| | 1 1 1 1 | Femalo Male Fatient d | to at halfs | intermental | | d |
|-----------------|---|---|---|-------------------|--|----------------|
| | | 2 agent to | TO OI DATE! | | 17771411-4 | 7 |
| | Patient address CF | ty | | State | Zía code | |
| ļ | Pationt Insurance ID# Hoath pien | | Group number | | | _] |
| | (LEFT BLANK) (LEFT | BLANK) | | T BLA | NK) | 7 |
| | Referring physician (if applicable) Provider Information | - | Referral number (if | | | _ = |
| | Rappahannock Rapidan Community Ser | rvices 23 | 7238 | 7218 | | ٦ |
| | 1. Name of the billing provider or facility (as it will appear on the sinks form) | | (TIN) or entity in box | | | _} |
| | | PT 4 OT 5 Both PT a | d OT 6 Home Ca | re 7 ATC 8 M | Other | |
| | 2. Name and credentials of the individual parterning the acrolled. Intant + Toddler Connection of Fire | | ODSE DY | | | _ ¬ |
| | RAPPA HANNICK RAPIDAN THER 4. Alterrante mutte (if any) of antity in box 81 | APIST NP | <u>(#)</u> | | 829-7480 | <u>)</u> |
| | 314 N. WEST STREET | CULPER | EP | | one number | 7 |
| | 7. Address of the billing provider or facility indicated in box #1 | a, City | <u> </u> | 9. Starts | 22701 | J |
| | Provider Completes This Section. | Date_of Sur | norv | Diagnos | is (ICD code) | 1 |
| | Date you want THIS submission to begin: Cause of Current Enlance | | I I | | isure all digita are red ecourately | _ |
| | submission to begin: Cause of Current Epiaode (1) Traumatic (4) Post-surgical - | Type of Surge | \ | 10 | | } |
| 7 | Unspecified (5) Work related | ACL Reconstruct | | 2* | | |
| | Patient Type (3) Repetitive (6) Motor vehicle | 2 Rotator Cutt/Lab | al Rep e ir | - | • | |
| \rightarrow | New to your office (#N i TYAL) | (3) Tendon Repair | | 3° | | T, |
| OR | (2) Est'd, new injury | (5) Joint Replacement | | <u> </u> | | 41 |
| > | (3) Est'd, new episode (A) Est'd, continuing care (REAUTH) | B Other | ı. | 4° | | |
| ٠, | DC ONLY | T Labour | WHORK AND THE | | | |
| | Mature of Condition (1) Initial onset (within last 3 months) - In ih a Anticipated CMT Level | 1 | | ional Measure : | <u>score</u> | |
| OR | 2 Recurrent (multiple episodes of < 3 months) 98940 98942 | Neck Inde | × | ASH | (other) | |
| <u>-</u> ⇒ | (3) Chronic (continuous duration > 3 months) | Back inde | x L | EF\$ | | |
| | Patient Completes This Section: | - <u>-</u> - | Indicate wher | e vou have pain | or other symptoms: | • |
| 7 | Symptoms began on: | | ļ | - y //w-0 pain | 4 | • |
| \ , | - ALL SECTIONS COMPLETED - | | 2 1 | | | |
| - | i. Direny describe your symptoms. | - / | -1 | 1 - 7 l | | |
| | 2. How did your symptoms start? | | $=\langle f \rangle$ | | | |
| - | | | 30% | May 15 | 1 295 | |
| { , | 3. Average pain intensity: Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) |) @ | | $\gamma^{(i)}$ | | |
| } | Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) |) (10) worst pain) (10) worst pain | الله الله الله الله الله الله الله الله | / | | |
| 4 | 1. How often do you experience your symptoms? | , , | | Apr. | 1 31 1 1 2 3 3 | |
| | (1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) | Occasionally (26% - 50% of | the time) (4) Inte | mittontly (0%-259 | of the time) | |
| 5 | . How much have your symptoms interfered with your usual daily | ^ | oth work outside the | home and house | vork) | · · · · · · |
| | (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 | | 2 | 6: A (-) | N | |
