

Otto E Snow
64 Leighton St
Bangor ME 04401-3851

2585517
Mar 26 2021 8:48 PM
OTTO SNOW

FL3026
Mar 31 2021 7:48 AM



97

CONFIDENTIAL - MEDICAL RECORDS

This packet may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient, please forward these records to the person(s) who handles medical records for your organization. Any misuse of this information is a violation of state and federal privacy laws and is strictly prohibited.

FLORIDA ORTHOPAEDIC INSTITUTE

Keeping you active.

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

In order to receive copies of your medical records and/or radiographic imaging (X-rays, MRI or CT scans) you are required to complete a Patient Authorization to Disclose Health Information form.

FULFILLMENT OF MEDICAL RECORD REQUEST: Due to high demand for records, the date this signed form to Disclose Health Information is received in the Patient Records Department (Telecom office), the request will be processed within **7-business days**. Holidays and weekends are excluded.

Your paper records will be mailed or sent electronically. There is a \$6.50 processing and mailing fee CD's of X-rays, MRI's or/CT's. This must be paid prior to mailing/emailing.

Please choose ONE delivery method below:

☒ ELECTRONICALLY ☐ MAIL

*please send as
pdf attachments*

Please print all information and sign where indicated below

Patient Name: Otto E Snow

DOB: 

Address: 64 Leighton St.

City: Bangor

State: ME

Zip: 04401

Phone #: 

Alternate: _____

Email Address: 

Fax #: _____

I hereby consent to the release and disclosure of my personal health information to:

(Please print the complete address. Any missing information may cause a delay in obtaining the records.)

Name (Organization if other than Patient): Otto E Snow

Address: 64 Leighton St.

City: Bangor

State: ME Zip: 04401

Fax #: _____

For the following purpose(s):

☒ Continuing Care ☒

Personal Use ☐

Info for Insurance ☐

Info for Attorney ☐

This authorization for release includes my personal health information consisting of:

Please select and specify below what is to be disclosed:

☐ Abstract of medical records; **Two years** of records including office notes, x-rays, CTs and MRI reports.

☐ Abstract of medical records; **One year** of records including office notes x-rays, CTs and MRI reports.

☐ Abstract of medical records; including office notes x-rays, CTs and MRI reports. **Date range:** _____

☐ Radiology Images; **date range:** _____

☒ Physical Therapy records; **date range:** Please include All PT Reports in Full

☐ Other (please be specific) _____

NOTE: Operative Reports must be obtained through the Hospital or Ambulatory Surgery Center where the procedure/surgery took place.

I understand that the information outlined in this release will be disclosed according to the instructions of this release within seven (7) business days of Florida Orthopaedic Institute's having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

This authorization will expire  of this request. This authorization is not valid if not completed.

Patient Signature: 

Date: 3/23/2021

Patient Records Request or additional information Phone Number: (813) 978-9700 Ext. 7136

*Thank you.
You guys are the best
Otto*

FLORIDA OR OPAEDIC INSTITUTE THERA. ARRIVAL LOG

PAT. NAME: OTTO SNOW MR#: 1027882 CLINIC: Telecom

Modalities/Procedures allowed/ visit: 4 units

Auth Required: ☐
Script Only: ☒

Ded. Amount: #VALUE! Ded. Met: Owes \$ #VALUE!

Max out of Pocket: \$2,000.00 Amount Met: \$94.58 Owes \$: \$1,905.42

Visit Limitations: 35 VISITS PER CAL YEAR COMBINED

Prescription Dates: 3/24/2014

RX LENGTH		# Visits	Auth'd	ARRIVAL DATE	USE ONLY	DATE: COMMUNICATION LOG	INITIALS
in visits					Auth Exp		
				4/11/14	✓	4/12/14	ns
				4/22/14	✓		
				4/25/14	✓		
				4/29/14	✓	6/13/14	pend 6/19/14
				5/2/14	⊙	2/7/14	ns
				5/3/14	⊙		
				5/9/14	⊙		
				5/13/14	⊙		
				5/16/14	⊙		
				5/20/14	⊙		
				5/23/14	⊙		
				5/27/14	⊙		
				5/29/14	⊙		
				6/11/14	⊙		
				6/24/14	⊙		
7/1/14	⊙						
19	19						
20	20						
21	21						
22	22						
23	23						
24	24						

DISCHARGE DATE: SAT SURVEY SENT DATE: INITIALS:

**FLORIDA ORTHOPAEDIC INSTITUTE THERAPY
BENEFIT VERIFICATION AND INSURANCE AUTHORIZATION FORM**

NPPES NPI Registry: [NPI Registry Search Home](http://www.nppes.com)

US Dept of Labor: [ACS Medical Bill Processing Portal - Home](http://www.dhs.gov/medicare)

AvMed: [AvMed for Providers and Healthcare Professionals](http://www.avmed.com)

Medicare: [medicare.gov](http://www.medicare.gov)

Tricare: [Humana Military Healthcare Services](http://www.tricare.mil)

Cigna: [Cigna](http://www.cigna.com)

United: <http://www.unitedhealthcareonline.com>

Availity [Log In to Availity®](http://www.availity.com)
Aetna [https://www.aetna.com](http://www.aetna.com)
Humana <http://www.humana.com/providers/>

Patient Name: OTTO SNOW		MR #: 1027882	Date: 4/1/2014
DOB: 1/15/56	Policy Number: H98019334	Dr. Palumbo	Tax ID: 592929608
Verifying: PT Benefits	CLINIC: Telecom		NPI: 1770784324
We will bill Place of Service: 11 OFFICE VISIT			If Medicare: FALSE
			If AvMed: FALSE
			If BCBS: 14PW2

Primary Insurance				Secondary Insurance			
Insurance Name:	BLUE CROSS	Effective:	2/1/14	Insurance Name:		Effective:	
Insurance Other Desc:	HEALTH OPTIONS	Expires:		Insurance Other Desc:		Expires:	
Is a Referral from PCP required	No			Is a Referral from PCP required			
Is Authorization Required?	No			Is Authorization Required?			
Therapy Visits Used this Year:	0			Therapy Visits Used this Year:			
Copay Amount:	\$20	Co-Insurance %:	0%	Copay Amount:		Co-Insurance %:	
Deductible Amount:	\$0.00	Deductible met:	\$0.00	Deductible Amount:		Deductible met:	
Max out of pocket:	\$2,000.00	\$ Amount met:	\$94.58	Max out of pocket:		\$ Amount met:	
Therapy Limitations:				Therapy Limitations:			
35 VISITS PER CAL YEAR COMBINED							
\$ Maximum per calendar year or insurance plan year? \$0.00 (Used)				\$ Maximum per calendar year or insurance plan year? (Used)			
Insurance:	BLUE CROSS			Insurance:			
Modality/Procedure/Unit Limit?:	4 units			Modality/Procedure/Unit Limit?:			
Restricted Procedures (CPT's):	97010, 97026, 97039			Restricted Procedures (CPT's):	#N/A		
Other Information: PER BCBS AUTH REP. AUTH IS NOT RQ REF@1-13451897671 MARTA S.				Other Information:			
Reference Number: AVAILITY/1-13451577221				Reference Number:			
Insurance Rep. Providing Information: MELY/AVAILITY				Insurance Rep. Providing Information:			
Authorization:				Authorization:			
From	To	Auth #/Name:	# Visits	Source	From	To	Auth #/Name:
SPLINT/ORTHOTIC AUTHORIZATION				SPLINT/ORTHOTIC AUTHORIZATION			
Splint/Orthotic Code:		DME Benefits:		Splint/Orthotic Code:		DME Benefits:	
DME Deductible Amount:		\$ Amount Met:		DME Deductible Amount:		\$ Amount Met:	
Copay:		Co-Insurance:		Copay:		Co-Insurance:	
Authorization Required:		Yes/No		Authorization Required:		Yes/No	
From	To	Auth #/Name:	# Units	Source	From	To	Auth #/Name:
Notes:				Notes:			

Therapy Representative: **TIA WILLIAMS**

PROVA # 412008 DR. P. LUMBO

Eligibility & Benefits Summary Results

[Learn More >>](#)

Transaction ID: 3234008376 Customer ID: 2279 Transaction Date: April 1, 2014

Physical Therapy

Patient Name: SNOW, OTTO
Date of Birth: 01/15/1956
Member ID: H98019334
Gender: Male

Payer: FLORIDA BLUE



Subscriber Information

Address 1: 9177 JENA RD
City, ST, Zip: SPRING HILL, FL 34608-4765
Plan: 02/01/2014 - 12/31/9999
Plan Begin: 01/01/2014
Plan End: 12/31/2014

Group Number: 99999
Plan Sponsor Name: QHP INDIVIDUAL UNDER65 ALL COP

[View Less](#)

Plan/Product Information

MARIA S. DEPI-13451891671
NO AUTH REQ

Status: Active Coverage

Service Type: Physical Therapy
Plan/Product: ALL COPAY PLAN 1491

Message: THIS MEMBER IS IN THE 1ST MONTH OF GRACE PERIOD. CLAIMS WILL BE PROCESSED ACCORDING TO THE TERMS OF THE MEMBER'S CONTRACT. ADDITIONAL CLAIMS INCURRED IN THE 2ND OR 3RD MONTH MAY BE PENDED UNTIL THE OUTSTANDING PREMIUM IS PAID IN FULL.

Payer: BLUECARE 1491
Address 1: PO BOX 1798
City, ST, Zip: JACKSONVILLE, FL 32231-0014

Status: Active Coverage

Service Type: Health Benefit Plan Coverage
Plan/Product: ALL COPAY PLAN 1491

[View Less](#)

Primary Care Provider

Primary Care Provider: MENEZES, LAKSHMI

Telephone: (352) 686-3991

National Provider Identifier: 1518983345

Address 1: 10494 NORTHCLIFFE BLVD
City, ST, Zip: SPRING HILL, FL 34608

Primary Care
Provider: 03/29/2005

[View Less](#)

Pre-Existing Information

Status: Pre-existing Condition
Coverage Level: Individual
Service Type: Plan Waiting Period
Message: PRE-EXISTING IS WAIVED

[View Less](#)

Other or Additional Payer

Date of Last
Update: 01/14/2014
Message: MEMBER HAS VERIFIED ONLY BCBSF COVERAGE

[View Less](#)

Service Type - Physical Therapy - In Network

View Additional Benefits

Eligibility & Benefit Information	Coverage Level	Auth/Cert Required	Amount	Quantity	Place Of Service	Time Period	Description
Co-Payment	Individual	No	\$10.00 Collect Payment		Office	Visit	BLUE PHYSICIAN RECOGNITION
	Individual	No	\$10.00 Collect Payment		Office	Visit	FAMILY PHYSICIAN
	Individual	No	\$300.00 Collect Payment		Outpatient Hospital	Visit	FACILITY BENEFIT
	Individual	No	\$20.00 Collect Payment		Outpatient Hospital	Visit	PHYSICIAN BENEFIT
Limitations		No		35 Visits	Outpatient Hospital		COMBINED FACILITY THERAPY MAXIMUM INCLUDES PT - HOSPITAL, OT, PT - PHYSICIAN, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

No	35 Visits	Outpatient Hospital	Remaining	COMBINED FACILITY THERAPY MAXIMUM INCLUDES PT - HOSPITAL, OT, PT - PHYSICIAN, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
No	35 Visits	Outpatient Hospital		COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY
No	35 Visits	Outpatient Hospital	Remaining	COMBINED PHYSICIAN THERAPY MAXIMUM INCLUDES PT - PHYSICIAN, OT, PT - HOSPITAL, SPEECH, CARDIAC REHAB - HOSPITAL, CARDIAC REHAB - PHYSICIAN, SPINAL MANIP, MASSAGE THERAPY

Out of Pocket (Stop Loss)	Family	\$4,000.00	Calendar Year
	Family	\$3,905.42	Remaining
	Individual	\$2,000.00	Calendar Year
	Individual	\$1,905.42	Remaining

Message:

\$94.58

Other or
Additional Payer: MEMBER HAS VERIFIED ONLY BCBSF COVERAGE

Benefit
Disclaimer: UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF
PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS
ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS MAY CHANGE AS ADDITIONAL CLAIMS
ARE PROCESSED.

Hide Messages


Coverage Guidelines Florida Blue Products and Plans

Eligibility & Benefits Summary Results

[Learn More >>](#)

Transaction ID: 3234018375 Customer ID: 2279 Transaction Date: April 1, 2014

Professional (Physician) Visit - Office

Patient Name: SNOW, OTTO
Date of Birth: 
Member ID: H98019334
Gender: Male

Payer: FLORIDA BLUE



Subscriber Information

Address 1: 9177 JENA RD
City, ST, Zip: SPRING HILL, FL 34608-4765

Group Number: 99999
Plan Sponsor Name: QHP INDIVIDUAL UNDER65 ALL COP

Plan: 02/01/2014 - 12/31/9999
Plan Begin: 01/01/2014
Plan End: 12/31/2014

[View Less](#)

Plan/Product Information

Status: Active Coverage

Service Type: Professional (Physician) Visit - Office
Plan/Product: ALL COPAY PLAN 1491

Message: THIS MEMBER IS IN THE 1ST MONTH OF GRACE PERIOD. CLAIMS WILL BE PROCESSED ACCORDING TO THE TERMS OF THE MEMBER'S CONTRACT. ADDITIONAL CLAIMS INCURRED IN THE 2ND OR 3RD MONTH MAY BE PENDING UNTIL THE OUTSTANDING PREMIUM IS PAID IN FULL.

Payer: BLUECARE 1491
Address 1: PO BOX 1798
City, ST, Zip: JACKSONVILLE, FL 32231-0014


Status: Active Coverage

Service Type: Health Benefit Plan Coverage
Plan/Product: ALL COPAY PLAN 1491

[View Less](#)

Primary Care Provider

Primary Care Provider: MENEZES, LAKSHMI

Telephone: 

National Provider Identifier: 1518983345

Address 1: 10494 NORTHCLIFFE BLVD
City, ST, Zip: SPRING HILL, FL 34608

Primary Care
Provider: 03/29/2005

[View Less](#)

Pre-Existing Information

Status: Pre-existing Condition
Coverage Level: Individual
Service Type: Plan Waiting Period
Message: PRE-EXISTING IS WAIVED

[View Less](#)

Other or Additional Payer

Date of Last
Update: 01/14/2014
Message: MEMBER HAS VERIFIED ONLY BCBSF COVERAGE

[View Less](#)

Service Type - Professional (Physician) Visit - Office - In Network

View Additional Benefits

Eligibility & Benefit Information	Coverage Level	Auth/Cert Required	Amount	Quantity	Place Of Service	Time Period	Description
Co-Payment	Individual	Yes	\$10.00 Collect Payment			Visit	BLUE PHYSICIAN RECOGNITION; AUTHORIZATION FOR PROVIDER ADMINISTERED DRUGS NOT APPLICABLE FOR DRUGS ADMINISTERED IN AN EMERGENCY ROOM, OBSERVATION UNIT OR DURING AN INPATIENT STAY.
	Individual	No	\$10.00 Collect Payment			Visit	CONVENIENT CARE CENTER
	Individual	No	\$10.00 Collect Payment			Visit	FAMILY PHYSICIAN - CONVENIENT CARE CENTER
	Individual	No	\$10.00 Collect Payment			Visit	SPECIALIST - CONVENIENT CARE CENTER
	Individual	Yes	\$10.00 Collect			Visit	FAMILY PHYSICIAN; AUTHORIZATION FOR PROVIDER

			Payment		ADMINISTERED DRUGS NOT APPLICABLE FOR DRUGS ADMINISTERED IN AN EMERGENCY ROOM, OBSERVATION UNIT OR DURING AN INPATIENT STAY.
Individual	Yes	\$20.00	Collect Payment	Visit	SPECIALIST; AUTHORIZATION FOR PROVIDER ADMINISTERED DRUGS NOT APPLICABLE FOR DRUGS ADMINISTERED IN AN EMERGENCY ROOM, OBSERVATION UNIT OR DURING AN INPATIENT STAY.
Individual	Yes	\$10.00	Collect Payment	Visit	AUTHORIZATION FOR PROVIDER ADMINISTERED DRUGS NOT APPLICABLE FOR DRUGS ADMINISTERED IN AN EMERGENCY ROOM, OBSERVATION UNIT OR DURING AN INPATIENT STAY.
Out of Pocket (Stop Loss)	Family	\$4,000.00		Calendar Year	
	Family	\$3,905.42		Remaining	
	Individual	\$2,000.00		Calendar Year	
	Individual	\$1,905.42		Remaining	

Message:

Other or Additional Payer: MEMBER HAS VERIFIED ONLY BCB&F COVERAGE

Benefit Disclaimer: UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

Hide Messages

Coverage Guidelines Florida Blue Products and Plans

FLORIDA ORTHOPAEDIC INSTITUTE

Medical History Summary

Patient Name: OTTO SNOW MR#: 1027882 Cell Phone #: _____

Please complete this brief history form of alert your therapist to your current medical condition. Completing this form enables the therapist to proceed immediately with your evaluation in the absence of your full medical record. We appreciate your cooperation.

