

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

### Provider Information

<input type="text"/>		<input type="text"/>																				
<b>1. Name of the billing provider or facility (as it will appear on the claim form)</b>		<b>2. Federal tax ID(TIN) of entity in box #1</b>																				
<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	_____				
<b>3. Name and credentials of the individual performing the service(s)</b>																						
<input type="text"/>																						
<b>4. Alternate name (if any) of entity in box #1</b>		<b>5. NPI of entity in box #1</b>																				
<input type="text"/>		<input type="text"/>																				
<b>6. Phone number</b>		<input type="text"/>																				
<input type="text"/>		<input type="text"/>																				
<b>7. Address of the billing provider or facility indicated in box #1</b>		<b>8. City</b>																				
<input type="text"/>		<input type="text"/>																				
<b>9. State</b>		<b>10. Zip code</b>																				
<input type="text"/>		<input type="text"/>																				

### Provider Completes This Section:

<p><b>Date you want THIS submission to begin:</b></p> <table border="1" style="width:100%; height:20px;"> <tr> <td style="width:33%;"></td> <td style="width:33%;"></td> <td style="width:33%;"></td> </tr> </table> <p><b>Patient Type</b></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><b>Cause of Current Episode</b></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><b>Date of Surgery</b></p> <table border="1" style="width:100%; height:20px;"> <tr> <td style="width:33%;"></td> <td style="width:33%;"></td> <td style="width:33%;"></td> </tr> </table> <p><b>Type of Surgery</b></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>				<p><b>Diagnosis (ICD code)</b></p> <p>Please ensure all digits are entered accurately</p> <p>1° <table border="1" style="width:100%; height:20px;"><tr><td style="width:33%;"></td><td style="width:33%;"></td><td style="width:33%;"></td></tr></table></p> <p>2° <table border="1" style="width:100%; height:20px;"><tr><td style="width:33%;"></td><td style="width:33%;"></td><td style="width:33%;"></td></tr></table></p> <p>3° <table border="1" style="width:100%; height:20px;"><tr><td style="width:33%;"></td><td style="width:33%;"></td><td style="width:33%;"></td></tr></table></p> <p>4° <table border="1" style="width:100%; height:20px;"><tr><td style="width:33%;"></td><td style="width:33%;"></td><td style="width:33%;"></td></tr></table></p>												
<p><b>Nature of Condition</b></p> <p><input type="radio"/> (1) Initial onset (within last 3 months)</p> <p><input type="radio"/> (2) Recurrent (multiple episodes of &lt; 3 months)</p> <p><input type="radio"/> (3) Chronic (continuous duration &gt; 3 months)</p>	<p style="text-align:center;"><b>DC ONLY</b></p> <p style="text-align:center;"><b>Anticipated CMT Level</b></p> <p><input type="radio"/> 98940      <input type="radio"/> 98942</p> <p><input type="radio"/> 98941      <input type="radio"/> 98943</p>	<p><b>Current Functional Measure Score</b></p> <p>Neck Index <table border="1" style="width:40px; height:20px;"></table> DASH <table border="1" style="width:40px; height:20px;"></table> <table border="1" style="width:40px; height:20px;"></table> <table border="1" style="width:40px; height:20px;"></table></p> <p>Back Index <table border="1" style="width:40px; height:20px;"></table> LEFS <table border="1" style="width:40px; height:20px;"></table> (other) _____</p>																			



### Patient Completes This Section:

(Please fill in selections completely)

**Symptoms began on:**

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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:** \_\_\_\_\_