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)

2. Federal tax ID(TIN) of entity in box #1

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

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:

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)

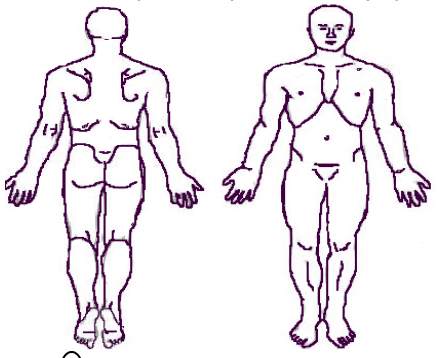
Back Index | LEFS

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:** _____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

For office use only : Total ÷ 40x100 = %

Provider Note: Please do NOT submit to Optum unless there is a records request

PO Box 880009 | San Diego, CA 92168-0009 | Toll Free: (800) 428-6337 | Phone: (619) 641-7100 | Fax (619) 641-7185

Patient Language Assistance Form

Patient Name: _____ **Date:** _____

Patient's Primary Language: □ English □ Spanish □ Mandarin Chinese

□ Other _____

Interpreter Needs: *(Interpretive services are provided at no cost for Optum patients, if needed)*

□ Yes, I am requesting interpretive service for language (s) _____

□ No, I will use my family and/or friends for interpretive services

□ Yes, family and/or friend is a minor (under age 18)

□ No, I do not require interpretive services

Other:

_____

_____

_____

I am aware of the availability of free language assistance services (interpretation and translation), by my health plan. I have completed the above information and understand I can change my preference if needed at any time and will let the clinic know if my preference changes.

Patient Signature: _____

Date: _____

****Provider office use only: Please do not submit to Optum unless requested****

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various mode of physical therapy and diagnostic x-rays, on me, (or on the patient named below), for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licenses Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

As: _____
Relationship or Authority of Patient's Representative

_____
Print Patient's Name

_____
Date Signed

_____
Signature of Patient

Print name(s) of doctor(s) treating this patient:

Dr. Kenneth Greenberg DC

_____

_____

Date_____

To be completed by doctor or staff
Name and address of clinic/office:

San Diego Chiropractic

8312 Lake Murray Blvd. Suite O

San Diego CA 92119

Witness to Patient's Signature:

Translated by:

To be completed by patient's representative, of necessary, e.g., if patient is a minor or physically or legally incapacitated:

_____
Print Name of Patient

_____
Print Name of Patient's Representative

_____
Signature of Patient's Representative

Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. We accept payment in the form of cash, check or credit card.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or considered necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Interest will be accrued at a rate of 18%. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

COVID-19 Pre-Visit Screening Survey

As essential healthcare workers, SAN DIEGO CHIROPRACTIC has been able to continue to serve our community with necessary chiropractic care. As such, we must do everything possible to mitigate risk to our staff and other members of the community so it is vitally important to you complete this form accurately prior to each visit.

Name: _____ Today's Date: _____

Have you been exposed to COVID-19 or do you believe that you have? ☐Yes ☐No

Please check any of the following symptoms you (or other members of your family that also have an appointment) are currently expressing:

☐ Shortness of breath ☐ Productive Cough ☐ Non-Productive Cough
☐ Bronchitis ☐ Respiratory infection ☐ Sore throat
☐ Fever ☐ Nausea ☐ Vomiting
☐ Diarrhea ☐ Severe fatigue (not related with travel)
☐ None of the above

Other: _____

Have you traveled to or from a high-risk geographic area in the past 14 days? ☐ Yes ☐No

If you are visiting SAN DIEGO CHIROPRACTIC with other family members, please list their names and which symptoms listed above (if any) they are currently experiencing:

_____

_____

By signing here, you are attesting that everything you stated above is truthful and accurate to the best of your knowledge.

_____ _____
Signed Date