Date of Injury/Illness: Hernia 11/12 Date of Surgery: 11/12 ☐ N/A

Job Title: Publisher

Description of Job Duties: _____

Please circle your response below and list any additional information:

Do you have any metal, plates, pins, screws or joint replacements? YES ☒ NO

If yes, please list: _____

Do you have any broken bones? YES ☒ NO

Are you currently taking any medication(s)?

If yes, please list:

Lorazepam, Navane, Singular, Vit D

Are you allergic to anything? YES ☒ NO

If yes, please list:

mold, any cortizone type meds

Have you had heart surgery? YES ☒ NO

If yes, please list: _____

Do you have a hearing aid? YES ☒ NO

Do you wear dentures?

YES ☒ NO

For women: Are you pregnant? YES ☒ NO

Please check if you have any of the following conditions?

- | | |
|---|---|
| <input type="checkbox"/> Heart condition or disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke (TIA or CVA) |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis (Osteoarthritis) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other |

ALL Patients: (please complete)

Are you currently receiving Home Health Therapy or Therapy in a Skilled Nursing facility? ☐ Yes ☒ No

☐ I have had previous Physical Therapy/Occupational Therapy for this condition / different condition in 2013.

Please circle

Please circle

Condition Treated: _____ Approximate visits: _____

Condition Treated: _____ Approximate visits: _____

Patient's Signature: _____ Date: 4/16/14

Therapist's Signature: [Signature] Date: 4-16-14

FLORIDA ORTHOPAEDIC INSTITUTE REHABILITATION CENTER
Patient Financial Responsibility Acknowledgement

*The following information was provided to us by your insurance company.
Please review and sign below to confirm your acknowledgement and understanding.*

PATIENT NAME: **OTTO SNOW** MR#: **1027882**
PRIMARY INSURANCE: **BLUE CROSS** Other: **HEALTH OPTIONS**
SECONDARY INSURANCE: Other:

	PRIMARY INS.	SECONDARY INS.	SPLINTS/ ORTHOTICS
Deductible Amount			
Ded. Amount Met			
Ded. Amount Owed			
Co-pay	\$20.00		
Co-Insurance			
Maximum out of pocket	\$2,000.00		
Maximum out of pocket met	\$94.58		
Benefits expire			
Authorization required	No		
Authorization Number/Name			
			Code Auth:

PRIMARY Ins. Limitations

35 VISITS PER CAL YEAR COMBINED
Dollar Maximum Per
Calendar/Insurance plan year
if applicable

Other:

PER BCBS AUTH REP. AUTH IS NOT RQ REF@1-13451897671 MARTA S.

SECONDARY Ins. Limitations

Dollar Maximum Per
Calendar/Insurance plan year if
applicable

Other:

***** Insurance Benefit Information Notice: (Patient please read fully)**

This does not constitute a guarantee of payment or an exact amount of your co-pay, co-insurance or deductible. This is a description of benefits from your insurance company given to us at this time. Should a dispute arise between this estimation and your Insurance Company Explanation of Benefits (EOB), the Patient Responsibility noted on your Insurance Explanation of Benefits (EOB) shall prevail. We urge you to contact your insurance company, at the phone number listed on your insurance card, and confirm these benefits, and review your Insurance EOB's as they come to you. In this way we can work together to ensure your financial responsibility.

SIGNATURE: _____

DATE: 4/16/14

WITNESS: _____

DATE: 4/16/14

FLORIDA ORTHOPAEDIC INSTITUTE

Account #: 1027882
Today's Date: 04/01/14
Recall: 062012

Appt Date: 04/02/14
Patient Bal: .00
Insurance Bal: 869.00


-----Patient Information-----Employer Information-----

Name: OTTO SNOW
Addr: 9177 JENA RD

Name: SELF EMPLOYED
Addr:

Phone: SPRING HILL FL 34608-4765

Phone: 999-999-9999

Dob: 
SS#

Sex: (M) MS: S Init.

ACCOUNT EMAIL:

-----Responsible Party Information-----Emergency Contact-----

Name: OTTO SNOW
Addr: 9177 JENA RD
SPRING HILL FL 34608-4765

Name:
Phone: -

Rltn 5 Init.

-----Referring Physician-----Primary Care Provider-----

Name: CHIRAG N PATEL, MD
Addr: STE 330
13906 LAKESHORE BLVD
HUDSON FL 34667
Phone: 727-863-7766

Name: MUKESH H MEHTA, MD
Addr: STE 250
17222 HOSPITAL BLVD
BROOKSVILLE FL 34601
Phone:

-----Primary Insurance-----Secondary Insurance-----

BCBS HEALTHOPTIONS HMO HEALTH INS
Ins Type: I
Policy: H98019334
Group: 99999
Subscriber: OTTO SNOW
1. BC01 2. 3. 4. 5.

Ins Type: P
Policy:
Group:
Subscriber:
6. 7. 8. Init.

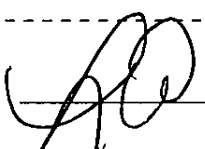
PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU BEING SEEN TODAY FOR AN AUTO RELATED ACCIDENT? YES NO ☒
2. ARE YOU BEING SEEN TODAY FOR A WORK RELATED ACCIDENT? YES NO ☒
3. IN THE PAST YEAR (SINCE 1/1/13), HAVE YOU HAD OR ARE YOU CURRENTLY PARTICIPATING IN OUTPATIENT PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY SERVICES, INCLUDING IN HOME HEALTH SETTING? YES NO ☒
4. IF YOUR INSURANCE IS MEDICARE, DO YOU CURRENTLY RESIDE IN OR HAVE YOU RESIDED IN A SKILLED NURSING FACILITY IN THE PAST 30 DAYS? YES NO ☒

BLUECARE HMO
PO BOX 1798
JACKSONVILLE FL 32231

ADJ NAME:
ADJ PHONE:
DATE OF INJ:
INS PHONE#:

Comments:

PATIENT SERVICE REP INITIALS: 



Patient: Otto Simon

Clinic: _____

Diagnosis: SI sprain/strain

MR #: _____

Sig. Medical Hx: _____

Next MD Visit: _____

Treatment Flow Sheet

Visit # (continuation)	1/ /	2/ /	3/ /	4/ /	5/ /	6/ /	7/ /	8/ /	9/ /	10/ /	11/ /	12/ /
Date:	6-24-14	6-24-14	6-24-14	6-26-14	7-1-14							
Modality/Exercise												
TM 3-way	2'ea	2'ea		2'	2'							
Car Canal	x10	x10										
Bridges	x10	x10										
Single leg bridge (alt)	2x10	2x10	2x10	4x5 3x10	4x5 3x10							
Track starts												
SIL hip BR	1x 3x10	1x 3x10	1x 3x10	1x 3x10	1x 3x10							
IR												
OK 40'	↓	↓	↓	↓	↓							
plank	2x11	2x11										
short med at stop	x30	x30	x30	x30	x30							
short med & ball	x30	x30	x30	x30	x30							
cred with	⑤ 1L	⑤ 1L	⑤ 1L	⑤ 1L	⑤ 1L							
monster with	⑤ 1L	⑤ 1L	⑤ 1L	⑤ 1L	⑤ 1L							
hip on Rung guard			2x10									
table bridge single leg			2x10	2x10	2x10							
standing T-band hip BR			② 2x10	② 2x10	② 2x10							
IR			② 2x10	② 2x10	② 2x10							
standing p.r. find at ball			3x20	3x20	3x20							
stop up 10"				x13	x15							
manual 2u notes					10'							
therapist Initials	MS, B.	B.	MS	MS	MS							

Telecom

FLORIDA
ORTHOPAEDIC
INSTITUTE

MR #: 1027882

Patient: OTTO SNOW

Keeping you active.

Next MD Visit:

5 | 1 | 1 | 2 |

Diagnosis: SI sprain/strain

Sig Medical HX:

Insurance: **BLUE CROSS** HEALTH OPTIONS

Restricted Modalities/Procedures: 97010, 97026, 97039

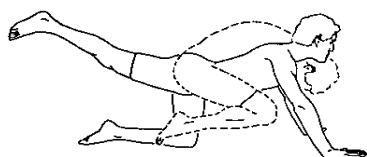
[illegible]

CHART COPY

Routine For:
Created By: Matthew Blevins, DPT, MTC

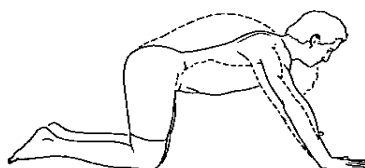
Jun 26, 2014

BACK - 15 Knee-to-Chest Stretch (All-Fours)



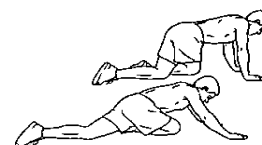
With back rounded, pull right knee in toward chest, then push leg backward, straightening knee and flattening back.
Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

BACK - 14 Angry Cat Stretch



Tuck chin and tighten stomach, arching back.
Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

BACK - 101 Piriformis Stretch (All-Fours)



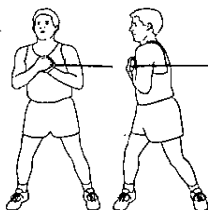
WE DO THIS AT THE TABLE WITH YOU STANDING ON LEFT LEG AND RIGHT LEG ON TABLE

With right leg crossed in front, slide other leg back, lowering hips until stretch is felt. HOLD 30 SECONDS
Repeat 3 times per set. Do _____ sets per session.
Do 1 sessions per day.

REHAB: TRUNK - 3 Rotation: Standing

STAND ON RIGHT LEG

Side toward anchor in shoulder width stance. Hands overlapping at chest, rotate body away from anchor.



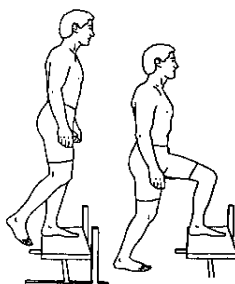
Repeat 10 times per set.
X Repeat to other side.
Do 3 sets per session.
Do 3 sessions per week.

Anchor Height: Chest

HIP / KNEE - 52 Step-Down / Step-Up

STEP UPS LEADING WITH RIGHT LEG

Repeat 10 times per set.
Do 3 sets per session.
Do 1 sessions per day.



TRUNK STABILITY - 13 Bridging: with Straight Leg Raise



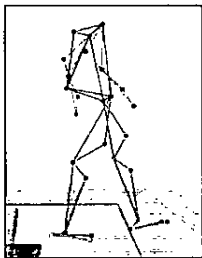
WE DID THIS AT THE LOW MAT TABLE

With legs bent, lift buttocks _____ inches from floor. Then slowly extend left knee, keeping stomach tight.
Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

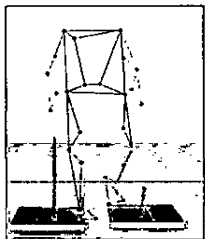
Congratulations on Completing Your Motion Analysis of Running!

Your personal data have been presented to you in a series of pictures about how your joints move in space. The reflective markers placed on your body reflected the infrared light from the camera rings around you during the test. The reflected light was captured by the cameras and the signals were processed by the computer. From this information, we created a 3 dimensional skeleton model of you while you run.

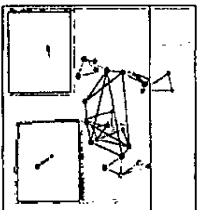
We measured your motion in three planes:



the sagittal plane (from the side)



the frontal plane (from the front)



the transverse plane (looking down from the top)

- * key is muscle weakness
- * anterior pelvic tilt
- * Left side of SI joint is "better" than right side
- * possible nerve impingement in spine (right toes unable to lift toes during descent in walking - makes loud steps.
- * consider EMG testing for the nerve testing (nerve conduction)
- * STRENGTHENING and STRETCHING IN PELVIS
core, lower extremity

Each of your joint motions was tracked during the gait cycle. A gait cycle is the time from one heel strike to the strike of the same foot again. The motion of the ankle, knee, hip, and pelvis are presented in the three planes. Information on your temporalspatial characteristics of your gait (cadence, step lengths and center of mass displacement) is provided.



GAIT CYCLE PHASES

Foot strike	Mid-stance	Late stance	Push off	Swing	Foot Strike
0% of cycle			~65%		100%

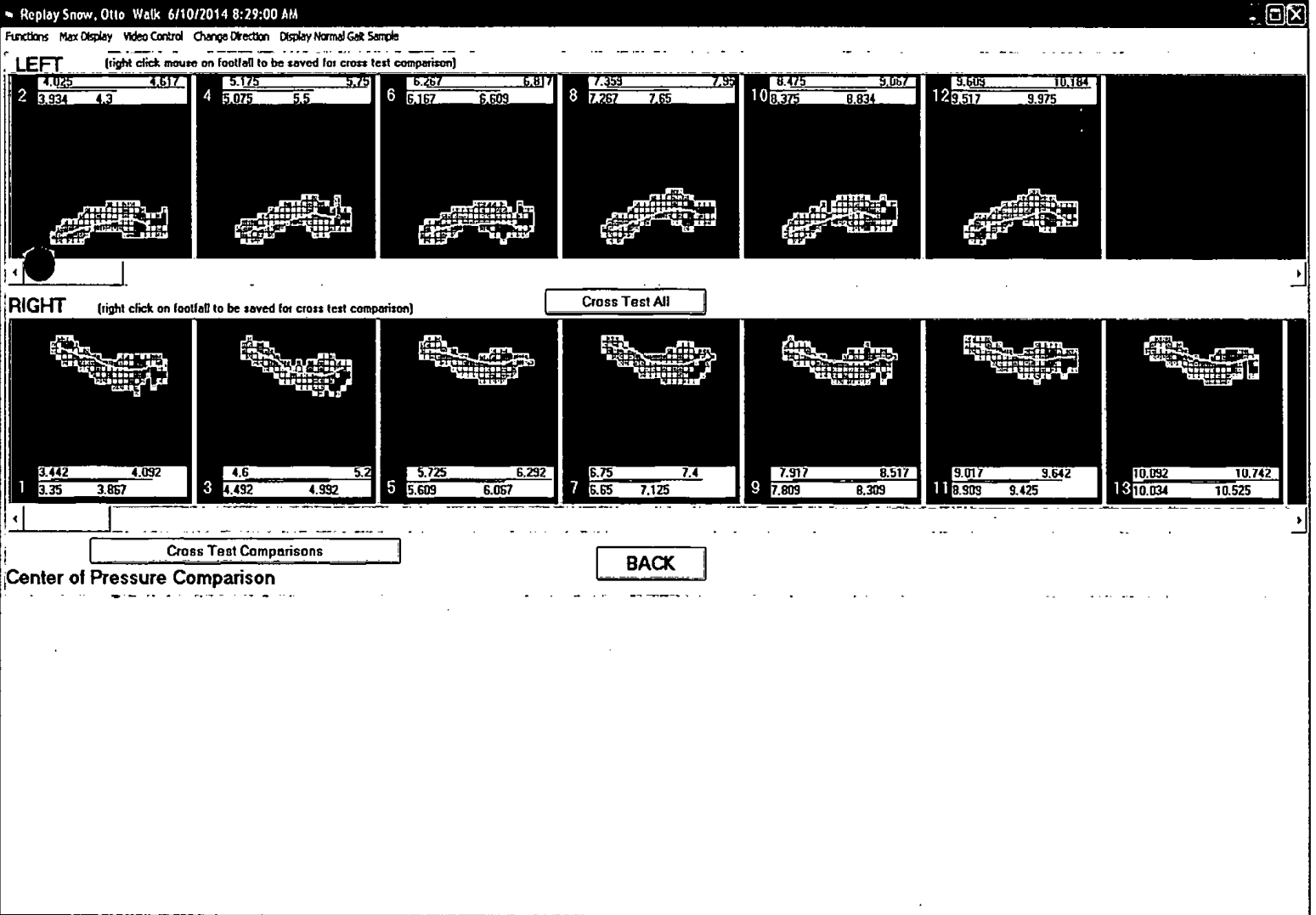
WALKING
WITH
SHOES

PARAMETER DESCRIPTION	Total/Left	Right
Step Count	33	
Distance	2120.77	
Ambulation Time	19.76	
✕ Velocity	107.3	
✕ Cadence	100.2	
Normalized Velocity	1.14	
Step Time Differential	0.04	
Step Length Differential	4.696	
Cycle Time Differential	0.005	
Functional Amb. Profile	94	
Leg Length(cm)	94.5	93
Step Time(sec)	0.617	0.577
✕ Step Length(cm)	62.131	66.827
Step Extremity(ratio)	0.66	0.72
Cycle Time(sec)	1.195	1.19
Stride Length(cm)	129.177	128.796
✕ HH Base Support(cm)	18.423	18.361
Swing Time(sec)	0.431	0.402
Stance Time(sec)	0.764	0.788
Single Supp. Time(sec)	0.402	0.431
Double Supp. Time(sec)	0.361	0.361
✕ Swing % of Cycle	36.1	33.8
✕ Stance % of Cycle	63.9	66.2
Single Supp % Cycle	33.6	36.2
Double Supp % Cycle	30.2	30.3
Toe In / Out	10.3	10.9
HeelOffOn Time	0.129	0.057
HeelOffOn Perc	10.8	4.8
Double Supp Load Time	0.175	0.186
Double Supp Load %GC	14.6	15.6
Double Supp Unload Time	0.186	0.174
Double Supp Unload %GC	15.6	14.6
Stride Velocity	108.169	108.3
Step Len Std Dev	2.707	2.484
Step Time Std Dev	0.021	0.015
Stride Length Std Dev	4.177	3.228
Stride Time Std Dev	0.025	0.023
Swing Time Std Dev	0.019	0.013
Stance Time Std Dev	0.021	0.016
Stride Velocity Std Dev	4.925	4.43
Single Supp Time Std Dev	0.013	0.019
Double Supp Time Std Dev	0.019	0.017
Heel Off On Std Dev	0.086	0.023
Supp Base On Std Dev	2.487	2.051
Foot Length	30.6	30.7
Foot Width	9.826	10.042
Standardize Amb Ti		
Trigger 1 First (0/1)		
Trigger 2 First (0/1)		
Trigger 1 Last (0/1)		
Trigger 2 Last (0/1)		

