CHECK ALL THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT (Including any that has worsened):

___ Headaches	___ Buzzing in Ears	___ Upset Stomach	___ Light Bothers Eyes
___ Neck Pain	___ Memory Loss	___ Depression	___ Head Seems too Heavy
___ Neck Stiff	___ Ears Ring	___ Feet Cold	___ Pins & Needles in Arms/Hands
___ Dizziness	___ Loss of Taste	___ Hands Cold	___ Pins & Needles in Legs/Feet
___ Upper Back Pain	___ Loss of Smell	___ Face Flushed	___ Numbness in Arms/fingers
___ Low Back Pain	___ Chest Pain	___ Fainting	___ Numbness in Legs/toes
___ Hip/Leg Pain	___ Nervousness	___ Loss of Balance	___ Sleeping Problems
___ Tension	___ Diarrhea	___ Fever	___ Irritability
___ Fatigue	___ Constipation	___ Cold Sweats	___ Shortness of Breath

Symptoms other than above: _____

_____

Did you have any symptoms/Physical Complaints before the accident, including or in addition to above? Yes or NO If Yes, Please List in detail the frequency and severity of each BEFORE the accident: _____

_____

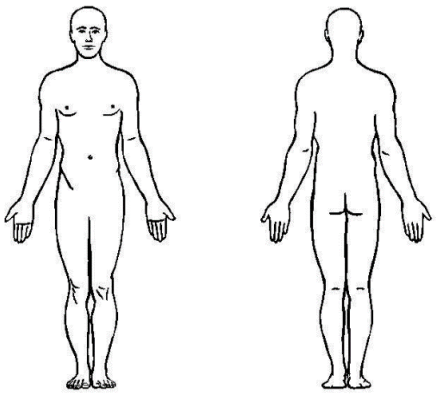
Have you lost time from work as a result of this accident? Yes or No If yes, please explain: _____

_____

Before the injury were you capable of working on an equal basis to others your age? Yes or no

NATURE OF INJURIES:

1. Please explain in detail how the accident happened: _____
   _____
   _____
2. Please describe how you felt during the accident/were you expecting impact:_____
   Where did you feel pain immediately after the accident: _____
   Later that day: _____ the next day: _____
   Since then:_____
3. List the extent of any injuries as you know them: _____
   _____
4. Were you knocked unconscious? YES or NO If yes, How Long: _____
5. Where were you taken after the accident: _____ What type of treatment did you receive: _____
6. Hospitalized? Yes or No
   If yes: Name of Hospital: _____ Were you admitted: Yes / No If Yes, How Long: _____
7. Were any other doctor(s) consulted after your accident? Yes or No
   If Yes: Name of Facility: _____ What was the diagnosis: _____
   How often did you see the doctor? _____ How Long did you see the doctor: _____
8. Since this injury are your symptoms (Circle One):
   IMPROVING SAME WORSE
9. Please Mark the areas on the diagram with the following LETTER(S) to describe your symptoms:
   R= Radiating B= Burning D= Dull A= Aching
   S=Sharp/Stabbing N= Numbness T=Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

When is (are) the problem(s) at its worst? AM PM Mid-Day Late PM

10. Quadruple Visual Analogue Scale
    Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

EXAMPLE: No pain _____ Back pain Headaches Worst possible pain

0 1 2 3 4 (5) 6 7 (8) 9 10

How would you rate your **pain RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10

What is your **typical** or **AVERAGE pain**?

0 1 2 3 4 5 6 7 8 9 10

What is your **pain level at its BEST**? (How close to 0 does your pain get at its best?)

0 1 2 3 4 5 6 7 8 9 10

What is your **pain level at its WORST**? (How close to 10 does your pain get at its worst?)

0 1 2 3 4 5 6 7 8 9 10

ACTIVITIES OF DAILY LIVING ASSESSMENT

Rate your current difficulties resulting from your incident regarding the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty.

0= No Restriction 1 = Slight Restriction 2= Mild Restriction 3= Moderate Restriction 4= Much Restriction 5= Completely Restricted

Mark NA if not applicable to your life.

