Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

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): Complete Care Health Centers

2. Federal tax ID(TIN) of entity in box #1: 26-4568992

3. Name and credentials of the individual performing the service(s): Yeonjoo Lee-Jones

1 MD/DO X 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: 1124134887

6. Phone number: 541-830-4325

7. Address of the billing provider or facility indicated in box #1: 3132 State Street Suite 110

8. City: Medford

9. State: OR

10. Zip code: 97504

Provider Completes This Section:

Date you want *THIS* submission to begin: ____

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

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 codes)
Please ensure all digits are entered accurately

1° ____
2° ____
3° ____
4° ____

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 FOM)

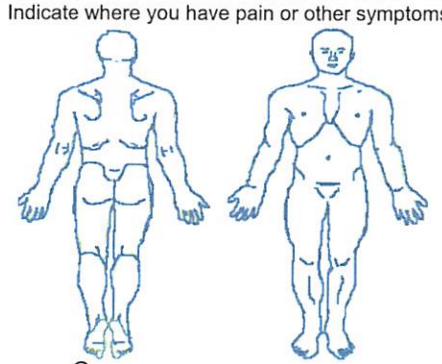
Back Index ____ LEFS ____

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:** ____