| | (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 | 3 - | | | | |
| | | 5) Poor | | | OF SIGN | |
| | | igN) | | 1 1 24 14 | | • • • • |

| | | | | | | | | €. | | |
|--|---------------------------------------|--|---|----------|---|-----------------------------------|-----------------|--|------------------------------|--|
| Patient Summary | Form PSF-750 (Rev. 2/18 | /20 09) | | | | | | Fleato Impelin As indi | e and fax to cated on Pte | its form, within the specific the specified fee number in Summary or plan info |
| Patient name Last | First | | Fer O Mel | | | | | matton | previously ; umber may : | provided. |
| | | | <u> </u> | | Facers | date of b | Hrtin | | | |
| Patient address | | | City | | | | | | State | Zip code |
| ation insurance Dr | | Health plan | | | | Grou | D Mulliber | | | |
| | | | | - | | T | | | - | · |
| rovidor Information | | - | sued it applicat | | | Rufe | rral number (if | applicat | le) | |
| Rappahannock Ra | | | ry Serv | Ces | | | 238 | | 3 | |
| tention of the mainly provided or taminy (at It was | appart on the cinine | | 2 DC 3 F | - Lb | | <u>`</u> | s Home C | | | |
| Name and credentials of the individual parter | ning the strvice(s | 1 | | | 8 BOOM P1 | | s Home C: | *** 7 · | ATC 8 A | Other |
| TNEANT & TODDI CONNECTION OF RA Alternate marrie (III arry) of entity in box #1 | PPAHAN | NO CK TRE | ADIDA | J | | | | | 54 | 0 829 748 |
| 314 N.WEST ST | | | 6. NPI of onliky in | | | 0.00 | | | | hore number |
| Address of the billing provider or facility indic | ated in box #1 | | | 8. City | JLPE | r e K | <u> </u> | | VA). State | 227 0 \ |
| Provider Completes This Section. | **** | | | | Date_of S | lituer. | , | | Diagno | sis (ICD code) |
| Date you want THIS submission to begin: Patient Type New to your office Est'd, new episode Est'd, continuing care ature of Condition Initial onset (within last 3 months) Recurrent (multiple episodes of < 3 3) Chronic (continuous duration > 3 m | 1 Traumatic 2 Unspecifie 3 Repetitive | Qurrent Epiace (4) Post-sc (5) Work in (6) Motor v DC O Anticipated () 98940 () 98941 | ungical — Adaled and and and and and and and and and an | | Vote of Sur- ACL Reconstit Rotator Cutt/L Tendon Repel Spinel Fusion Joint Replace Cither Neck II Back in | nuction Abral Re ir ment G ndex | urrent Fund | 1° 2° 3° 4° CHOMAI | | Score (other) |
| ationt Completes This Section: See fill in adjustions completely) Briefly describe your symptol | | ns began on: | | | | | indicate who | ere you | have pai | n or other sympto |
| . How did your symptoms start | ? | | | | | | | | | |
| Average pain intensity: Lest 24 hours: no pain 0 Past week: no pain 0 How often do you experience | ② ③ (your sympt | | 7 8 9 7 8 9 | 6 | worst pain | | SAN A | The state of the s | idali (| A A A A A A A A A A A A A A A A A A A |
| (1) Constantly (76%-100% of the time) . How much have your sympton (1) Not at all (2) A little bit | ns interfere | d with your i | usual daily | activit | l es? (Includi | | | | • • | 5% of the time) sework) |
| (1) Not at all (2) A little bit is. How is your condition chang (0) N/A — This is the initial visit | ng, since ca | . 0 | <i>thi</i> s facility | 7 | emely 4) No char | nge (5) | A little bette | er (6) | Better | (7) Much better |
| 7. In general, would you say you 1 Excellent 2 Very good | ı r overali he ③ Good | eaith right no 4 Fa | | Poor | | | | | | |
| Patient Signature: X | _ | | | | | | D | ate: | _ | |