

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

| | | | | |
|--|---|--|------------------------------|------------------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="radio"/> Female | <input type="text"/> |
| Patient name Last | First | MI | <input type="radio"/> Male | Patient date of birth |
| <input type="text"/> | | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Patient address | | City | State | Zip code |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Patient insurance ID# | Health plan | Group number | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | | |
| Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable) | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | | |

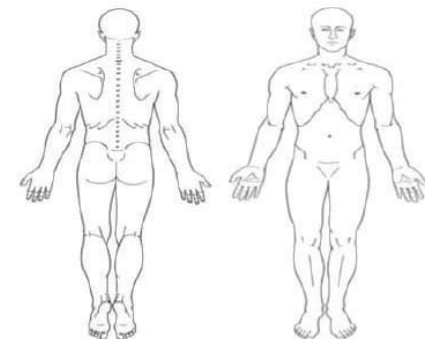
Provider Information

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|---|-------|---|----|---|-------|---|----|---|----------------|---|-----------|---|----------------|---|-----------|---|-------|-------|----|---|-------|-------|
| <input type="text"/> | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |
| 1. Name of the billing provider or facility (as it will appear on the claim form) | | 2. Federal tax ID(TIN) of entity in box #1 | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |
| <table style="width:100%; border:none;"> <tr> <td style="border:1px solid black; padding:2px;">1</td> <td style="border:1px solid black; padding:2px;">MD/DO</td> <td style="border:1px solid black; padding:2px;">2</td> <td style="border:1px solid black; padding:2px;">DC</td> <td style="border:1px solid black; padding:2px;">3</td> <td style="border:1px solid black; padding:2px;">PT</td> <td style="border:1px solid black; padding:2px;">4</td> <td style="border:1px solid black; padding:2px;">OT</td> <td style="border:1px solid black; padding:2px;">5</td> <td style="border:1px solid black; padding:2px;">Both PT and OT</td> <td style="border:1px solid black; padding:2px;">6</td> <td style="border:1px solid black; padding:2px;">Home Care</td> <td style="border:1px solid black; padding:2px;">7</td> <td style="border:1px solid black; padding:2px;">ATC</td> <td style="border:1px solid black; padding:2px;">8</td> <td style="border:1px solid black; padding:2px;">MT</td> <td style="border:1px solid black; padding:2px;">9</td> <td style="border:1px solid black; padding:2px;">Other</td> <td style="border:1px solid black; padding:2px;">_____</td> </tr> </table> | | | | 1 | MD/DO | 2 | DC | 3 | PT | 4 | OT | 5 | Both PT and OT | 6 | Home Care | 7 | ATC | 8 | MT | 9 | Other | _____ |
| 1 | MD/DO | 2 | DC | 3 | PT | 4 | OT | 5 | Both PT and OT | 6 | Home Care | 7 | ATC | 8 | MT | 9 | Other | _____ | | | | |
| 3. Name and credentials of the individual performing the service(s) | | | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | |
| 4. Alternate name (if any) of entity in box #1 | | 5. NPI of entity in box #1 | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |
| 6. Phone number | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |
| 7. Address of the billing provider or facility indicated in box #1 | | 8. City | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |
| 9. State | | 10. Zip code | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | | <input type="text"/> | | | | | | | | | | | | | | | | | | | | |

Provider Completes This Section:

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|---|---|--|----------------------|----------------------|--|---|----------------------|----------------------|----------------------|----------------------|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <p>Date you want THIS submission to begin:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> </tr> </table> <p>Patient Type</p> <p><input type="radio"/> (1) New to your office</p> <p><input type="radio"/> (2) Est'd, new injury</p> <p><input type="radio"/> (3) Est'd, new episode</p> <p><input type="radio"/> (4) Est'd, continuing care</p> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <p>Cause of Current Episode</p> <p><input type="radio"/> (1) Traumatic <input type="radio"/> (4) Post-surgical</p> <p><input type="radio"/> (2) Unspecified <input type="radio"/> (5) Work related</p> <p><input type="radio"/> (3) Repetitive <input type="radio"/> (6) Motor vehicle</p> | <p>Date of Surgery</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> <td style="width:25%;"><input type="text"/></td> </tr> </table> <p>Type of Surgery</p> <p><input type="radio"/> (1) ACL Reconstruction</p> <p><input type="radio"/> (2) Rotator Cuff/Labral Repair</p> <p><input type="radio"/> (3) Tendon Repair</p> <p><input type="radio"/> (4) Spinal Fusion</p> <p><input type="radio"/> (5) Joint Replacement</p> <p><input type="radio"/> (6) Other _____</p> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <p>Diagnosis (ICD code)</p> <p><i>Please ensure all digits are entered accurately</i></p> <p>1° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>2° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>3° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>4° <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Nature of Condition</p> <p><input type="radio"/> (1) Initial onset (within last 3 months)</p> <p><input type="radio"/> (2) Recurrent (multiple episodes of < 3 months)</p> <p><input type="radio"/> (3) Chronic (continuous duration > 3 months)</p> | <p style="text-align:center;">DC ONLY</p> <p style="text-align:center;">Anticipated CMT Level</p> <p><input type="radio"/> 98940 <input type="radio"/> 98942</p> <p><input type="radio"/> 98941 <input type="radio"/> 98943</p> | <p>Current Functional Measure Score</p> <p>Neck Index <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>Back Index <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>DASH <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>LEFS <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p style="text-align:right;">(other) <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> | | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | | | | | | | | | | |
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| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Patient Completes This Section:

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|---|----------------------|----------------------|----------------------|--|
| <p>(Please fill in selections completely)</p> <p style="text-align:right;">Symptoms began on: <table border="1" style="width:100%; border-collapse: collapse;"><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></table></p> <p>1. Briefly describe your symptoms:</p> <p>_____</p> <p>2. How did your symptoms start?</p> <p>_____</p> <p>3. Average pain intensity:</p> <p>Last 24 hours: no pain <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 worst pain</p> <p>Past week: no pain <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 worst pain</p> <p>4. How often do you experience your symptoms?</p> <p><input type="radio"/> (1) Constantly (76%-100% of the time) <input type="radio"/> (2) Frequently (51%-75% of the time) <input type="radio"/> (3) Occasionally (26% - 50% of the time) <input type="radio"/> (4) Intermittently (0%-25% of the time)</p> <p>5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)</p> <p><input type="radio"/> (1) Not at all <input type="radio"/> (2) A little bit <input type="radio"/> (3) Moderately <input type="radio"/> (4) Quite a bit <input type="radio"/> (5) Extremely</p> <p>6. How is your condition changing, since care began at this facility?</p> <p><input type="radio"/> (0) N/A — This is the initial visit <input type="radio"/> (1) Much worse <input type="radio"/> (2) Worse <input type="radio"/> (3) A little worse <input type="radio"/> (4) No change <input type="radio"/> (5) A little better <input type="radio"/> (6) Better <input type="radio"/> (7) Much better</p> <p>7. In general, would you say your overall health right now is...</p> <p><input type="radio"/> (1) Excellent <input type="radio"/> (2) Very good <input type="radio"/> (3) Good <input type="radio"/> (4) Fair <input type="radio"/> (5) Poor</p> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <p>Indicate where you have pain or other symptoms:</p>  |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | | |

Patient Signature: X **Date:** _____