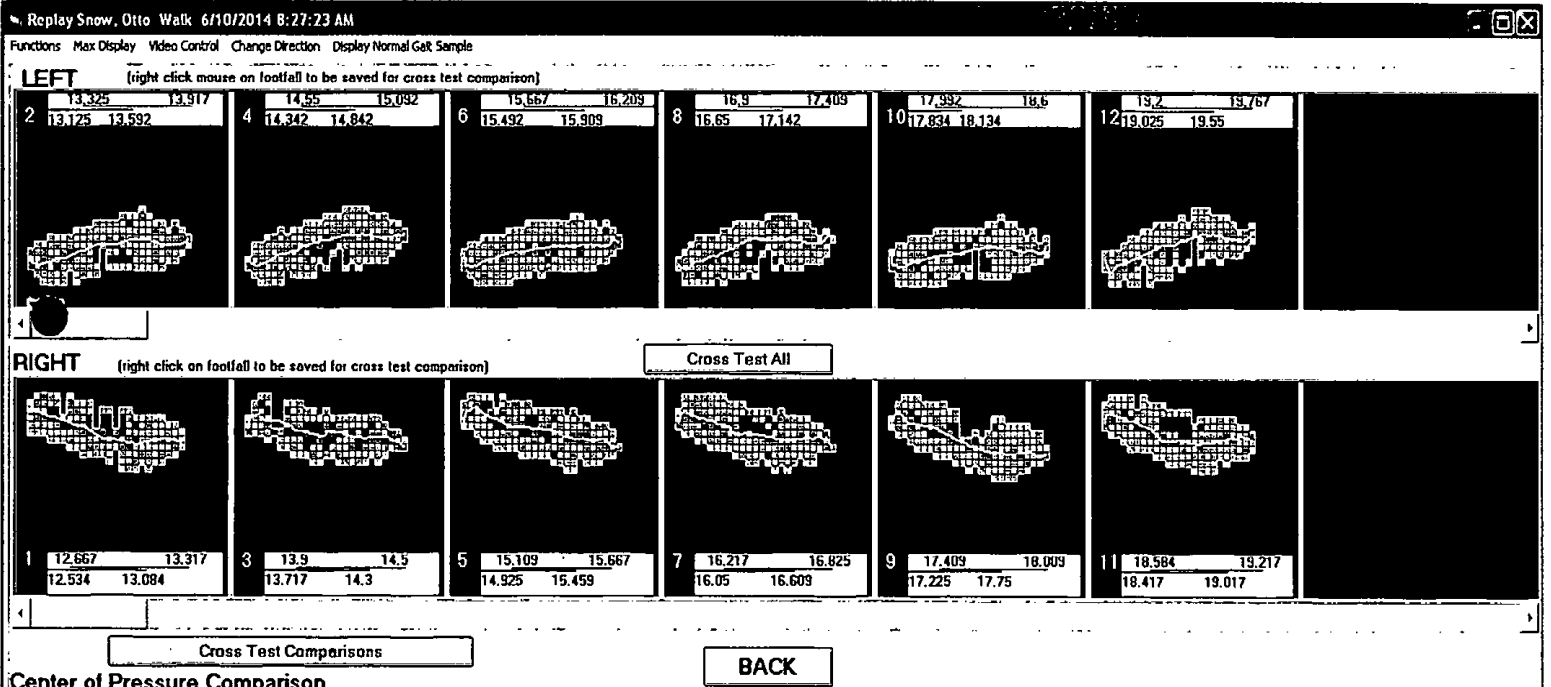
WALKING
BAREFOOT

PARAMETER DESCRIPTION	Total/Left	Right
Step Count	37	
Distance	2161.28	
Ambulation Time	20.92	
Velocity	103.3	
Cadence	106.1	
Normalized Velocity	1.1	
Step Time Differential	0.031	
Step Length Differential	4.79	
Cycle Time Differential	0.005	
Functional Amb. Profile	89	
Leg Length(cm)	94.5	93
Step Time(sec)	0.581	0.55
Step Length(cm)	56.083	60.873
Step Extremity(ratio)	0.59	0.65
Cycle Time(sec)	1.135	1.13
Stride Length(cm)	117.37	117.353
HH Base Support(cm)	18.775	18.581
Swing Time(sec)	0.445	0.41
Stance Time(sec)	0.69	0.72
Single Supp. Time(sec)	0.41	0.445
Double Supp. Time(sec)	0.278	0.274
Swing % of Cycle	39.2	36.3
Stance % of Cycle	60.8	63.7
Single Supp % Cycle	36.1	39.4
Double Supp % Cycle	24.5	24.2
Toe In / Out	7.3	10.7
HeelOffOn Time	0.127	0.08
HeelOffOn Perc	11.2	7.1
Double Supp Load Time	0.14	0.138
Double Supp Load %GC	12.3	12.2
Double Supp Unload Time	0.139	0.136
Double Supp Unload %GC	12.2	12
Stride Velocity	103.521	103.955
Step Len Std Dev	2.914	2.116
Step Time Std Dev	0.02	0.027
Stride Length Std Dev	4.264	3.91
Stride Time Std Dev	0.033	0.04
Swing Time Std Dev	0.02	0.028
Stance Time Std Dev	0.027	0.024
Stride Velocity Std Dev	5.301	4.843
Single Supp Time Std Dev	0.028	0.02
Double Supp Time Std Dev	0.023	0.021
Heel Off On Std Dev	0.063	0.033
Supp Base On Std Dev	1.832	1.407
Foot Length	25.6	26.2
Foot Width	7.225	6.993
Standardize Amb Ti	.	.
Trigger 1 First (0/1)	.	.
Trigger 2 First (0/1)	.	.
Trigger 1 Last (0/1)	.	.
Trigger 2 Last (0/1)	.	.

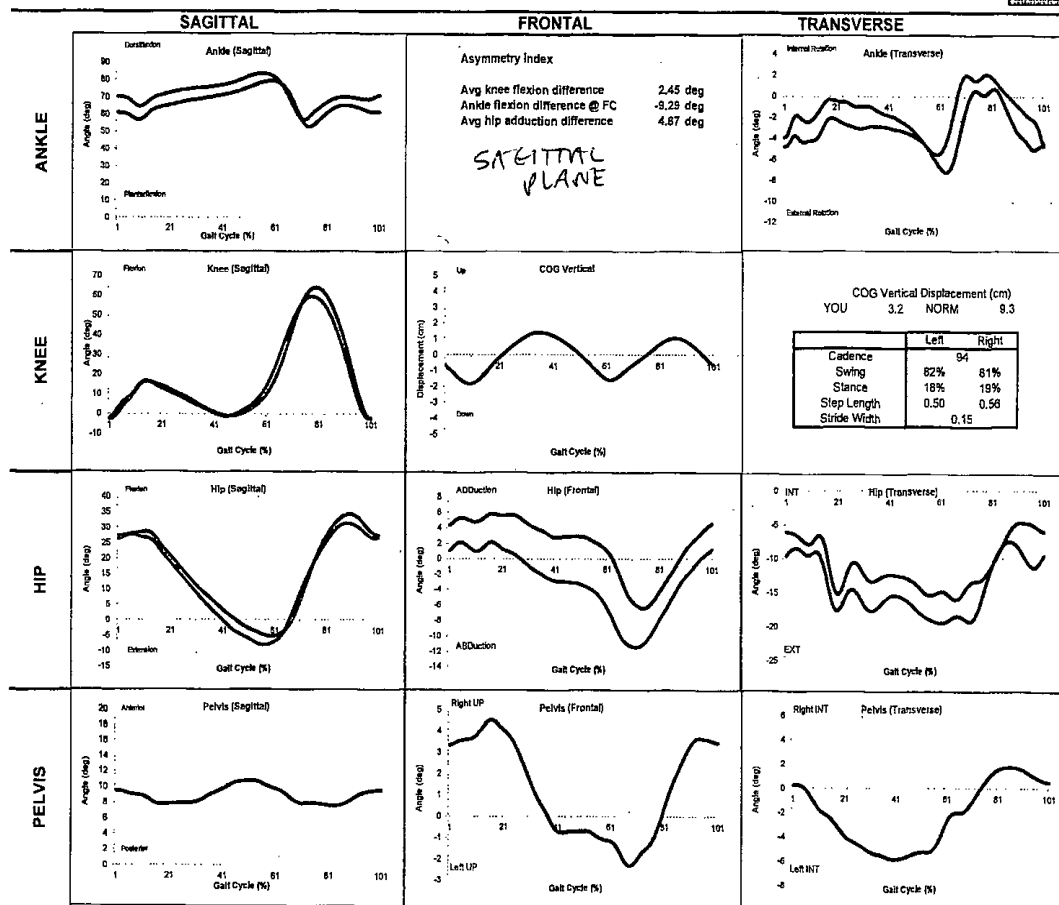
Barefoot

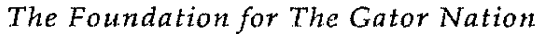


Shod



ID 2524
Date 6/10/2014
Speed 1.9 mph





**Department of Orthopaedics
& Rehabilitation
PO Box 112727
Gainesville FL 32611
352-273-7073
352-273-7388
Contact: Darlene Bailey
bailede@ortho.ufl.edu**

INVOICE

Invoice #: 110

Invoice Date: 6/10/2014

Terms: Net 45 days

Customer Information:

Billing Address:	
Company:	
Name:	Otto Snow
Address:	9177 Jena Road
City/State/Zip	Spring Hill, FL 34608

Date	Product Description	Quantity	Rate	Amount
6/10/2014	Gait Analysis, Motion Analysis	1	295	295
				0
				0
				0
				0
Comments: Please make checks payable to: <i>University of Florida</i> Method: check CK# 2200				
			Grand Total:	\$295

CK. NO. 2200
DATE Internal Use Only

<div style="text-align: right;">DATE: </div> <div style="text-align: center;">Internal Use Only</div>	
Principle Investigator: Study Name: Project #:	
Deposit: 29170100	

CHART COPY

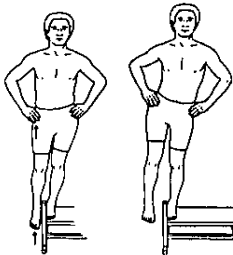
FLORIDA
ORTHOPAEDIC
INSTITUTE
Keeping you active.

Routine For:
Created By: Matt Weaver, PT, DPT, MTC

May 20, 2014

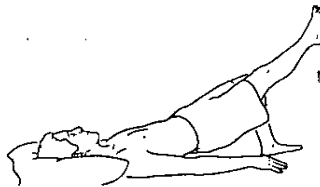
HIP / KNEE - 56

Stand on step, left leg
off step, knee straight.
Raise unsupported hip,
keeping knee straight.



Repeat 10 times
per set.
Do 3 sets
per session.
Do 1 sessions
per day.

TRUNK STABILITY - 13 Bridging: with Straight Leg Raise

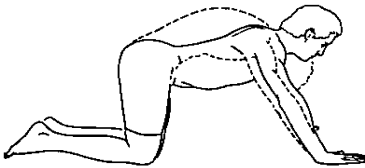


With legs bent, lift buttocks _____ inches from floor. Then
slowly extend right knee, keeping stomach tight.

Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

CHART COPY

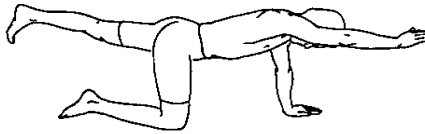
BACK - 14 Angry Cat Stretch



Tuck chin and tighten stomach, arching back.

Repeat 10 times per set. Do 2 sets per session.
Do 1 sessions per day.

BACK - 10 Arm / Leg Extension: Alternate (All-Fours)



Raise right arm and opposite leg. Do not arch neck. Then Switch.

Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

CHART COPY

Routine For:
Created By: Michele Bochert, MA, ATC, LAT

May 07, 2014

Crab Walk

With tubing loop wrapped around your shoes, slightly bend your knees and make sure your feet are facing forward. Side step across the room (____ feet) keeping knees bent and maintaining feet forward. Then side step back across the room, leading with opposing leg. Repeat this ____ times.

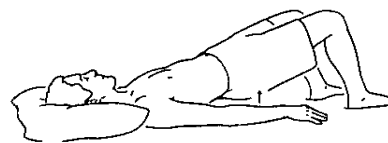


Monster Walk

Place tubing loop around ankles. Keep feet facing forward and knees straight, walk across the room, swinging each leg out and around to take a step. Maintain feet facing forward and knees straight. Walk ____ feet. Repeat this exercise ____ times.

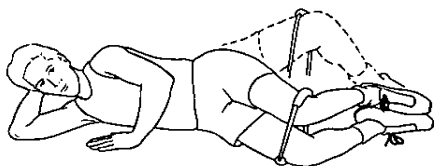


TRUNK STABILITY - 9 Bridging



Slowly raise buttocks from floor, keeping stomach tight.
Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

REHAB: LOWER EXTREMITY - 6 Hip Abduction: Side-Lying (Single Leg)



Lie on side with knees bent, tubing around thighs just above knees. Raise top leg, keeping knee bent.
Repeat 10 times per set. ____ Repeat on other side.
Do 3 sets per session. Do ____ sessions per week.

CHART COPY

Routine For:
Created By: Michele McCoy, MA, ATC, LAT

Apr 29, 2014

SLR Glut Medius

Lying on your side with affected leg as your top leg, straighten knee and pull toes towards you. Lift leg about 8 inches and then move it back, not allowing your hip to roll backwards. Hold this position for _____ seconds. Return to starting position. Repeat _____ times. Do _____ sets.



Double 90's

Lying on your side, slide your bottom knee up until your hip and knee are at a 90 degree angle. Maintaining a 90 degree angle at your hip and knee, raise your foot up so that your knee rotates down. Then lower your foot so that your knee rotates up. Repeat this exercise _____ times.



Triple 90's

Lying on your side, bend top leg so that your hip is at 90 degrees and your knee is bent to 90 degrees. Keep knee elevated, do not allow your hip to rotate forward so that your knee is resting on the table. Slowly raise your foot so that your knee rotates down. Then slowly lower foot so that your knee rotates up. Repeat this exercise _____ times.



Crab Walk

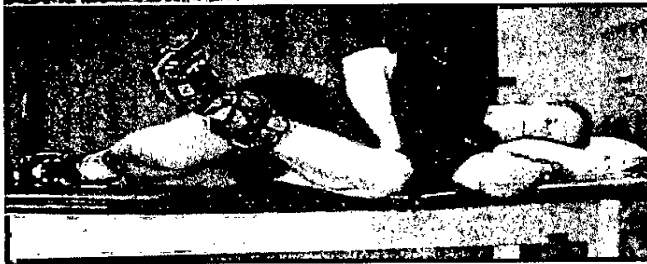
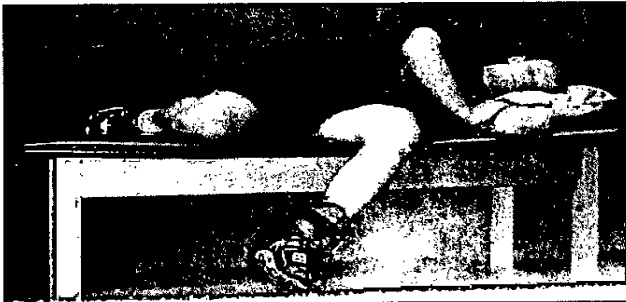
With tubing loop wrapped around your shoes, slightly bend your knees and make sure your feet are facing forward. Side step across the room (_____ feet) keeping knees bent and maintaining feet forward. Then side step back across the room, leading with opposing leg. Repeat this _____ times.



