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
Haley Chiropractic	22-3297777

3. Name and credentials of the individual performing the service(s): Dr. Robert J. Haley. DC

1 MD/DO [X] 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	5. NPI of entity in box #1	6. Phone number
	1861475485	201. 531. 9400

7. Address of the billing provider or facility indicated in box #1	8. City	9. State	10. Zip code
528 Valley Brook Ave.	Lyndhurst	NJ	07071

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

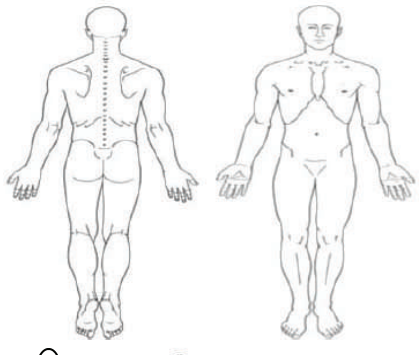
Neck Index | DASH | (other)
Back Index | LEFS

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:** _____