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.

COMPLETED BY SERVICE COORDINATOR

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): (LEFT BLANK) | Date referral issued (if applicable): (LEFT BLANK) | Referral number (if applicable): (LEFT BLANK)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form): Rappahannock Rapidan Community Services
2. Federal tax ID(TIN) of entity in box #1: 237238218
3. Name and credentials of the individual performing the service(s): (THERAPIST NAME) — 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ___ ← CHOOSE ONE!
4. Alternate name (if any) of entity in box #1: Infant + Toddler Connection of RAPPAHANNOCK RAPIDAN
5. NPI of entity in box #1: (THERAPIST NPI #)
6. Phone number: 540 829-7480
7. Address of the billing provider or facility indicated in box #1: 314 N. WEST STREET
8. City: CULPEPER
9. State: VA
10. Zip code: 22701

COMPLETED BY PROVIDER

Provider Completes This Section.

Date you want *THIS* submission to begin: →

Cause of Current Episode
1 Traumatic
* 2 Unspecified (filled)
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° ___ . ___ ← NEED INFO
2° ___ . ___
3° ___ . ___
4° ___ . ___

Patient Type
→ 1 New to your office (INITIAL)
OR 2 Est'd, new injury
3 Est'd, new episode
→ 4 Est'd, continuing care (REAUTH)

DO NOT COMPLETE

DC ONLY
Anticipated CMT Level
○ 98940 ○ 98942
○ 98941 ○ 98943

Nature of Condition
→ 1 Initial onset (within last 3 months) - Initial
OR 2 Recurrent (multiple episodes of < 3 months)
→ 3 Chronic (continuous duration > 3 months) Continuing!

Current Functional Measure Score
Neck index ___ DASH ___ ___ (other)
Back index ___ LEFS ___

SECTION COMPLETED BY PARENT

Patient Completes This Section:
(Please fill in selections completely)

Symptoms began on: ✓

— ALL SECTIONS COMPLETED —

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 (PARENT MUST SIGN) Date: (DATE OF SIGNATURE)

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Patient Information

Patient name: Last ____ First ____ MI ____ ◯ Female ◯ Male Patient date of birth ____

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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): Rappahannock Rapidan Community Services
2. Federal tax ID(TIN) of entity in box #1: 237238218

3. Name and credentials of the individual performing the service(s): ____ 1 MD/DO 2 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: INFANT + TODDLER CONNECTION OF RAPPAHANNOCK RAPIDAN
5. NPI of entity in box #1: ____
6. Phone number: 540 829 7480

7. Address of the billing provider or facility indicated in box #1: 314 N. WEST ST
8. City: CULPEPER
9. State: VA
10. Zip code: 22701

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)
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3 Chronic (continuous duration > 3 months)

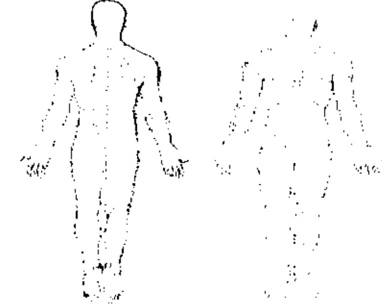
DC ONLY
Anticipated CMT Level
◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

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)

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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:** ____