Monster Walk

Place tubing loop around ankles. Keep feet facing forward and knees straight, walk across the room, swinging each leg out and around to take a step. Maintain feet facing forward and knees straight. Walk _____ feet. Repeat this exercise _____ times.

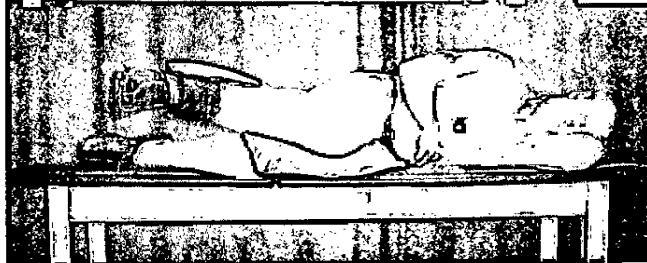
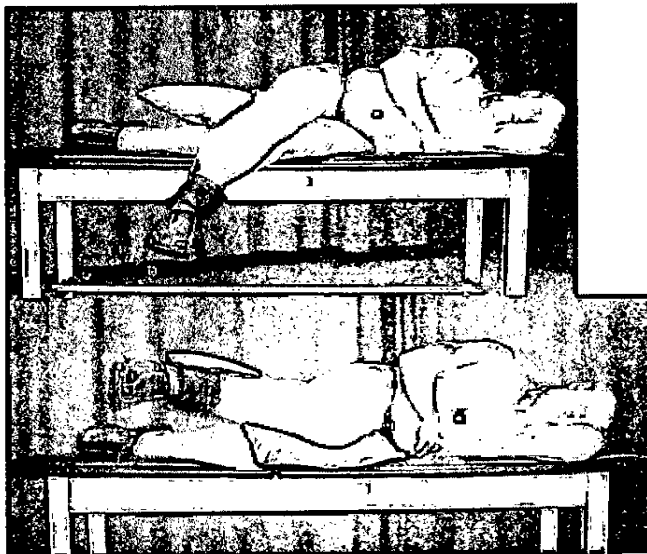




Lay on _____ side. Rotate
BOTTOM hip to bring foot
up.
Slowly lower foot to start
position.

Perform _____ sets of
_____ repetitions.

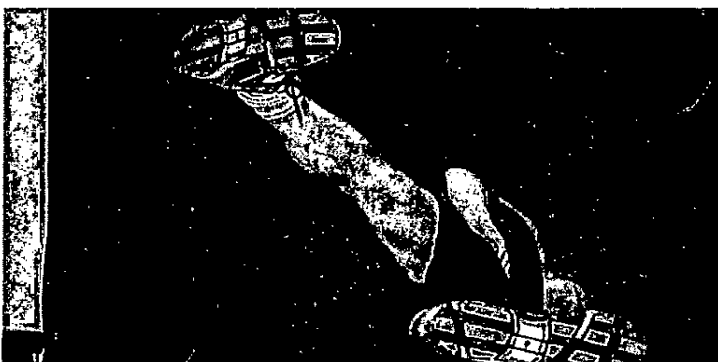
Perform _____ times a day.



Lay on _____ side. Rotate
UPPER hip to bring foot up.
Slowly lower foot to start
position.

Perform _____ sets of
_____ repetitions.

Perform _____ times a day.



Lay on _____ side. Kick
UPPER leg UP and BACK at
a 45 degree angle.

Perform _____ sets of
_____ repetitions.

Perform _____ times a day.



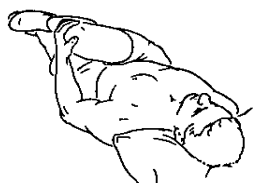
CHART COPY

FLORIDA
ORTHOPAEDIC
INSTITUTE
Keeping you active.

Routine For:
Created By: Matthew Blevins, DPT, MTC

Apr 16, 2014
Lumbar Routine

HIP / KNEE - 66 Stretching: Piriformis (Supine)



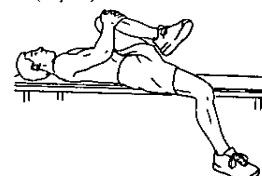
Pull right knee toward opposite shoulder. Hold 30 seconds. Relax.
Repeat 3 times per set. Do sets per session.
Do 2 sessions per day.

HIP / KNEE - 48 Piriformis (Supine)



Cross legs, left on top. Gently pull other knee toward chest until stretch is felt in buttock/hip of top leg. Hold 30 seconds.
Repeat 3 times per set. Do sets per session.
Do 2 sessions per day.

SPINAL MOBILIZATION - 32 Pelvic Rotation: Knee-to-Chest (Supine)



With right leg hanging over side of bench, other knee to chest, relax leg as much as possible. Hold 30 seconds. Relax.
Repeat 3 times per set. Do sets per session.
Do 2 sessions per day.

UPPER LEG - 1 Quadriceps



USE A BELT OR STRAP TO ASSIST

Lying on stomach with thighs together, gently pull ankle toward buttocks until stretch is felt. Hold 30 seconds. Repeat with other ankle.
Repeat 3 times. Do 2 sessions per day.

HEAT IN THE MORNING

ICE OTHERWISE

10-15 MIN

2-3 TIMES A DAY

. OF THERAPY BILLING GUIDELINES

Aetna: Cannot Bill: 1) 95831/95851 together MMT Ext.&Trunk/ROM Ext& Trunk 2) 95832/95852 together MMT hand/Rom hand 3) 97033 into	Auto: General: 1) First visit require signed GREEN D&A Form 2) Therapist and Patient sign bottom of charge ticket daily 3) Must have secondary insurance which FOI is a provider																																																																																																																																			
Blue Cross Blue Shield of Florida General: Cannot Bill Hot/cold pack 97010 Infrared 97026 Out of State: varies by state confirm benefits Iontophoresis 97033 ADL 97535	AVMED: 1) Cannot bill 97010 Managed Care: General: 1) Consult Arrival Log to identify insurance restrictions 2) No ROM/MMT's procedures w/in 30 days of each other 3) No Eval/Re-eval w/in 30 days of each other																																																																																																																																			
Medicare: General: 1) Complete billing worksheet for time/service based units 2) Modifiers: GP: by all Physical Therapy charges GO: by all Occupational Therapy charges -59: distinct separate site/procedure/time period KX: when \$1900 cap reached and patient has valid exception 4) Medicare Special codes: Electric Stim (97014) bill as G0283 5) Cannot bill Hot/cold pack 97010 Anodyne Infrared 97039 * Infrared 97026: Cannot bill on Diabetic wounds, ulcers, neuropathies		3) 8 min rule guideline: 0-7 min 0 units 8-22 min 1 unit 23-37 min 2 units 38-52 min 3 units 53-67 min 4 units 68-82 min 5 units 83-97 min 6 units																																																																																																																																		
Tricare: 1) Cannot Bill Hot/Cold pack 97010 2) Cannot Bill Anodyne 97039 3) Cannot Bill Infrared 97026	United: 1) Cannot Bill Hot/Cold pack 97010 2) Electrical Stim use G0283 3) Cannot Bill Anodyne 97039 , Bill Infrared 97026																																																																																																																																			
US Dept of Labor: Cannot Bill 1) Hot Pack/ Coldpack 97010 MMT 97752 2) Can Bill: PT Eval * 97001 OT Eval * 97003 * 1 per claim every 6 mths.	<table><tr><th colspan="2">Modifiers:</th></tr><tr><td>97140</td><td>97530 (59)</td></tr><tr><td>97012</td><td>97140 (59)</td></tr><tr><td>all</td><td>97002 (59)</td></tr><tr><td>all</td><td>97004 (59)</td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>	Modifiers:		97140	97530 (59)	97012	97140 (59)	all	97002 (59)	all	97004 (59)					<table><tr><th>CPT</th><th>Supplies:</th><th>W/C</th><th>Non-WC</th></tr><tr><td>99070</td><td>electrodes 2x2</td><td>\$4.00</td><td></td></tr><tr><td></td><td>electrodes 2x4</td><td>\$5.75</td><td></td></tr><tr><td></td><td>45 cm Ball</td><td>\$14.00</td><td>\$23.00</td></tr><tr><td></td><td>55 cm Ball</td><td>\$16.75</td><td>\$27.50</td></tr><tr><td></td><td>65 cm Ball</td><td>\$19.50</td><td>\$32.00</td></tr><tr><td></td><td>75 cm Ball</td><td>\$31.00</td><td>\$41.00</td></tr><tr><td></td><td>9" Overball</td><td>\$8.50</td><td>\$14.00</td></tr><tr><td></td><td>Hybresis Patch</td><td>\$10.00</td><td>\$10.00</td></tr><tr><td></td><td>home pulley</td><td>\$10.00</td><td>\$16.00</td></tr><tr><td></td><td>cerv/std ice/hot pack</td><td>\$15.50</td><td>\$25.00</td></tr><tr><td></td><td>lumbar ice/hot pack</td><td>\$23.00</td><td>\$38.00</td></tr><tr><td></td><td>putty 4oz.</td><td>\$4.50</td><td>\$7.00</td></tr><tr><td></td><td>otoform 2 oz.</td><td>\$5.00</td><td>\$8.50</td></tr><tr><td></td><td>otoform 4 oz.</td><td>\$10.00</td><td>\$16.25</td></tr><tr><td></td><td>otoform 6 oz.</td><td>\$15.00</td><td>\$24.50</td></tr><tr><td></td><td>silicone 1/4</td><td>\$9.00</td><td>\$14.50</td></tr><tr><td></td><td>silicone 1/2</td><td>\$17.00</td><td>\$28.25</td></tr><tr><td></td><td>coban 1" (per roll)</td><td>\$1.50</td><td>\$2.00</td></tr><tr><td></td><td>digital gel tube (ea)</td><td>\$5.00</td><td>\$8.50</td></tr><tr><td></td><td>digital gel cap (ea)</td><td>\$4.50</td><td>\$7.50</td></tr><tr><td></td><td>buddy strap</td><td>\$2.50</td><td>\$3.75</td></tr><tr><td></td><td>Biofreeze 3 oz</td><td>\$8.00</td><td>\$12.75</td></tr><tr><td></td><td>Biofreeze 16 oz</td><td>\$25.00</td><td>\$41.00</td></tr><tr><td></td><td>Lumbar Roll</td><td>\$9.50</td><td>\$15.50</td></tr><tr><td></td><td>Ex. Handle</td><td>\$5.00</td><td>\$8.50</td></tr><tr><td></td><td>Mini Vibrator</td><td>\$15.00</td><td>\$24.00</td></tr><tr><td></td><td>Oedema Glove</td><td>\$5.50</td><td>\$8.50</td></tr><tr><td>L3030</td><td>Orthotics</td><td></td><td>\$65.00</td></tr></table>	CPT	Supplies:	W/C	Non-WC	99070	electrodes 2x2	\$4.00			electrodes 2x4	\$5.75			45 cm Ball	\$14.00	\$23.00		55 cm Ball	\$16.75	\$27.50		65 cm Ball	\$19.50	\$32.00		75 cm Ball	\$31.00	\$41.00		9" Overball	\$8.50	\$14.00		Hybresis Patch	\$10.00	\$10.00		home pulley	\$10.00	\$16.00		cerv/std ice/hot pack	\$15.50	\$25.00		lumbar ice/hot pack	\$23.00	\$38.00		putty 4oz.	\$4.50	\$7.00		otoform 2 oz.	\$5.00	\$8.50		otoform 4 oz.	\$10.00	\$16.25		otoform 6 oz.	\$15.00	\$24.50		silicone 1/4	\$9.00	\$14.50		silicone 1/2	\$17.00	\$28.25		coban 1" (per roll)	\$1.50	\$2.00		digital gel tube (ea)	\$5.00	\$8.50		digital gel cap (ea)	\$4.50	\$7.50		buddy strap	\$2.50	\$3.75		Biofreeze 3 oz	\$8.00	\$12.75		Biofreeze 16 oz	\$25.00	\$41.00		Lumbar Roll	\$9.50	\$15.50		Ex. Handle	\$5.00	\$8.50		Mini Vibrator	\$15.00	\$24.00		Oedema Glove	\$5.50	\$8.50	L3030	Orthotics		\$65.00
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all	97004 (59)																																																																																																																																			
CPT	Supplies:	W/C	Non-WC																																																																																																																																	
99070	electrodes 2x2	\$4.00																																																																																																																																		
	electrodes 2x4	\$5.75																																																																																																																																		
	45 cm Ball	\$14.00	\$23.00																																																																																																																																	
	55 cm Ball	\$16.75	\$27.50																																																																																																																																	
	65 cm Ball	\$19.50	\$32.00																																																																																																																																	
	75 cm Ball	\$31.00	\$41.00																																																																																																																																	
	9" Overball	\$8.50	\$14.00																																																																																																																																	
	Hybresis Patch	\$10.00	\$10.00																																																																																																																																	
	home pulley	\$10.00	\$16.00																																																																																																																																	
	cerv/std ice/hot pack	\$15.50	\$25.00																																																																																																																																	
	lumbar ice/hot pack	\$23.00	\$38.00																																																																																																																																	
	putty 4oz.	\$4.50	\$7.00																																																																																																																																	
	otoform 2 oz.	\$5.00	\$8.50																																																																																																																																	
	otoform 4 oz.	\$10.00	\$16.25																																																																																																																																	
	otoform 6 oz.	\$15.00	\$24.50																																																																																																																																	
	silicone 1/4	\$9.00	\$14.50																																																																																																																																	
	silicone 1/2	\$17.00	\$28.25																																																																																																																																	
	coban 1" (per roll)	\$1.50	\$2.00																																																																																																																																	
	digital gel tube (ea)	\$5.00	\$8.50																																																																																																																																	
	digital gel cap (ea)	\$4.50	\$7.50																																																																																																																																	
	buddy strap	\$2.50	\$3.75																																																																																																																																	
	Biofreeze 3 oz	\$8.00	\$12.75																																																																																																																																	
	Biofreeze 16 oz	\$25.00	\$41.00																																																																																																																																	
	Lumbar Roll	\$9.50	\$15.50																																																																																																																																	
	Ex. Handle	\$5.00	\$8.50																																																																																																																																	
	Mini Vibrator	\$15.00	\$24.00																																																																																																																																	
	Oedema Glove	\$5.50	\$8.50																																																																																																																																	
L3030	Orthotics		\$65.00																																																																																																																																	
Work Comp: General: 1) 4 procedures per visit (only) unless special written auth. to bill more ie) 2 Dx or body parts. 2) Supplies do not count as a procedure ie) can do 4 units plus a supply, (attach invoice) 3) No ROM/MMT procedures w/in 30 days of each other 4) Can Bill Initial Evaluation PT or OT 97001/97003 Follow up MMT= 97752 Follow up MMT+ROM= 97752 Follow up ROM= 95851 or 95852 HOT PACK 97010																																																																																																																																				
VA: 1) Modifiers: GP: by all Physical Therapy charges GO: by all Occupational Therapy charges																																																																																																																																				

FLORIDA ORTHOPAEDIC INSTITUTE

Physical Therapy Discharge Summary

Patient: Otto Snow

Date: 7/15/14

Physician: Palumbo

MR Number: 1027882

Diagnosis: SI sprain

Visits ordered/ attended: 17/18

TREATMENT:

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Neuro-muscular Re-education |
| <input checked="" type="checkbox"/> Manual Therapy | <input type="checkbox"/> Gait Training | <input type="checkbox"/> Heat / Ice |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Traction | <input type="checkbox"/> Other: _____ |

The patient was taught a home exercise program: ☒ complete ☐ incomplete ☐ none

The pt. is independent with the HEP as instructed. ☒ yes ☐ no ☐ unknown

PHYSICAL EXAMINATION:

☐ Last noted objective measurements dated: _____

☐ The patient was not available to be examined for this discharge summary. Initial presentation and measurements can be found on the evaluation dated: _____

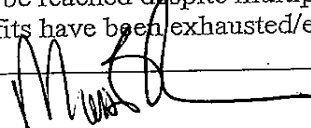
GOALS: (based on observation and assessment during recent appointments)
Initial goals can be found on the evaluation.

