

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

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

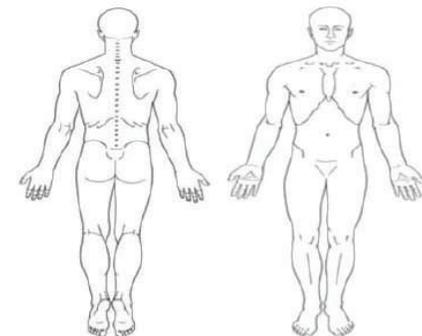
Provider Information

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				
3. Name and credentials of the individual performing the service(s)					4. Alternate name (if any) of entity in box #1				
4. Alternate name (if any) of entity in box #1					5. NPI of entity in box #1				
6. Phone number					7. Address of the billing provider or facility indicated in box #1				
8. City					9. State				
10. Zip code									

Provider Completes This Section:

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

Patient Completes This Section:

Symptoms began on: <input type="text"/>	Indicate where you have pain or other symptoms: 
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	

Patient Signature: X Date: _____