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

○ Female ○ 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
Rocky Mountain Chiropractic & Sports Injury Centers	26-3511191

3. Name and credentials of the individual performing the service(s): Brent G. Hextell

1 MD/DO ✓ DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1	5. NPI of entity in box #1	6. Phone number
	1013162791	(970)674-0147

7. Address of the billing provider or facility indicated in box #1	8. City	9. State	10. Zip code
1230 West Ash St., Suite 1	Windsor	CO	80550

Provider Completes This Section:

Date you want *THIS* submission to begin: ___ ___ ___

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° ___ ___ ___ . ___ ___

Patient Type

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

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

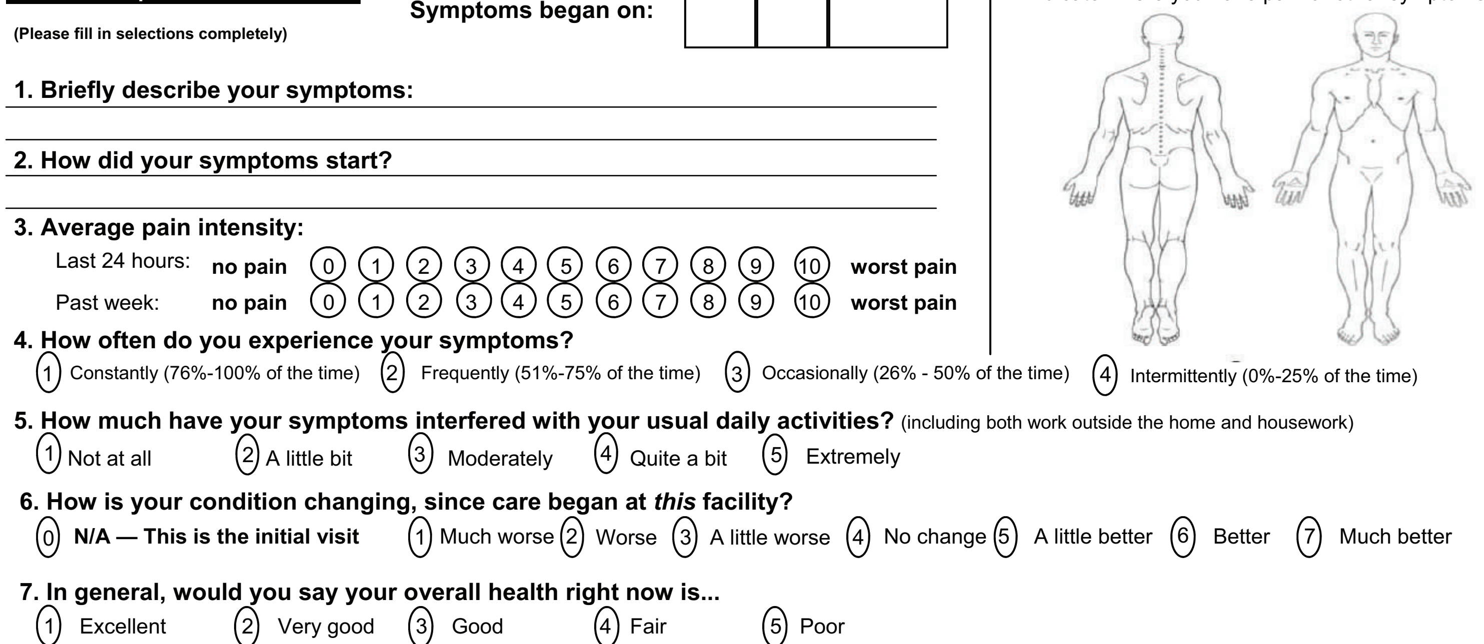
Anticipated CMT Level

○ 98940 ○ 98942
○ 98941 ○ 98943

Current Functional Measure Score

Neck Index ___ DASH ___ ________ ___ (other)

Back Index ___ LEFS ___



Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on: ___ ___ ___

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:** ____________