- | | | | | | |
|---------------------|---|----------------------------------|----------------------------------|---|-------|
| 1) ROM goals | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: | _____ |
| 2) Strength goals | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: | _____ |
| 3) Functional goals | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: | _____ |
| 4) Other: _____ | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: | _____ |

ASSESSMENT AND PLAN:

The patient will be discharged at this time because:

- ☐ the patient was discharged by the physician.
- ☒ the patient met all goals; instructed to continue HEP for ROM/strength.
- ☒ the patient can continue on an independent basis to regain final ROM/strength.
- ☐ the patient does not want to return to therapy because their condition improved.
- ☐ the patient does not want to return to therapy because they feel therapy has not helped.
- ☐ the patient cannot be reached despite multiple attempts.
- ☐ the patient's benefits have been exhausted/expired; patient offered private pay, but denied..
- ☐ other: _____

Therapist's Signature: 

Date: 7-15-14

OTTO SNOW DOB: [REDACTED] SEX: M AKA: HEALTH INS CBS HEALTHOPTIONS HMO ACCOUNT #: 1027882 ARGE SLIP: 5570609

07/01/14 EF30 12:30P INJ DATE: THERAPY COPAY: 20.00
 LAST SEEN BY INJ STATE: PT BALANCE: 20.00
 AUTH # 35VTS PERCALYR4MODNODED... TWILL INS BALANCE: 636.00
 DX: 8461 DX: DX: DX: 44
 REF PHYS: PAL BRIAN PALUMBO, MD INS FCP: COP CHIRAG N PATEL, MD
 POS: PTERI SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: Feeling a little stiff in @ hip		
97001	PT Evaluation					
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:		
97530	Therapeutic Activities	1 2 3 4 5		sm/mfc to @ pmtm		
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Proprioception <input type="checkbox"/> Posture <input type="checkbox"/> Coordination		
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: CP 5' in @ pmtm		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Progressing well to PT		
97597	Active wound care < 20 cm			D/C next visit		
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
G0283	Elec Stim. (MC & United)					
97018	Paraffin					
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			PLAN: [Signature] 7-1-14 THERAPIST SIGNATURE: [Signature]		
SPLINTING/ORTHOTICS/SUPPLIES				DATE:		CO-PAY/CO-INS. INFORMATION
SPLINT/ORTHOTIC #	QTY	L-Code	MOD	SCHEDULE/INSTRUCTIONS		SUPPLY PAYMENT INFORMATION
97760	Orthotics man. and training	1 2 3 4 5		1 2 3 4 5 times per week for week(s)		Amt Pd: \$ 20.00
97762	C/O for orthotic/prosthetic	1 2 3 4 5		Schedule w/ TEAM		Amt Pd: \$
L3030	Orthotics custom			SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		Payment Method: (circle one)
Supply 99070		FEE: \$75 deposit		SPECIAL SCHEDULING INSTRUCTIONS:		Payment Method: (circle one)
		FEE:		<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule <input type="checkbox"/> ME30 <input type="checkbox"/> ME50 <input type="checkbox"/> MP60 <input type="checkbox"/> # authorized visits left: 1 <input type="checkbox"/> Expiry Date:		VISA MC CASH DISC AMEX CHECK/CC # Initials:
MODIFIER EXPLANATION-List modifier next to CPT code				POOL THERAPY SCHEDULING:		
-59	Distinct separate site/procedure			Pool Visits		
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)			Land Visits		
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
 (Auto Related Injuries)

OTTO SNOW D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: [REDACTED] SEX: M COBS HEALTHOPTIONS HMO CHARGE SLIP: 5561730
 06/26/14 EP30 11:30A INJ DATE: THERAPY COPAY: 20.00
 LAST SEEN BY INJ STATE: PT BALANCE: 20.00
 AUTH # 35075PERCALYR4MODNODED... TWILL INS BALANCE: 368.00
 DX: 8461 DX: DX: DX:
 REF PHYS: PAUL BRIAN PALUMBO, MD INS PCP: COP CHIRAG N PATEL, MD
 POS: PFCU SNF PT? 33

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: <i>Left walking in 3mm ltr m 2</i>		
97001	PT Evaluation			<i>shoe and no problems</i>		
97002	PT Re-Evaluation			<i>Long morning task to need to "pop"</i>		
97003	OT Evaluation			<i>(K) ST then he is fine</i>		
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation			<i>Heal to sit and drive</i>		
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To Improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97530	Therapeutic Activities	1 2 3 4 5				
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input type="checkbox"/> OTHER:		
97035	Ultrasound	1 2 3 4 5		<i>CP 8' to Low Back/piriformis</i>		
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pl. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			<i>At needs to be consistent in life in 2 shoe</i>		
97597	Active wound care < 20 cm			<i>to make up for 4mm leg length.</i>		
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
60283	Elec Stim. (MC & United)					
97018	Paraffin			PLAN: <i>[Signature]</i>		
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			OD/C IN VISITS		
SPLINTING/ORTHOTICS/SUPPLIES				THERAPIST SIGNATURE:		DATE:
				SCHEDULING GUIDE		COPAY/CO-INS. INFORMATION
SPLINT/ORTHOTIC #:				1 2 3 4 5 times per week for week(s).		Amt Pd: \$
97760	Orthotics man. and training	1 2 3 4 5		Schedule w/ TEAM: <i>p51</i>		Amt Pd: \$
97762	C/O for orthotic/prosthetic	1 2 3 4 5		SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		Payment Method: (circle one)
L3030	Orthotics custom	FEE: \$75 deposit		SPECIAL SCHEDULING INSTRUCTIONS:		Payment Method: (circle one)
Supply		FEE:		<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		VISA MC CASH DISC AMEX
99070				<input type="checkbox"/> Medicare Schedule M350 M360 MP60		VISA MC CASH DISC AMEX
MODIFIER				<input type="checkbox"/> # authorized visits left: <i>2</i>		CHECK/CC #
MODIFIER EXPLANATION-list modifier next to CPT code				<input type="checkbox"/> Expiry Date:		CHECK/CC #
-59	Distinct separate site/procedure			POOL THERAPY SCHEDULING:		Initials: <i>TTO</i>
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)			Pool Visits		
KX	MC Annual Benefit Cap exceeded and qualifies for exception			Land Visits		

Patient Signature: _____
 (Auto Related Injuries)

OTTO SNOH D/A: HEALTH INS ACCOUNT #: 1027882
DOB: [REDACTED] SEX: M COBS HEALTHOPTIONS HMO CHARGE SLIP: 5561731
06/24/14 EP30 2:30P INJ DATE: THERAPY COFAY: 20.00
LAST SEEN AT INJ STATE: PT BALANCE: 20.00
AUTH: 95TSPERCALYR4MODNODED... TWILL INS BALANCE: 368.00
DX: 84.31 DX: DX: DX:
REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: CGP CHIRAG N PATEL, MD
POS: PTFOI SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: <i>Feels pressure on R peroneus today</i>		
97001	PT Evaluation					
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation			<i>LE can be slightly longer than L in supine</i>		
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To Improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97599	Therapeutic Activities	1 2 3 4 5				
97119	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: <i>CP 8 to Low Back</i>		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pl. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			<i>R hol R/L</i>		
97597	Active wound care < 20 cm			<i>Focus on R give max/med</i>		
97012	Mechanical Traction			<i>Needs 4mm latam L shoe</i>		
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
97028	Elec Stim. (MC & United)					
97018	Paraffin			PLAN <i>Mark</i> <i>6-24-14</i>		
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)					
SPLINTING/ ORTHOTICS/ SUPPLIES				THERAPIST SIGNATURE: <i>[Signature]</i> DATE: <i>6-24-14</i>		
SPLINT/ORTHOTIC #:	QTY	L-Code	MOD	SCHEDULING GUIDE		
97760	Orthotics man. and training	1 2 3 4 5		1 2 3 4 5 times per week for week(s).		
97762	C/O for orthotic/prosthetic	1 2 3 4 5		Schedule w/ TEAM: <i>[Signature]</i>		
L3030	Orthotics custom	FEE: \$65 deposit		SPECIAL SERVICES: <input type="checkbox"/> Wkly pool		
Supply 99070		FEE:		SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code			SUPPLY PAYMENT INFORMATION		
-59	Distinct separate site/procedure			Armt Pd: \$		
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)			Payment Method: (circle one) VISA MC CASH DISC AMEX		
KX	MC Annual Benefit Cap exceeded and qualifies for exception			CHECK/ CC #		
				Initials:		
				DATE: COPAY/CO-INS. INFORMATION		
				VISA MC CASH DISC AMEX		
				CHECK/ CC #		
				Initials:		
				POOL THERAPY SCHEDULING: <input type="checkbox"/> Land Visits		

Patient Signature: _____
(Auto Related Injuries)

OT TO SNOW D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/55 SEX: M S HEALTHOPTIONS HMO CHARGE SLIP: 5554811
 06/19/14 EP00 12:30P INJ DATE: THERAPY COFAY: 20.00
 LAST SEEN DT INJ STATE: PT BALANCE: 20.00
 AUTH #: 35UTSPERCALYR4MODNODED... TWILL INS BALANCE: 1412.00
 DX: S461 DX: DX: DX:
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: CGP CHIRAG N PATEL, MD
 POS: PTFOT SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY			
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:					
97001	PT Evaluation			It has been doing better overall had a joint assessment at UF					
97002	PT Re-Evaluation								
97003	OT Evaluation								
97004	OT Re-Evaluation								
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:					
97799	Func. Capacity Evaluation			Pain Level: /10					
95831	MMT Extremity, Trunk								
95851	ROM Meas. Extremity, Trunk								
64550	TENS Eval/Checkup								
97752	MMT (WC ONLY)			TREATMENT:					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD						
97113	Aquatic Therapy	1 2 3 4 5					<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5							
97112	Neuromuscular Reeducation	1 2 3 4 5							
97750	PPT/Isokinetic Test	1 2 3 4 5							
97530	Therapeutic Activities	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:					
97110	Therapeutic Exercise	1 2 3 4 5							
97140	Manual Therapy Techniques	1 2 3 4 5							
97116	Gait Training	1 2 3 4 5							
97033	Iontophoresis (No Aetna)	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination					
97032	Electrical Stimulation (Manual)	1 2 3 4 5							
97035	Ultrasound	1 2 3 4 5							
97039	Anodyne Infrared (No MC)	1 2 3 4 5							
NOTRMT	Pl. arrived but not treated			<input type="checkbox"/> OTHER: CP 8' to LBS/piriformis					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD						
97598	Active wound care > 20 cm						ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY): R to L R to R Will cont to build on therapy		
97597	Active wound care < 20 cm								
97012	Mechanical Traction								
97022	Whirlpool/Fluidotherapy								
97014	Elec Stim. (No MC & United)			PLAN: <i>[Signature]</i> 6-19-14 DD/C IN VISITS					
970283	Elec Stim. (MC & United)								
97018	Paraffin								
97016	Vasopneumatic treatment								
97026	Infrared			THERAPIST SIGNATURE: <i>[Signature]</i> SCHEDULING GUIDE: 1 2 3 4 5 times per week for week(s). Schedule w/ TEAM: <i>[Signature]</i> SPECIAL SERVICES: <input type="checkbox"/> Whirlpool SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME20 ME60 MP60 <input type="checkbox"/> # authorized visits left: <i>[Signature]</i> <input type="checkbox"/> Expiry Date: _____ POOL THERAPY SCHEDULING: Pool Visits _____ Land Visits _____					
97010	Hot/Cold Pack (WC and Auto only)								
SPLINTING/ ORTHOTICS/ SUPPLIES	QTY	L-Code	MOD						
SPLINT/ORTHOTIC #:									
97760	Orthotics man. and training	1 2 3 4 5		SUPPLY PAYMENT INFORMATION Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # _____ Initials: _____					
97762	C/O for orthotic/prosthetic	1 2 3 4 5							
L3030	Orthotics custom	FEE: \$65 deposit							
Supply 99070		FEE:							
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code								
-59	Distinct separate site/procedure								
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)								
KX	MC Annual Benefit Cap exceeded and qualifies for exception								

Patient Signature: _____
 (Auto Related Injuries)

FLORIDA ORTHOPAEDIC INSTITUTE
 13020 Telecom Parkway North, Tampa, FL 33637 - (813) 978-9700
 www.floridortho.com, TAX ID# 59-2929608

TOTAL COUNT #:	1027882
LARGE SLIP #:	5528421

THERAPY CO-PAY: 20.00

FT BALANCE: 40.00

INS BALANCE:	644.00
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INS FCP: CGP CHIRAG N PATEL, MD

DATE: 12/1/79

Rev. 11/4/2013

OTTO SNOW /A HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M LOBS HEALTHOPTIONS HMO LARGE SLIP: 5528614
 05/27/14 EF30 1:30P INJ DATE: F04-MATTHEW BLEVINS
 LAST SEEN DT INJ STATE: THERAPY COPAY: 20.00
 AUTH # 3005PERCALYR4MODNODE... TWILL PT BALANCE: 20.00
 DX: 8461 DX: DX: INS BALANCE: 900.00
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: COP CHIRAG N PATEL, MD
 PCP: PCP

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:			
97001	PT Evaluation			Pt. cc: cont joint med / pinjms			
97002	PT Re-Evaluation			pain / tightness			
97003	OT Evaluation						
97004	OT Re-Evaluation			Pain Level: /10			
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:			
97799	Func. Capacity Evaluation						
95831	MMT Extremity, Trunk						
95851	ROM Meas. Extremity, Trunk						
64550	TENS Eval/Checkup						
97752	MMT (WC ONLY)						
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:			
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To increase Rom <input checked="" type="checkbox"/> To increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To increase Strength <input checked="" type="checkbox"/> To increase flexibility <i>Swim</i>			
97535	Patient Education/ADL	1 2 3 4 5					
97112	Neuromuscular Reeducation	1 2 3 4 5					
97750	PPT/Isokinetic Test	1 2 3 4 5		<input checked="" type="checkbox"/> MANUAL THERAPY: <input checked="" type="checkbox"/> To increase Joint Mobility <input checked="" type="checkbox"/> To improve circulation <input checked="" type="checkbox"/> To decrease tightness/spasm <input checked="" type="checkbox"/> Other:			
97530	Therapeutic Activities	1 2 3 4 5		<input checked="" type="checkbox"/> SIL EXTER NET <input checked="" type="checkbox"/> SIL HIPSCOTT NET			
97110	Therapeutic Exercise	1 2 3 4 5		<input checked="" type="checkbox"/> NEUROMUSCULAR RE-ED: <input checked="" type="checkbox"/> Balance <input checked="" type="checkbox"/> Posture <input checked="" type="checkbox"/> Proprioception <input checked="" type="checkbox"/> Coordination			
97140	Manual Therapy Techniques	1 2 3 4 5					
97116	Gait Training	1 2 3 4 5					
97033	Iontophoresis (No Aetna)	1 2 3 4 5					
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: <i>Ice 45 min</i>			
97035	Ultrasound	1 2 3 4 5					
97039	Anodyne Infrared (No MC)	1 2 3 4 5					
NOTRMT	Pt. arrived but not treated						
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):			
97598	Active wound care > 20 cm			<i>At 10 exercises - no to back or joint</i> <i>med pain / tightness & drms</i>			
97597	Active wound care < 20 cm						
97012	Mechanical Traction						
97022	Whirlpool/Fluidotherapy						
97014	Elec Stim. (No MC & United)						
90283	Elec Stim. (MC & United)						
97018	Paraffin			PLAN: cont dx for <i>med</i>			
97016	Vasopneumatic treatment						
97026	Infrared						
97010	Hot/Cold Pack (WC and Auto only)			THERAPIST SIGNATURE: <i>Michael [Signature]</i> DATE: 5/27/14			
SPLINTING/ ORTHOTICS/ SUPPLIES				SCHEDULING GUIDE		COPAY/CO-INS. INFORMATION	
SPLINT/ORTHOTIC #:	QTY	L-Code	MOD	SUPPLY PAYMENT INFORMATION			
97760	Orthotics man. and training	1 2 3 4 5		1 2 3 4 5 times per week for ____ week(s). Schedule w/ TEAM: <i>4</i> SPECIAL SERVICES: <input type="checkbox"/> Whirlpool SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input type="checkbox"/> # authorized visits left: <i>6</i> <input type="checkbox"/> Expiry Date: _____ POOL THERAPY SCHEDULING: Pool Visits _____ Land Visits _____		Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # _____ Initials: <i>u</i>	
97762	C/O for orthotic/prosthetic	1 2 3 4 5					
L3030	Orthotics custom						
Supply 99070							
MODIFIER EXPLANATION-list modifier next to CPT code							
-59	Distinct separate site/procedure						
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)						
KX	MC Annual Benefit Cap exceeded and qualifies for exception						

Patient Signature: _____
 (Auto Related Injuries)