Difficulties with Self-Care and Personal Hygiene Activities

___ Bathing ___ Drying Hair ___ Brushing Teeth ___ Putting on Shoes ___ Tying Shoes
___ Preparing Meals ___ Showering ___ Combing Hair ___ Making Bed ___ Eating
___ Doing Laundry ___ Washing Hair ___ Washing Face ___ Getting Dressed ___ Cleaning Dishes
___ Sleep ___ Shaving ___ Going to the restroom ___ Sexual Activities

Difficulties with Physical Activities

___ Standing ___ Static Standing ___ Sitting ___ Static Sitting ___ Walking
___ Garbage ___ Pet Care ___ Yard Work ___ Standing from Seated ___ Walking long periods
___ Sweep/Vacuum ___ Kneeling ___ Reaching ___ Twisting ___ Bending
___ Leaning ___ Reclining ___ Squatting

Difficulties with Functional Activities

___ Carrying Small Objects ___ Carrying Large Objects ___ Carrying Groceries ___ Carrying Bag
___ Lifting Items ___ Lifting Weights ___ Climbing Stairs ___ Climbing Inclines
___ Pushing things while sitting ___ Pushing things while standing ___ Extended Computer Use ___ Exercising Arms
___ Pulling Things While Standing ___ Pulling things while seated ___ Exercising Upper body ___ Exercising Lower Body
___ Exercising Legs

Difficulties with Social and Recreational Activities

___ Bowling ___ Jogging ___ Swimming ___ Competitive Sports
___ Golfing ___ Dancing ___ Hobbies ___ Dining out
___ Other:_____

Difficulties with Traveling

___ Driving ___ Riding as a Passenger
___ Driving for long periods of time ___ Riding as a passenger for long periods of time

Difficulties with Different Forms of Communication

___ Concentrating ___ Hearing ___ Listening ___ Speaking
___ Reading ___ Writing ___ Using a Keyboard

Difficulties with the Senses

___ Seeing ___ Hearing ___ Touch ___ Taste ___ Smell

Write in below any additional information regarding your Activities of Daily Living affected (that wasn't covered above):

_____

The above information is complete and correct to the best of my knowledge. I understand that this information is confidential and is only being asked of me to help determine if chiropractic care through Vita Chiropractic would be beneficial. If it is in the doctor's opinion that he believes I will not respond satisfactorily, Vita Chiropractic will not accept my case.

_____ _____

PATIENT SIGNATURE OR GUARDIAN SIGNATURE DATE

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE, WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAINS/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES. ONE OF THE RAREST COMPLICATIONS ASSOCIATED WITH CHIROPRACTIC CARE OCCURING AT A RATE BETWEEN ONE INSTANCE PER ONE MILLION TO ONE PER TWO MILLION CERVICAL SPINE (NECK) ADJUSTMENTS MAY BE A VERTEBRAL INJURY THAT COULD LEAD TO A STROKE.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR, YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IF NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT NAME HERE

_____ _____

PATIENT SIGNATURE OR GUARDIAN SIGNATURE DATE

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PATIENT WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. ZACH NELSON AND ANY AND ALL VITA CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY VITA CHIROPRACTIC.

_____ _____

GUARDIAN SIGNATURE AND RELATIONSHIP TO MINOR/CHILD DATE

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

_____ _____

PATIENT SIGNATURE DATE

TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimal health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic.

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art and practice. It is not the practice of medicine.
B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve process.
C. The chiropractic adjustment process, as defined in the law of this jurisdiction, involves the application of a specific directional thrust to a region, or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.
D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of need.
E. Chiropractic does not seek to replace or compete with your medical, dental, or other type(s) of health professionals. They retain responsibility or care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
F. Your compliance with care plans, home and self-care, etc., is essential to maximum healing and optimal health through chiropractic .
G. We invite you to speak frankly to the doctor or any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment .

By my signature below, I have read and fully understand the above statements.

_____ _____

PATIENT SIGNATURE DATE

PERSONAL INJURY PATIENT-PROVIDER CONTRACT AND PROMISSORY NOTE

Entered this day between Vita Chiropractic (Hereinafter 'Provider') and _____ (Patient Name), (Hereinafter 'Patient'). Provider hereby agrees to establish an active account for the patient and to provide essential services for the purposes of benefitting and improving the Patient's current health condition. Patient agrees to pay Provider in full for services performed by Provider. Patient and Provider acknowledge that Patient retains any and all rights of suit to procure payment for and benefit Patient may be entitled. It is further acknowledged by both parties that this document does not create an express or implied assignment of benefits from any liability insurance carrier, Patient representative, or from Patient to Provider.

In consideration of and for Provider rendering essential chiropractic or medical services to Patient, and for the temporary suspension of any collection activity by Provider by the maintenance of a active account while not receiving payment at the point of service. Patient hereby authorizes and directs the following actions be taken on the Patient's behalf.

