

# 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			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:

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

### Patient Completes This Section:

**Symptoms began on:**

(Please fill in selections completely)

1. Briefly describe your symptoms: \_\_\_\_\_

2. How did your symptoms start? \_\_\_\_\_

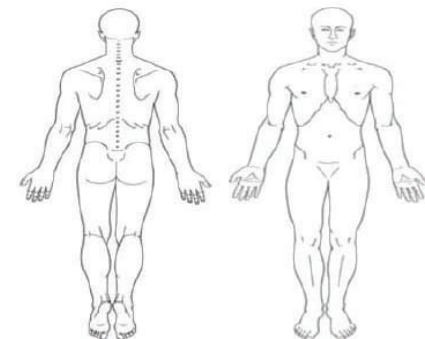
3. Average pain intensity:  
Last 24 hours: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain  
Past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

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?  
① N/A — This is the initial visit ② Much worse ③ Worse ④ A little worse ⑤ No change ⑥ A little better ⑦ Better ⑧ 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: \_\_\_\_\_