FLORIDA ORTHOPAEDIC INSTITUTE
 13020 Telecom Parkway North, Tampa, FL 33637 - (813) 979-9700
 www.floridaortho.com, TAX ID# 59-2829608

Rev 1/4/2013
 10 Short Therapy/THERAPY CHARGE TICKET Dec 2012 Printing: PO Therapy CT

Pay on Friday

OTTO SNOW D/O: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M CBS HEALTHOPTIONS HMO CHARGE SLIP: 5519137
 05/23/14 10:30A INJ DATE: THERAPY COPAY: 20.00
 LAST SEEN DT INJ STATE: PT BALANCE: 20.00
 AUTH #: 35VTSPHICALYR4MODNODED...TWILL INS BALANCE: 900.00
 DX: 8461 DX: DX: 31
 REF PHYS: FAL BRIAN FALUMBO, MD INS FCP: CBF CHIRAG N PATEL, MD
 POS: PTF01 SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: Feels like PT is working		
97001	PT Evaluation			scheduled for next lab visit		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:		
97530	Therapeutic Activities	1 2 3 4 5		<input checked="" type="checkbox"/> 1/2 hr hip ROM MET <input checked="" type="checkbox"/> 1/2 hr hip strength MET		
97110	Therapeutic Exercise	1 2 3 4 5		<input checked="" type="checkbox"/> NEUROMUSCULAR RE-ED: <input checked="" type="checkbox"/> Balance <input checked="" type="checkbox"/> Proprioception <input type="checkbox"/> Posture <input type="checkbox"/> Coordination		
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input type="checkbox"/> OTHER: OP to low back 10		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Pt not Rx with		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
00283	Elec Stim. (MC & United)					
97018	Paraffin			PLAN:		
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			THERAPIST SIGNATURE: DATE: DD/C IN VISITS		
SPLINTING/ ORTHOTICS/ SUPPLIES				THERAPIST SIGNATURE: SCHEDULING GUIDE		DATE: COPAY/CO-INS. INFORMATION
SPLINT/ORTHOTIC #:	QTY	L-Code	MOD	SUPPLY PAYMENT INFORMATION		DATE: COPAY/CO-INS. INFORMATION
97760	Orthotics man. and training	1 2 3 4 5		1 2 3 4 5 times per week (or) week(s) Schedule w/ TEAM: (4) SPECIAL SERVICES: <input type="checkbox"/> Wheelchair SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input type="checkbox"/> # authorized visits left: (7) <input type="checkbox"/> Expiry Date:		Amt Pd: \$ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # Initials:
97762	C/O for orthotic/prosthetic	1 2 3 4 5				Amt. Pd: \$ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # Initials:
L3030	Orthotics custom	FEE: \$85 deposit				
Supply 99070		FEE:				
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code					
-59	Distinct separate site/procedure					
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)					
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
 (Auto Related Injuries)

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18 Shared Therapy THERAPY CHARGE TICKET Dec 2012 Printing: POB Therapy CT Rev 11/2011

OTTO SNOW D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M CBS HEALTHOPTIONS HMO CHARGE SLIP: 5519134
 05/20/14 EP30 10:30A INJ DATE: THERAPY CO-PAY: 20.00
 LAST SEEN DT INJ STATE: PT BALANCE: 20.00
 AUTH #: 35VTSHERCALYR4MODNODED...TWILL INS BALANCE: 1101.00
 DX: 8461 DX: DX: DX:
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCF: CGF CHIRAG N PATEL, MD
 POS: RTFOI SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: <i>Feet that he is "off"</i>			
97001	PT Evaluation						
97002	PT Re-Evaluation						
97003	OT Evaluation						
97004	OT Re-Evaluation			Pain Level: /10			
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE: <i>Pt did a self mobilization exercise on @ leg (anterior click) then felt even/better</i>			
97799	Func. Capacity Evaluation						
95831	MMT Extremity, Trunk						
95851	ROM Meas. Extremity, Trunk						
64550	TENS Eval/Checkup						
97752	MMT (WC ONLY)						
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:			
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility			
97535	Patient Education/ADL	1 2 3 4 5					
97112	Neuromuscular Reeducation	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:			
97750	PPT/Isokinetic Test	1 2 3 4 5					
97530	Therapeutic Activities	1 2 3 4 5					
97110	Therapeutic Exercise	1 2 3 4 5		<input checked="" type="checkbox"/> NEUROMUSCULAR RE-ED: <input checked="" type="checkbox"/> Balance <input checked="" type="checkbox"/> Proprioception <input checked="" type="checkbox"/> Posture <input checked="" type="checkbox"/> Coordination			
97140	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> OTHER: <i>CP to LES</i>			
97116	Gait Training	1 2 3 4 5					
97033	Iontophoresis (No Aetna)	1 2 3 4 5					
97032	Electrical Stimulation (Manual)	1 2 3 4 5					
97035	Ultrasound	1 2 3 4 5					
97039	Anodyne Infrared (No MC)	1 2 3 4 5					
NOTRMT	Pt. arrived but not treated						
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):			
97598	Active wound care > 20 cm			<i>Pt did Rx well</i>			
97597	Active wound care < 20 cm			<i>Need a biomechanical assessment of foot - over pronator</i>			
97012	Mechanical Traction						
97022	Whirlpool/Fluidotherapy						
97014	Elec Stim. (No MC & United)						
60283	Elec Stim. (MC & United)						
97018	Paraffin			PLAN: <i>Try to not sleep on stomach & hip in ✓/R/L</i> <i>6-20-14</i>			
97016	Vasopneumatic treatment						
97026	Infrared						
97010	Hot/Cold Pack (WC and Auto only)			DATE: / /			
SPLINTING/ORTHOTICS/ SUPPLIES				THERAPIST SIGNATURE: <i>[Signature]</i>		DATE: / /	
QTY	L-Code	MOD	SCHEDULING GUIDE		SUPPLY PAYMENT INFORMATION		
SPLINT/ORTHOTIC #:				1 2 3 4 5 times per week for week(s).		DATE: / /	
97760	Orthotics man. and training	1 2 3 4 5	Schedule w/ TEAM: <i>[Signature]</i>		Amt Pd: \$		
97762	C/O for orthotic/prosthetic	1 2 3 4 5	SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		Amt. Pd: \$		
L3030	Orthotics custom	FEE: \$65 deposit	SPECIAL SCHEDULING INSTRUCTIONS:		Payment Method: (circle one)		
Supply 99070		FEE:	<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input type="checkbox"/> # authorized visits left: <i>[Signature]</i>		VISA MC CASH DISC AMEX CHECK/ CC # Initials:		
MODIFIER EXPLANATION-list modifier next to CPT code				POOL THERAPY SCHEDULING:		COPAY/CO-INS. INFORMATION	
-59	Distinct separate site/procedure			Pool Visits		Initials:	
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)			Land Visits			
KX	MC Annual Benefit Cap exceeded and qualifies for exception						

Patient Signature: _____
 (Auto Related Injuries)

FLORIDA ORTHOPAEDIC INSTITUTE
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Rev 1/1/2013
 US Shred Therapy/THERAPY CHARGE TICKET (Rev 2012) Printing: FOR Therapy CT

OTTO SNOW D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M - BCBS HEALTHOPTIONS HMO CHARGE SLIP: 5514787
 05/16/14 EP30 9:30A INJ DATE: F54-MATTHEW BLEVINS
 LAST SEEN AT INJ STATE: THERAPY CO-PAY: 20.00
 AUTH # 35VTSFPCALYR4MODNODED... TWILL PT BALANCE: 20.00
 DX: 8461 DX: DX: INS BALANCE: 825.00
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: CGP CHIRAG N PATEL, MD
 POS: PTFUI SNF PT? 20.

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: Falls like 57 on (R) 15 out clo to highest in (R) piriformis		
97001	PT Evaluation					
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:		
97530	Therapeutic Activities	1 2 3 4 5		(2) 5/1 hip BR in Met for manual motion (2) 5/1 hip scissor MET for distal fem.		
97119	Therapeutic Exercise	1 2 3 4 5		<input checked="" type="checkbox"/> NEUROMUSCULAR RE-ED: <input checked="" type="checkbox"/> Balance <input checked="" type="checkbox"/> Posture <input checked="" type="checkbox"/> Proprioception <input checked="" type="checkbox"/> Coordination		
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input type="checkbox"/> OTHER: UP to lumbar spine		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Died with a cell new therapy		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
60283	Elec Stim. (MC & United)					
97018	Paraffin			PLAN: M. 5-16-14		
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			DATE: 5-16-14		
SPLINTING/ ORTHOTICS/ SUPPLIES				THERAPIST SIGNATURE		DATE: 5-16-14
QTY	L-Code	MOD	SCHEDULING GUIDE		SUPPLY PAYMENT INFORMATION	DATE: 5-16-14
SPLINT/ORTHOTIC #:			1 2 3 4 5 times per week for week(s).		Amt Pd: \$	Amt. Pd: \$
97760	Orthotics man. and training	1 2 3 4 5	Schedule w/ TEAM: (2)		Payment Method: (circle one)	Payment Method: (circle one)
97762	C/O for orthotic/prosthetic	1 2 3 4 5	SPECIAL SERVICES: (2) Whirlpool		VISA MC CASH DISC AMEX	VISA MC CASH DISC AMEX
L3030	Orthotics custom	FEE: \$65 deposit	SPECIAL SCHEDULING INSTRUCTIONS:		CHECK/ CC #	CHECK/ CC #
Supply 99070		FEE:	<input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input type="checkbox"/> # authorized visits left: (9) <input type="checkbox"/> Expiry Date:		Initials:	Initials:
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code		POOL THERAPY SCHEDULING:			
-59	Distinct separate site/procedure		Pool Visits			
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)		Land Visits			
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
 (Auto Related Injuries)

OTTO SNOW
DOB: 01/15/56 SEX: M HEALTH INS
CBS HEALTHOPTIONS HMO

ACCOUNT #: 1027882
ARGE SLIP: 5509747

05/13/14 EF30 2:30P

INJ DATE:

THERAPY COPAY: 20.00

LAST SEEN IN

INJ STATE:

PT BALANCE: .00

AUTH #: 35VSPERCALYR4MODNODE... TWILL

INS BALANCE: 1613.00

DX: 84-61 DX: DX:

DX:

REF PHYS: FAL BRIAN PALUMBO, MD

INS PCP: CGP CHIRAG N PATEL, MD

PCP: FAL BRIAN PALUMBO, MD

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: less time of pain			
97001	PT Evaluation			hip 5 High 6/10			
97002	PT Re-Evaluation			Knee 5			
97003	OT Evaluation			IRC 5			
97004	OT Re-Evaluation			Pain Level: 10			
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:			
97799	Func. Capacity Evaluation			phunk 1mn			
95831	MMT Extremity, Trunk						
95851	ROM Meas. Extremity, Trunk						
64550	TENS Eval/Checkup						
97752	MMT (WC ONLY)						
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:			
97113	Aquatic Therapy	1 2 3 4 5		<input type="checkbox"/> THER EX SEE FLOW <input type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase flexibility			
97535	Patient Education/ADL	1 2 3 4 5					
97113	Neuromuscular Reeducation	1 2 3 4 5					
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:			
97530	Therapeutic Activities	1 2 3 4 5		9 IL MET session for iliac rot			
97110	Therapeutic Exercise	1 2 3 4 5					
97140	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination			
97116	Gait Training	1 2 3 4 5					
97033	Iontophoresis (No Aetna)	1 2 3 4 5					
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input type="checkbox"/> OTHER:			
97035	Ultrasound	1 2 3 4 5		CP 6 to 4:30pm			
97039	Anodyne Infrared (No MC)	1 2 3 4 5					
NOTRMT	Pt. arrived but not treated						
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):			
97598	Active wound care > 20 cm			Pt needs to have foot assessed for possible issues leading to ant rot of immobility			
97597	Active wound care < 20 cm						
97012	Mechanical Traction						
97022	Whirlpool/Fluidotherapy						
97014	Elec Stim. (No MC & United)						
00283	Elec Stim. (MC & United)						
97018	Paraffin			PLAN: cont. PPT			
97016	Vasopneumatic treatment			MKB 5-3-14			
97026	Infrared			DATE: 5-3-14			
97010	Hot/Cold Pack (WC and Auto only)			THERAPIST SIGNATURE: [Signature]			
SPLINTING/ ORTHOTICS/ SUPPLIES				SCHEDULING GUIDE		SUPPLY PAYMENT INFORMATION	
SPLINT/ORTHOTIC #:				1 2 3 4 5 times per week for week(s):		Amt Pd: \$	
97760 Orthotics man. and training				Schedule w/ TEAM: (4)		Amt Pd: \$	
97762 C/O for orthotic/prosthetic				SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		Payment Method: (circle one)	
L3030 Orthotics custom				SPECIAL SCHEDULING INSTRUCTIONS:		Payment Method: (circle one)	
Supply 99070				<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		VISA MC CASH DISC AMEX	
MODIFIER				<input type="checkbox"/> Medicare Schedule ME30 ME60 MP60		CHECK/ CC #	
-59 Distinct separate site/procedure				<input type="checkbox"/> # authorized visits left: (4)		CHECK/ CC #	
GP/GO GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)				<input type="checkbox"/> Expiry Date:		Initials:	
KX MC Annual Benefit Cap exceeded and qualifies for exception				POOL THERAPY SCHEDULING:		Initials:	
				Pool Visits		Land Visits	

Patient Signature: _____
(Auto Related Injuries)

FLORIDA ORTHOPAEDIC INSTITUTE
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www.floridortho.com, TAX ID# 59-2929608

(1) Shared Therapy / THERAPY CHANGE TICKET Due 2012 Pricing, POI Therapy CT

OTTO SNOW D/A: HEALTH INS
DOB: 01/15/56 SEX: M BOBS HEALTHOPTIONS HMO

ACCOUNT #: 1027882
CHARGE SLIP: 5504651
F54-MATTHEW BLEVINS
THERAPY COPAY: 20.00
PT BALANCE: .00
INS BALANCE: 1418.00

05/09/14 EP30 11:30A INJ DATE:
LAST SEEN DT INJ STATE:
AUTH #: 35VTSFPERCALYR4MODNODED...TWILL
DX: S461 DX: DX: DX:
REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: CGP CHIRAG N PATEL, MD
POS: PTFOT SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			<i>I feel the muscle on the right side of my back; it's been out since 7-8 days of the back. The back is still sore and it's hard to sit.</i>		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT: <input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility <i>See physical</i>		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD			
97113	Aquatic Therapy	1 2 3 4 5				
97535	Patient Education/ADL	1 2 3 4 5				
97113	Neuromuscular Reeducation	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To Improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5				
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5				
97035	Ultrasound	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: <i>I am 45 Supine & LE @ 90</i>		
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pl. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD			
97598	Active wound care > 20 cm			ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY): <i>Pl. did not do 45 pin & the</i>		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)			PLAN: <i>cont per OT</i>		
90283	Elec Stim. (MC & United)					
97018	Paraffin					
97016	Vasopneumatic treatment					
97026	Infrared			THERAPIST SIGNATURE: <i>Michael J. [Signature]</i> DATE: 5/9/14 SCHEDULING GUIDE: 1 2 3 4 5 times per week for ____ week(s). Supply Payment Information: Amt Pd: \$ ____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC #: ____ Initials: ____ COPAY/CO-INS. INFORMATION: Amt. Pd: \$ ____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC #: ____ Initials: ____		
97010	Hot/Cold Pack (WC and Auto only)					
SPLINTING/ ORTHOTICS/ SUPPLIES	QTY	L-Code	MOD			
SPLINT/ORTHOTIC #:						
97760	Orthotics man. and training	1 2 3 4 5				
97762	C/O for orthotic/prosthetic	1 2 3 4 5				
L3030	Orthotics custom	FEE: \$65 deposit				
Supply 99070		FEE:				
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code					
-59	Distinct separate site/procedure					
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)					
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
(Auto Related Injuries)

OTTO SNOW D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M COBS HEALTHOPTIONS HMO CHARGE SLIP: 5500215
 05/07/14 EP30 10:30A INJ DATE: P54-MATTHEW BLEVINS
 LAST SEEN D INJ STATE: THERAPY COPAY: 20.00
 AUTH N: 3507SPERCALYR4MODNODED... TWILL FT BALANCE: .00
 DX: 8461 DX: DX: INS BALANCE: 1418.00
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: COP CHIRAG N PATEL, MD
 POS: PTFOT SNF PT? 22