I. PATIENT AUTHORIZATION TO LIABILITY INSURANCE CARRIER: In consideration of the services to be rendered to Patient by Provider that Patient and Provider are privy of contact, and in lien of Provider sending direct billing to liability insurance carrier Patient authorizes and directs liability insurance company to disclose the settlement status of Patient claim to Provider upon request, including settlement amounts thereof. After such time that Patient has settled the claim with the liability carrier, in consideration that Provider has not demanded payment at the point of service. Patient directs the liability carrier to include the name of the Provider on any check to Patient after such settlement. In the event payment is made to Patient attorney after settlement of claim, Patient further authorizes and directs the liability company to issue check to Provider for the full amount owed for chiropractic and/or medical services rendered to fully satisfy Patient's obligation to Provider.

II. PATIENT AUTHORIZATIONS TO ATTORNEY IF REPRESENTED: If patient hires an attorney; Patient acknowledges that Patient is represented by _____ , Attorney at Law. Patient and Provider stipulates, that representation by the above named attorney prior to settlement, judgement, or verdict in the Patient's claim. Provider shall have the option to terminate this agreement and immediately collect from Patient the full amount then owed to the Provider. Patient directs attorney to disclose to Provider upon request the settlement status and amount of Patient claim to include amount of all outstanding medical bills, dollar amount of any offers and counter offers as well as date and reason of termination or dismissal, Patient's last address, telephone number, and place of employment known to attorney. Patient further directs attorney to honor this agreement and to deduct medical expenses from total settlement prior to contingency fee being deducted and to pay Provider for services rendered after any settlement, judgement, or verdict rendered in Patient's claim. Patient acknowledges and agrees to remain personally liable to Provider for any unpaid account balance to Provider. This agreement survives this attorney-client relationship and all others that may follow in reference to this claim.

III. BINDING ARBITRATION: In the event liability, insurance carrier or Patient's attorney do not honor this agreement, both parties agree to submit to binding arbitration prior to the insurance with any funds after settlement is reached. Both parties shall be entitled to legal representation at such hearing with Patient's attorney the likely representative for Patient.

IV. PROMISORY NOTE: For the consideration stated above, Patient promises to pay Provider the full balance in Patient's account for services rendered to Patient. Payment shall be due and payable within 120 days of the last date of service or within 3 (three) days of settlement with liability carrier for injuries sustained by Patient and treated by Provider whichever event occurs first, provided agreement has not been terminated by parties prior to these events in which case the account balance will be due in full 3 (three) days after termination. Further Patient agrees to the following:

> IN THE EVENT PATIENT'S ACCOUNT IS NOT PAID IN FULL WITHIN 120 DAYS OF THE LAST DATE OF SERVICE OR WITHIN 3 (THREE) DAYS OF SETTLEMENT WITH LIABILITY CARRIER OR ATTORNEY FOR INJURIES SUSTAINED BY PATIENT AND TREATED BY PROVIDER, OR WITHIN 3 (THREE) DAYS OF TERMINATION, WHICHEVER EVENT OCCURS FIRST, PATIENT'S ACCOUNT WILL BECOME DELIQUINT. IF PATIENT'S ACCOUNT BECOMES DELIQUINT, PATIENT AGREES TO PAY COLLECTION AGENCY FEES AT 40% OF THE PATIENT ACCOUNT BALANCE AS OF THE LAST DATE OF SERVICE. THE COLLECTION FEE WILL BE 40% OF THE ACCOUNT BALANCE IN ADDITION TO THE PATIENT BALANCE. PATIENT FURTHER AGREES TO PAY ALL COSTS AND ATTORNEY FEES SHOULD THOSE EFFECTS BE UNDERTAKEN BY THE PROVIDER.

Either party may terminate this agreement at any time, provided Patient's account remains in active status. It is agreed that, in the event Patient terminates this agreement, Patient shall pay full balance of Patient's account within 3 (Three) days of termination or the account shall be in default. Patient and Provider acknowledge that this document contains full, final, and entire agreement between both parties. There are no other terms to this agreement. Patient has read and fully understands the terms of this agreement. In the event any portion of this agreement is rendered null or void it is expressly agreed by the parties that all remaining provision shall remain in full force.

Date of Agreement: _____

_____ _____

PATIENT NAME PATIENT SIGNATURE OR LEGAL GUARDIAN (IF A MINOR OR POA)

_____ _____

PROVIDER SIGNATURE WITNESS

File#:_____
DOB:____/____/_____

X-Ray Authorization

AS YOUR HEALTHCARE PROVIDER, WE ARE LEGALLY RESPONSIBLE FOR YOUR CHIROPRACTIC RECORDS.

