

# 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

Female  
 Male

Patient name: Last [ ] First [ ] MI [ ] 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 [ ] 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:

[ ] [ ] [ ]

#### Patient Type

- 1 New to your office
- 2 Est'd, new injury
- 3 Est'd, new episode
- 4 Est'd, continuing care

#### Cause of Current Episode

- 1 Traumatic
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 6 Motor vehicle

#### Date of Surgery

[ ] [ ] [ ]

#### 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° [ ] [ ] [ ] [ ] [ ] [ ]

2° [ ] [ ] [ ] [ ] [ ] [ ]

3° [ ] [ ] [ ] [ ] [ ] [ ]

4° [ ] [ ] [ ] [ ] [ ] [ ]

#### Nature of Condition

- 1 Initial onset (within last 3 months)
- 2 Recurrent (multiple episodes of < 3 months)
- 3 Chronic (continuous duration > 3 months)

#### DC ONLY

#### Anticipated CMT Level

98940     98942  
 98941     98943

#### Current Functional Measure Score

Neck Index [ ] [ ] DASH [ ] [ ] [ ] [ ]  
 Back Index [ ] [ ] LEFS [ ] [ ] [ ] [ ] (other) [ ] [ ]

### 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 (78%-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

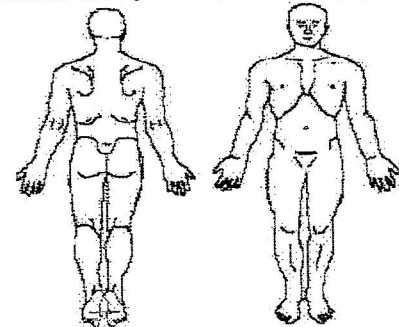
6. How is your condition changing, since care began at this facility?

- 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: \_\_\_\_\_