

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

<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"/>	
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"/>	
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"/>	

Provider Completes This Section:

<p>Date you want THIS submission to begin:</p> <input type="text"/>	<p>Cause of Current Episode</p> <table style="width:100%;"> <tr> <td><input type="radio"/> 1 Traumatic</td> <td><input type="radio"/> 4 Post-surgical</td> </tr> <tr> <td><input type="radio"/> 2 Unspecified</td> <td><input type="radio"/> 5 Work related</td> </tr> <tr> <td><input type="radio"/> 3 Repetitive</td> <td><input type="radio"/> 6 Motor vehicle</td> </tr> </table>	<input type="radio"/> 1 Traumatic	<input type="radio"/> 4 Post-surgical	<input type="radio"/> 2 Unspecified	<input type="radio"/> 5 Work related	<input type="radio"/> 3 Repetitive	<input type="radio"/> 6 Motor vehicle	<p>Date of Surgery</p> <input type="text"/>	<p>Diagnosis (ICD code) Please ensure all digits are entered accurately</p> <p>1° <input type="text"/></p> <p>2° <input type="text"/></p> <p>3° <input type="text"/></p> <p>4° <input type="text"/></p>
<input type="radio"/> 1 Traumatic	<input type="radio"/> 4 Post-surgical								
<input type="radio"/> 2 Unspecified	<input type="radio"/> 5 Work related								
<input type="radio"/> 3 Repetitive	<input type="radio"/> 6 Motor vehicle								
<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>	<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 <input type="text"/></p>	<p>DC ONLY</p> <p>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>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>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/></p>								

Patient Completes This Section:

Symptoms began on:

(Please fill in selections completely)

1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

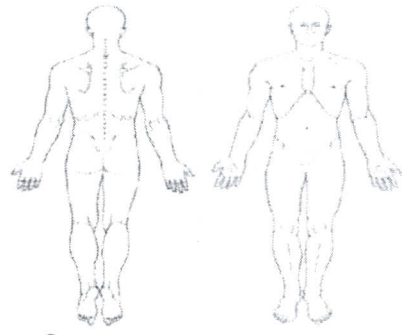
6. How is your condition changing, since care began at this facility?

0 N/A — This is the initial visit 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

7. In general, would you say your overall health right now is...

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X Date: _____