WE MUST MAINTAIN A RECORD OF YOUR X-RAYS IN OUR FILES.

AT YOUR REQUEST, WE WILL PROVIDE YOU WITH A COPY OF YOUR X-RAYS IN OUR FILES.

THE FEE FOR COPYING YOUR X-RAYS ON A DISC IS $15.00. THIS FEE MUST BE PAID IN ADVANCE.

DIGITAL X-RAYS ON CD WILL BE AVAILABLE WITHIN 72 HOURS OF PREPAYMENT ON ANY REGULAR PRACTICE HOURS DAY.

PLEASE NOTE: X-RAYS ARE UTILIZED IN THIS OFFICE TO HELP LOCATE AND ANALYZE VERTEBRAL SUBLUXATIONS. THESE X-RAYS ARE NOT USED TO INVESTIGATE FOR MEDICAL PATHOLOGY. THE DOCTOR OF VITA CHIROPRACTIC DOES NOT DIAGNOSE OR TREAT MEDICAL CONDITIONS; HOWEVER, IF ANY ABNORMALITIES ARE FOUND, WE WILL BRING IT TO YOUR ATTENTION SO THAT YOU CAN SEEK PROPER MEDICAL ADVICE.

BY SIGNING BELOW YOU ARE AGREEING TO THE ABOVE TERMS AND CONDITIONS.

_____ _____

PRINT NAME HERE DATE OF BIRTH

_____ _____

SIGNATURE DATE

FEMALE PATIENT ONLY: TO THE BEST OF MY KNOWLEDGE, I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT VITA CHIROPRACTIC.

SIGNATURE: _____ Date:_____

-- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE -- DO NOT WRITE BELOW THIS LINE --

☐ Lat Cervical ☐ Flex/Ext

CM	Kvp	Time	MAS
☐10-11	☐78	☐1/24	12.5
☐12-13	☐	☐1/20	15
☐14-15		☐1/15	20
☐16-17		☐1/10	30
		☐2/15	40

MA 300 Size 8x10

☐ Lower Cervical

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

☐ APOM

CM	Kvp	Time	MAS
☐14-15	☐70	☐1/10	20
☐16-17	☐	☐2/15	30
☐18-19		☐3/20	40
☐20-21		☐2/10	50
☐22-23			

MA 300 Size 8x10

Other
View _____

CM_____ Kvp _____

MAS_____ MA_____

Size _____

Sex: M / F

NOTES: _____
_____
_____
_____
_____
_____

☐ Lateral Thoracic

CM	Kvp	Time	MAS
☐22-23	☐80	☐1/15	20
☐24-25	☐	☐1/10	30
☐26-27		☐2/15	40
☐28-29		☐2/10	50
☐30-31		☐1/4	75
☐32-33		☐3/10	90
☐34-35		☐2/5	120
☐36-37		☐1/2	150

MHA 300 Size14x17

☐ Lateral Lumbar

CM	Kvp	Time	MAS
☐26-27	☐88	☐2/10	30
☐28-29	☐90	☐1/4	40
☐30-31	☐92	☐3/10	50
☐32-33	☐94	☐2/5	70
☐34-35	☐96	☐1/2	90
☐36-37	☐	☐3/5	120
☐38-39		☐4/5	160
☐40-41		☐1	200
☐42-43		☐1 1/2	
		☐2	

MA 200 Size 14x17

CA Initials: _____

☐ A-P Thoracic

CM	Kvp	Time	MAS
☐16-17	☐75	☐1/20	17
☐18-19	☐	☐1/15	22
☐20-21		☐1/10	30
☐22-23		☐2/15	40
☐24-25		☐2/10	50
☐26-27		☐1/4	75
☐28-29		☐3/10	90
☐30-31		☐2/5	120

MA 300 Size14x17

☐ A-P Lumbar

CM	Kvp	Time	MAS
☐20-21	☐76	☐1/15	40
☐22-23	☐78	☐1/10	50
☐24-25	☐80	☐2/15	75
☐26-27	☐	☐2/10	90
☐28-29		☐1/4	120
☐30-31		☐3/10	150
☐32-33		☐2/5	120
☐34-35		☐1/2	170
☐36-37		☐3/5	210
☐38-39		☐4/5	
☐40-41		☐1	
☐42-43		☐1 1/2	
		☐2	

MA 300 Size 14x17