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			Pain free for 2 days but still feels in pharynx/jaw area; Feet Rx is helping		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5		See jawline - Head ST pop station per jaw		
97112	Neuromuscular Reeducation	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:		
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5				
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97033	Iontophoresis (No Aetna)	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: Tw to 45 (Supine)		
97032	Electrical Stimulation (Manual)	1 2 3 4 5				
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pl. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Pt. to be seen; Feet balance with help; Station has passed the test		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
97018	Paraffin			PLAN: Gait 2x/15		
97016	Vasopneumatic treatment			THERAPIST SIGNATURE: [Signature] SCHEDULING GUIDE: SUPPLY PAYMENT INFORMATION: DATE: 5/1/14		
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			COPAY/CO-INS. INFORMATION:		
SPLINT/ORTHOTICS/ SUPPLIES				1 2 3 4 5 times per week for ___ week(s).		
97760	Orthotics man. and training	1 2 3 4 5		Amt Pd: \$		
97762	C/O for orthotic/prosthetic	1 2 3 4 5		Amt. Pd: \$		
L3030	Orthotics custom	FEE: \$65 deposit		SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		
Supply 99070		FEE:		SPECIAL SCHEDULING INSTRUCTIONS:		
MODIFIER				<input type="checkbox"/> Medicare Schedule ME30 ME60 MP60		
-59 Distinct separate site/procedure				<input type="checkbox"/> # authorized visits left: 6		
GP/GO GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)				<input type="checkbox"/> Expiry Date:		
KX MC Annual Benefit Cap exceeded and qualifies for exception				POOL THERAPY SCHEDULING:		
				CHECK/ CC #		
				Initials:		

Patient Signature: _____
 (Auto Related Injuries)

FLORIDA ORTHOPAEDIC INSTITUTE
 13020 Telecom Parkway North, Tampa, FL 33637 - (813) 978-9700
 www.floridortho.com, TAX ID# 59-2929608

L3030 Therapy/Therapy Charge Ticket Dec 2012 Printing: POF Therapy CT

OTTO SNOW D/OA: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M COBS HEALTHOPTIONS HMO CHARGE SLIP: 5489347
 05/02/14 EP30 10:30A INJ DATE: P54-MATTHEW BLEVINS
 LAST SEEN DT INJ STATE: THERAPY COPAY: 20.00
 AUTH #: 3501SPERCALYR4MODNODED... TWILL PT BALANCE: .00
 DX: 8441 DX: DX: INS BALANCE: 916.00
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: M33 MUKESH H MEHTA, MD
 POS: PTFOT SNF PT? 29

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			Back is feeling better but doc says I have OA and it's in my hip. I feel like I can keep my st in joint better now - it doesn't slip		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation			PAIN LEVEL: /10		
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility		
97113	Aquatic Therapy	1 2 3 4 5		See protocol		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To Improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97119	Therapeutic Exercise	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97140	Manual Therapy Techniques	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER:		
97116	Gait Training	1 2 3 4 5		Ice to 45 (spine)		
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5				
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Pt. to ex w/...		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)			PLAN: cont per PR		
60283	Elec Stim. (MC & United)			Michael B...		
97018	Paraffin					
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			THERAPIST SIGNATURE: DATE: 5/2/14		
SPLINTING/ ORTHOTICS/ SUPPLIES				CD/C IN VISITS		
CODE	DESCRIPTION	QTY	L-Code	MOD	DATE: 5/2/14	
SPLINT/ORTHOTIC #:				THERAPY SCHEDULING GUIDE		
97760	Orthotics man. and training	1 2 3 4 5			1 2 3 4 5 times per week for ___ week(s). Schedule w/ TEAM: 4	
97762	C/O for orthotic/prosthetic	1 2 3 4 5			SPECIAL SERVICES: <input type="checkbox"/> Whirlpool SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min	
L3030	Orthotics custom		FEE: \$65 deposit		Payment Method: (circle one) VISA MC CASH DISC AMEX	
Supply 99070			FEE:		CHECK/CC # Initials:	
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code					
-59	Distinct separate site/procedure					
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)					
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
 (Auto Related Injuries)

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 www.floridortho.com, TAX ID# 59-2929808

(S) Shared Therapy/THERAPY CHARGE TICKET Dec 2012 Printing, POC Therapy CT

OTTO SNOW D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M TOWN: HEALTH OPTIONS HMO LARGE SLIP#: 5478354
 04/29/14 EP30 10:30A INJ DATE: P54-MATTHEW BLEVINS
 LAST SEEN DT INJ STATE: THERAPY COPAY#: 20.00
 AUTH #: 30UTSPERCALYR4MODNODED... TWILL PT BALANCE#: .00
 DX: 8461 DX: DX: INS BALANCE: 650.00
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: M33 MUKESH H MEHTA, MD
 POS: PTFOT SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			Back is feeling better		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation			related WFO		
95831	MMT Extremity, Trunk			normal leg length		
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To Increase flexibility <input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97113	Aquatic Therapy	1 2 3 4 5		See feedback		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5				
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5				
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Pt. Dr. ex w/ - Dr. Jones ex & RC		
97597	Active wound care < 20 cm			one w/ing. Pt. felt chelungal		
97012	Mechanical Traction			w/one (ex)		
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
60283	Elec Stim. (MC & United)					
97018	Paraffin			PLAN: cont on RC		
97016	Vasopneumatic treatment			Michael Brent, DC		
97026	Infrared			DATE: 4/29/14		
97010	Hot/Cold Pack (WC and Auto only)			THERAPIST SIGNATURE: Michael Brent, DC		
SPLINTING/ ORTHOTICS/ SUPPLIES				SCHEDULING GUIDE		
QTY	L-Code	MOD	SUPPLY PAYMENT INFORMATION			
SPLINT/ORTHOTIC #:			COPAY/CO-INS. INFORMATION			
97760	Orthotics man. and training	1 2 3 4 5	1 2 3 4 5 times per week for week(s).			
97762	C/O for orthotic/prosthetic	1 2 3 4 5	Schedule w/ TEAM: 4			
L3030	Orthotics custom	FEE: \$65 deposit	SPECIAL SERVICES: <input type="checkbox"/> Whirlpool			
Supply		FEE:	SPECIAL SCHEDULING INSTRUCTIONS:			
99070			<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input type="checkbox"/> # authorized visits left: 14 <input type="checkbox"/> Expiry Date:			
MODIFIER			AMT Pd: \$			
-59 Distinct separate site/procedure			Payment Method: (circle one)			
GP/GO GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)			VISA MC CASH DISC AMEX			
KX MC Annual Benefit Cap exceeded and qualifies for exception			CHECK/ CC #			
			Initials:			
			POOL THERAPY SCHEDULING:			
			Pool Visits Land Visits			

Patient Signature: _____
 (Auto Related Injuries)

OTTU # 40W D/A: HEALTH INS ACCOUNT #: 1027882
 DOB: 01/15/56 SEX: M CRS HEALTHOPTIONS HMO LARGE SLIP: 5478347
 04/25/14 EP30 10:30A INJ DATE: THERAPY COFAY: 20.00
 LAST SEEN BY: INJ STATE: PT BALANCE: .00
 AUTH: 35UTSPERCALYR4MODNODED... TWILL INS BALANCE: 670.00
 DX: 8461 DX: DX: DX:
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: M33 MUKESH H MEHTA, MD
 POS: PTFOT SNF PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation					
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE: (2) ilial ant supm (2) LE longer than (2)		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	TREATMENT:		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> THER EX SEE FLOW <input type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase flexibility		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To Improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97530	Therapeutic Activities	1 2 3 4 5		(2) sidalping hip screen MET		
97110	Therapeutic Exercise	1 2 3 4 5				
97114	Manual Therapy Techniques	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		<input type="checkbox"/> OTHER: CC 8' to low Back.		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97598	Active wound care > 20 cm			Focus on leg length and core		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
90283	Elec Stim. (MC & United)					
97018	Paraffin			PLAN: MBS 4-25-14		
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)			DATE: 4-25-14		
SPLINTING/ ORTHOTICS/ SUPPLIES				THERAPIST SIGNATURE		DATE: 4-25-14
QTY	L-Code	MOD	SCHEDULING GUIDE		SUPPLY PAYMENT INFORMATION	
SPLINT/ORTHOTIC #:			1 2 3 4 5 times per week for week(s).		Amt Pd: \$	
97760	Orthotics man. and training	1 2 3 4 5	Schedule w/ TEAM: (4)		Amt. Pd: \$	
97762	C/O for orthotic/prosthetic	1 2 3 4 5	SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		Payment Method: (circle one)	
L3030	Orthotics custom	FEE: \$65 deposit	<input type="checkbox"/> 1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 NE60 MP60		VISA MC CASH DISC AMEX Payment Method: (circle one)	
Supply 99070		FEE:	<input type="checkbox"/> # authorized visits left: (12) <input type="checkbox"/> Expiry Date:		CHECK/ CC # Initials:	
MODIFIER			POOL THERAPY SCHEDULING:		DATE: 4-25-14	
-59 Distinct separate site/procedure			Pool Visits		COPAY/CO-INS. INFORMATION	
GP/GO GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)			Land Visits		VISA MC CASH DISC AMEX	
KX MC Annual Benefit Cap exceeded and qualifies for exception					CHECK/ CC #	
					Initials:	

Patient Signature: _____
 (Auto Related Injuries)

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 www.floridaortho.com, TAX ID# 59-2929608

(2) Shared Therapy/TH-RAAPY CHARGE TICKET Dec 2012 Printing: F28 Therapy CT Rev 10/2013

OTTO SNOW
 DOB: 01/15/56 SEX: M V/A: HEALTH INS ACCOUNT #: 1027882
 CBS HEALTHOPTIONS HMO LARGE SLIP: 5478339
 04/22/14 EP30 2:30P INJ DATE: F54-MATTHEW BLEVINS
 LAST SEEN DT INJ STATE: THERAPY COFAY: 20.00
 AUTH: 35NTSPERCALYR4MODNODED... TWILL PT BALANCE: .00
 DX: B461 DX: DX: INS BALANCE: 368.00
 REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: M33 MUKESH H MEHTA, MD
 POS: PTENT SNE PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			PT. rpt. "have pain just for 2 days" after initial eval but still need to "pop it into place."		
97002	PT Re-Evaluation			Pain Level: /10		
97003	OT Evaluation			OBJECTIVE:		
97004	OT Re-Evaluation			45° limitation @ side		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	TREATMENT:		
97799	Func. Capacity Evaluation			<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To increase Rom <input checked="" type="checkbox"/> To increase Strength <input checked="" type="checkbox"/> To increase Endurance/Activity Tolerance <input checked="" type="checkbox"/> To increase flexibility See flexion		
95831	MMT Extremity, Trunk			MANUAL THERAPY:		
95851	ROM Meas. Extremity, Trunk			<input checked="" type="checkbox"/> To increase Joint Mobility <input checked="" type="checkbox"/> To decrease tightness/spasm <input checked="" type="checkbox"/> To improve circulation <input checked="" type="checkbox"/> Other: MET for pain station in @ 5/6 supine		
64550	TENS Eval/Checkup			<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97752	MMT (WC ONLY)			OTHER:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	ASSESSMENT: (PROGRESS/REASON TO CONTINUE THERAPY):		
97113	Aquatic Therapy	1 2 3 4 5		At the end of session - feet better with flexion.		
97535	Patient Education/ADL	1 2 3 4 5		PLAN: cont per POC		
97112	Neuromuscular Reeducation	1 2 3 4 5		M. M. M.		
97750	PPT/Isokinetic Test	1 2 3 4 5		THERAPIST SIGNATURE: [Signature]		
97530	Therapeutic Activities	1 2 3 4 5		DATE: 7/12/14		
97110	Therapeutic Exercise	1 2 3 4 5		COPAY/CO-INS. INFORMATION		
97140	Manual Therapy Techniques	1 2 3 4 5		1 2 3 4 5 times per week for ____ week(s). Schedule w/ TEAM: 4 SPECIAL SERVICES: <input type="checkbox"/> Whirlpool SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input type="checkbox"/> # authorized visits left: 16 <input type="checkbox"/> Expiry Date: _____ POOL THERAPY SCHEDULING: Pool Visits _____ Land Visits _____		
97116	Gait Training	1 2 3 4 5		Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____		
97033	Iontophoresis (No Aetna)	1 2 3 4 5		Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____		
97032	Electrical Stimulation (Manual)	1 2 3 4 5		Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____		
97035	Ultrasound	1 2 3 4 5		Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____		
97039	Anodyne Infrared (No MC)	1 2 3 4 5		Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____		
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD			
97598	Active wound care > 20 cm					
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
60283	Elec Stim. (MC & United)					
97018	Paraffin					
97016	Vasopneumatic treatment					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)					
SPLINTING/ORTHOTICS/ SUPPLIES				THERAPIST SIGNATURE: [Signature]		
QTY	L-Code	MOD	DATE: 7/12/14			
SPLINT/ORTHOTIC #:			COPAY/CO-INS. INFORMATION			
97760	Orthotics man. and training	1 2 3 4 5	Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____			
97762	C/O for orthotic/prosthetic	1 2 3 4 5	Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____			
L3030	Orthotics custom	FEE: \$65 deposit	Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____			
Supply 99070		FEE:	Amt Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/CC # _____ Initials: _____			
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code					
-59	Distinct separate site/procedure					
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)					
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
 (Auto Related Injuries)

OTTO SNOW
DOB: 01/15/56 SEX: M
VA: HEALTH INS
CBS HEALTHOPTIONS HMO
ACCOUNT #: 1027882
HARGE SLIP: 5468198
04/16/14 NED 2:30P INJ DATE:
LAST SEEN DT INJ STATE:
AUTH #: 35VTSFPERCALYR4MODNODED... TWILL
DX: 8461 DX: DX: DX:
REF PHYS: PAL BRIAN PALUMBO, MD INS PCP: MB3 MUKESH H MEHTA, MD
POS: PTEN SNE PT?

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation	1		Pain Level: /10		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	<input checked="" type="checkbox"/> THER EX SEE FLOW <input type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase flexibility		
97113	Aquatic Therapy	1 2 3 4 5		<input checked="" type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other: ① all hip scissor mat for iliac abduct. symptoms to ② LOS second session		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5		<input type="checkbox"/> OTHER: CP B below 5min		
97032	Electrical Stimulation (Manual)	1 2 3 4 5				
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pl. arrived but not treated			ASSESSMENT: (PROGRESS/REASON TO CONTINUE THERAPY):		
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	PLAN: Ward		
97598	Active wound care > 20 cm					
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy			THERAPIST SIGNATURE: SCHEDULING GUIDE		
97014	Elec Stim. (No MC & United)					
60283	Elec Stim. (MC & United)					
97018	Paraffin					
97016	Vasopneumatic treatment			SUPPLY PAYMENT INFORMATION		
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)					
SPLINTING/ ORTHOTICS/ SUPPLIES	QTY	L-Code	MOD			
SPLINT/ORTHOTIC #:						
97760	Orthotics man. and training	1 2 3 4 5				
97762	C/O for orthotic/prosthetic	1 2 3 4 5				
L3030	Orthotics custom	FEE: \$65 deposit		CHECK/ CC # 2143		
Supply 99070		FEE:				
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code					
-59	Distinct separate site/procedure					
GP/GO	GP Phys. Therapy/ GO Occ. Therapy (Medicare and United)					
KX	MC Annual Benefit Cap exceeded and qualifies for exception					

Patient Signature: _____
(Auto Related Injuries)



Facility: Telecom
MR #: _____

Physical Therapy Spine Evaluation

Patient: <u>OTO Snow</u>	Physician: <u>Palumbo</u>
Diagnosis: <u>SI strain</u>	Onset/Surgery Date: _____
Medical History: <u>hernia surgery (mesh) 11-12</u>	Occupation: <u>Publisher</u>
Diagnostic Testing: _____	Sport/Leisure: <u>hiking, walking</u>
History: Age: _____ Weight: _____	Prior Level of Function: <u>Unrestricted/Restricted</u>
Living Situation: _____	Current Level of Function: <u>Patient's Functional Limitations</u>
<u>Had hernia surgery Nov 2012.</u>	
<u>started hiking again and no pain (R)</u>	<u>Laying on stomach is (R) hip out</u>
<u>SI jt.</u>	
Pain Scale: (0 = no pain, 10 Emergency Room pain): Best <u>0</u> Worst <u>8-9</u> Activity _____ At Rest _____	
Location: <u>(R) sacral sulcus</u>	Type: <u>Feet out of joint</u>
Frequency: <u>Constant/Intermittent</u>	Since Onset: <u>Better/Worse/Same</u>
Increased Symptoms (Worse): _____	
Decreased Symptoms (Better): _____	
Functional Assessment Tool: _____	
Observation: <u>pas phonus</u> <u>(R) ileum over Pub</u>	

ROM:

Motor Function	Cervical	Thoracic	Lumbar	Comments
Forward Bending	(60)	(50)	(60) <u>WNL</u>	
Extension	(75)		(25)	
Right Lateral Flex	(45)		(25)	
Left Lateral Flex	(45)		(25)	
Right Rotation	(80)	(30)		
Left Rotation	(80)	(30)		

ROM

Strength

Action:	R	L	R	L
Sh. Flex				
Sh. Abd				
Sh. ER				
Sh. IR				
Elb. Flex				
Elb. Ext				
Wrist Flex				
Wrist Ext				
Grip				

ROM

Strength

Action:	R	L	R	L
Hip Flex			5 (P)	5
Hip Ext.				
Hip ER			4+	5
Hip IR			4+ (P)	5
Knee Flex			5	5
Knee Ext			5	5
Ankle DF			5	5
Ankle PF			5	5
Abdomen				
Prone Plank			15'	
Side Plank				

Patient: ① H O Snow



Page 2

Accessory Motion Tests:

Special Tests: SLR (-)	Slump (-)	SI comp/distr (+)	Neurologic: <u>nr</u>
Spurling	VACT	Alar instability	Reflexes:
Skin/Soft Tissue/Palpation: point tenderness at:			Gait: <u>WNL</u>

Assessment/PT Problems/ Functional Limitations:	PT Goals:	
<u>steps to consistent & d/o i f/d</u>	<u>25% better</u>	3
<u>control of lumbar dynamic stab</u>	<u>2 mmr of @ hip IR 5/2</u>	3
<u>til mmr of @ hip EE/IR</u>	<u>③ maintain SI position WNL</u>	3
<u>cont rotational ilium on ③</u>	<u>2 mmr of @ hip ER 5/5</u>	6
	<u>< hold plank 60"</u>	6
	<u>6 ② @ hip</u>	6

Rehab Potential: Excellent ☒ Good ☐ Fair ☐ Poor Due to: _____

Plan: _____ Frequency/Duration: 3 x/week for 6 weeks

Procedures:

<input checked="" type="checkbox"/> Therapeutic Exercise	<input checked="" type="checkbox"/> ROM	<input checked="" type="checkbox"/> Stabilization/Postural Exercise
<input checked="" type="checkbox"/> Soft Tissue/Joint Mobs	<input checked="" type="checkbox"/> Muscle Re-ed	<input type="checkbox"/> Functional Training
<input type="checkbox"/> Discuss Diagnosis and Prognosis with Patient		<input type="checkbox"/> HEP
<input type="checkbox"/> Other: _____		

Modalities:

<input checked="" type="checkbox"/> Heat/Cold	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> E-Stim
<input type="checkbox"/> Iontophoresis	<input type="checkbox"/> Paraffin	<input type="checkbox"/> Traction: Cervical/Lumbar
<input type="checkbox"/> Other: _____		

Therapist's Signature: [Signature] Date: 4-16-15

Physician's Signature: _____ Date: _____

00119708
0490746

PROTOCOL

REHABILITATION PRESCRIPTION & PLAN OF CARE

Physical & Occupational / Hand Therapy

Preoperative Authorization is medically necessary

NAME: OTTO SNOW MRN: 1027882 DATE: 3/24/2014

DIAGNOSIS: 846.1 SPRAIN/STRAIN SACROILIAC DOI:

DOS:

PROCEDURE:

FREQUENCY: ☐ 5xWk ☒ 3xWk ☐ 2xWk ☐ 1xWk DURATION: ☒ 6 Wks ☐ 4 Wks ☐ 3 Wks ☐ Other STATUS: WB ☐ FWB ☐ PWB ☐ TTWB ☐ WBAT ☐ %WB

☒ EVALUATE AND TREAT ☐ HOME PROGRAM ☐ MODALITIES PRN

TREATMENT		PROTOCOLS / PROGRAMS	
THERAPEUTIC EXERCISE		LOWER EXTREMITY	
<input type="checkbox"/> Range of Motion		<input type="checkbox"/> Ankle Program	
<input type="checkbox"/> Passive		<input type="checkbox"/> Ankle Fusion	
<input type="checkbox"/> Active - Assist		<input type="checkbox"/> Meniscus Tear	
<input type="checkbox"/> Active		<input type="checkbox"/> Meniscus Repair	
<input type="checkbox"/> Strengthening		<input type="checkbox"/> ACL Phase:	
<input type="checkbox"/> Stabilization		<input type="checkbox"/> Anterior Knee Pain Protocol	
<input type="checkbox"/> Flexibility		<input type="checkbox"/> Total Knee Replacement Protocol	
<input type="checkbox"/> Home Program Tband Free Wts		<input type="checkbox"/> Total Knee - Revision Protocol	
<input type="checkbox"/> Closed Chain Stressloading		<input type="checkbox"/> Total Hip Replacement Protocol	
MANUAL THERAPY / PROCEDURES		<input type="checkbox"/> Total Hip - Revision Protocol	
<input checked="" type="checkbox"/> Massage		<input type="checkbox"/> Post Arthroscopy	
<input type="checkbox"/> Myofascial Release		<input type="checkbox"/> Protonics	
<input type="checkbox"/> Manual Mobilization		UPPER EXTREMITY	
<input type="checkbox"/> Traction		<input type="checkbox"/> Rotator Cuff Impingement	
<input type="checkbox"/> Proprioception		<input type="checkbox"/> Shoulder Impingement	
<input type="checkbox"/> Balance		<input type="checkbox"/> Rotator Cuff Repair	
<input type="checkbox"/> Gait Training WB Status: %		<input type="checkbox"/> Shoulder Stabilization	
<input type="checkbox"/> Edema Management		<input type="checkbox"/> Shoulder Dislocation	
<input type="checkbox"/> Coordination		<input type="checkbox"/> Total Shoulder Arthroplasty Phase:	
<input type="checkbox"/> Dexterity		ELBOW	
<input type="checkbox"/> Flicking		<input type="checkbox"/> Total Elbow	
<input type="checkbox"/> Desensitization		<input type="checkbox"/> Radial Tunnel Syndrome	
<input type="checkbox"/> Sensorv Re-education		<input type="checkbox"/> Epicondylitis	
PATIENT EDUCATION / ADLs		<input type="checkbox"/> Lateral Epicondylitis Release	
<input type="checkbox"/> Patient Education / ADL		<input type="checkbox"/> Cubital Tunnel Syndrome	
<input type="checkbox"/> Ergonomics Instruction		WRIST / HAND	
<input type="checkbox"/> Work Simplification		<input type="checkbox"/> Ulnar Nerve Transposition	
<input type="checkbox"/> Joint Protection		<input type="checkbox"/> Distal Radius Fracture	
WOUND CARE		<input type="checkbox"/> Flexor Tendon Repair - Zone	
<input type="checkbox"/> Wound Debridement		<input type="checkbox"/> Extensor Tendon Repair - Zone	
<input type="checkbox"/> Scar Management		<input type="checkbox"/> 1st Dorsal Compartment Release	
MODALITIES		<input type="checkbox"/> Dupuytren's Release	
<input type="checkbox"/> Hot / Cold Packs		<input type="checkbox"/> Tenolysis	
<input type="checkbox"/> Iontophoresis / Phonophoresis		<input type="checkbox"/> Trigger Finger Release	
<input type="checkbox"/> Contrast Baths		<input type="checkbox"/> CMC Arthroplasty	
<input type="checkbox"/> Fluidotherapy		<input type="checkbox"/> MP Arthroplasty	
<input type="checkbox"/> Paraffin		<input type="checkbox"/> Tendon Transfer	
<input type="checkbox"/> Whirlpool		<input type="checkbox"/> Carpal Tunnel Syndrome	
<input type="checkbox"/> Ultrasound			
<input type="checkbox"/> Electrical Stimulation			
<input type="checkbox"/> US / Electrical Stimulation			
<input type="checkbox"/> TENS			
<input type="checkbox"/> Anodyne / Infrared			
		SPINE	
		<input type="checkbox"/> Lumbar Stabilization Level:	
		<input type="checkbox"/> Williams Flexion Exercises	
		<input type="checkbox"/> MacKenzie Extension	
		<input type="checkbox"/> Back School / Body Mech. Educ.	
		<input type="checkbox"/> Postural Exercises	
		<input type="checkbox"/> Cervical Stabilization	
		ORTHOTICS / SPLINT	
		<input type="checkbox"/> Type of Splint	
		<input type="checkbox"/> Static Progressive	
		<input type="checkbox"/> Dynamic	
		<input type="checkbox"/> Static	
		<input type="checkbox"/> Adjustment	
		<input type="checkbox"/> Custom Foot Orthotic	
		SPECIAL TESTS	
		<input type="checkbox"/> Functional Capacity Evaluation FCE	
		<input type="checkbox"/> Physical Capacity Assessment PCA	
		<input type="checkbox"/> Isokinetic Testing (Biodex)	
		SPECIAL PROGRAMS	
		<input type="checkbox"/> Physical Reconditioning	
		<input type="checkbox"/> Work Conditioning / Hardening	
		<input type="checkbox"/> Aquatic Therapy	
		OTHER	
		SPECIAL INSTRUCTIONS / PRECAUTIONS	
		SI JOINT STRETCHING	

☐ Verbal Order Date: Therapist Signature: I certify that the above rehabilitation treatment and plan of care is medically necessary. The Plan of Care will be reviewed at least every 30 days.

PHYSICIAN'S SIGNATURE: Brian Palumbo, MD DATE: 3/24/2014

FOR OFFICE USE ONLY: DATE: TIME: PROVIDER: FACILITY: LOCATION: INS TYPE: NOTES:

FLORIDA ORTHOPAEDIC INSTITUTE THERAPY ARRIVAL LOG

Pt. Name: Otto Snow MR#: 1007882 CLINIC Telecom

Modalities/Procedures allowed per visit 4

Auth Required: ☒
Script only: ☐

☒ Deductible \$ 2000 Met/Not Met Owe \$ —

Prescription Dates 7/10/12

Benefits Expire: 600 vts per cal yr

RX LENGTH in visits	# AUTH'D VISITS	ARRIVAL DATE	Front Desk USE ONLY Auth Exp Date:	COMMUNICATION LOG	
				DATE:	MESSAGE: INITIALS
<u>EVAL</u>	<u>1</u>	<u>7.17.12</u>	<u>mel</u>	<u>*97001 EVAL ONLY*</u>	
<u>2</u>	<u>2</u>	<u>7.20.12</u>	<u>mel</u>		
<u>3</u>	<u>3</u>	<u>8.1.12</u>	<u>mel</u>		
<u>4</u>	<u>4</u>	<u>8.8.12</u>	<u>mel</u>		
<u>5</u>	<u>5</u>	<u>8.15.12</u>	<u>mel</u>		
<u>6</u>	<u>6</u>	<u>8.22.12</u>	<u>mel</u>		
<u>7</u>	<u>7</u>	<u>8.29.12</u>	<u>mel</u>		
<u>8</u>	<u>8</u>				
<u>9</u>	<u>9</u>				
<u>10</u>	<u>10</u>				
<u>11</u>	<u>11</u>				
<u>12</u>	<u>12</u>				
<u>13</u>	<u>13</u>				
<u>14</u>	<u>14</u>				
<u>15</u>	<u>15</u>				
<u>16</u>	<u>16</u>				
<u>17</u>	<u>17</u>				
<u>18</u>	<u>18</u>				
<u>19</u>	<u>19</u>				
<u>20</u>	<u>20</u>				
<u>21</u>	<u>21</u>				
<u>22</u>	<u>22</u>				
<u>23</u>	<u>23</u>				
<u>24</u>	<u>24</u>				

DISCHARGE DATE: 8-30-12 SATISFACTION SURVEY SENT DATE: _____ INITIALS 93

**FLORIDA ORTHOPAEDIC INSTITUTE
THERAPY DEPARTMENT**

BENEFIT VERIFICATION ♦ INSURANCE AUTHORIZATION FORM

Pt. Name: THO SNOW MR#: 1027882 Date: July 10, 2012

Verifying ☒ PT benefits ☐ OT benefits Dr. Hilgers provider # _____

We bill incident to the physician

PRIMARY INSURANCE

Ins Name: First Health

☐ Pt has **OUT** of Network Benefits(*Co-Ins./Ded amts*)

- Referral from PCP is Required YES NO (circle one)
- Authorization is Required YES NO (circle one)
- Has the pt used any therapy visits this year YES NO (circle one) If so, how many? _____

Copay \$ — Co-Ins. 50 % (Physician PT)

Deductible \$ 5000 Amt Met \$ 5000

Max out of pocket \$ 4000 Amt.met \$ 4135

Therapy Limitations:

— Consec. Days per cond/ per cal yr. (circle one)

100 Visits: per condition/ per cal yr. (circle one)

\$ — Max. per cal yr Visits Medical Necessity

Benefits Effective: 7/1/11 Expire: _____

Mod/Procedure/Unit Limit MO (#) Per visit

Restricted Procedures (CPTs) ☐ 97039 ☐ 97124 ☐ 97010

☐ 97535 ☐ 97033 ☐ 97014 ☐ 97140-manip.tx ☐ 97112 ☐ 97026

Other information:

Reference #: 07145012

Ins. Rep providing info: Janice M.

AUTHORIZATION

From	Thru	Auth #/Name	# Visits	Source
7-17-12	8-31-12	20120722	21000014	(7)

SPLINT/ORTHOTIC AUTHORIZATION

Splint/Orthotic # _____ DME Benefits? Y / N

DME Deductible \$ _____ Amt Met \$ _____

Copay \$ _____ CoIns _____ %

Is L-code billable? Yes / No Use L Code: _____

Authorization Required Yes / No

From	Thru	Auth #/Name	# Vis	Source

Notes: 877-304-1399

97001 eval only

SECONDARY INSURANCE

Ins Name: _____

☐ Pt has **OUT** of Network Benefits(*Co-Ins./Ded amts*)

- Referral from PCP is Required YES NO (circle one)
- Authorization is Required YES NO (circle one)
- Has the pt used any therapy visits this year YES NO (circle one) If so, how many? _____

Copay \$ _____ Co-Ins. _____ % (Physician PT)

Deductible \$ _____ Amt Met \$ _____

Max out of pocket \$ _____ Amt.met \$ _____

Therapy Limitations:

_____ Consec. Days per cond/ per cal yr. (circle one)

_____ Visits: Per condition/ per cal yr. (circle one)

\$ _____ Max. per cal yr Visits Medical Necessity

Benefits Effective: _____ Expire: _____

Mod/Procedure/Unit Limit _____ (#) Per visit

Restricted Procedures (CPTs) ☐ 97039 ☐ 97124 ☐ 97010

☐ 97535 ☐ 97033 ☐ 97014 ☐ 97140-manip.tx ☐ 97112 ☐ 97026

Other information:

Reference #: _____

Ins. Rep providing info: _____

AUTHORIZATION

From	Thru	Auth #/Name	# Visits	Source

SPLINT/ORTHOTIC AUTHORIZATION

Splint/Orthotic # _____ DME Benefits? Y / N

DME Deductible \$ _____ Amt Met \$ _____

Copay \$ _____ CoIns _____ %

Is L-code billable? Yes / No Use L Code: _____

Authorization Required Yes / No

From	Thru	Auth #/Name	# Vis	Source

Notes: _____

07/23/2012 15:35 FAX 914 681

ORTHONET GEHA

0002/0002

Page 6 of 6

OrthoNet
P.O. Box 5046
White Plains, NY 10602-5046



Date: 07/20/2012

OTTO SNOW
9177 JENA RD
SPRING HILL, FL 34608

FLORIDA ORTHOPAEDIC INSTITUTE
TIN # 592929608
PHONE: (813) 978-9779 FAX: (813) 558-6415

Member Name: OTTO SNOW Member Number: 2412847201

Date(s) of Service: 07/17/2012 through 08/31/2012

Diagnosis: 736.81 UNEQUAL LEG LENGTH

OrthoNet Reference Number: 2012072021000014

OrthoNet has been authorized by GEHA to administer the review of physical, occupational, and speech therapy services. OrthoNet has received your request for coverage verification and authorization for the following service(s) for the member referenced above.

PHYSICAL THERAPY VISIT Visits Requested: 08 Visits Approved (subject to calendar year limits): 7

PLEASE NOTE: One visit is equal to up to two hours in length or eight- fifteen minute increments. If services billed in one visit are greater than the two hour maximum plan allowable- the additional units will be denied based upon the daily benefit limitation.

If additional visits are required after the number of approved visits have been exhausted or if the approved date of service period has passed, the attending physician or therapy provider can submit a request for additional visits to OrthoNet by fax at 1-877-304-4398 or by phone at 1-877-304-4399. Medical necessity for future visits is best determined near the end of the currently approved visits.

Note: All therapy services must be preauthorized by OrthoNet. For any services provided, but not yet reviewed for medical necessity by OrthoNet, please submit supporting clinical information to OrthoNet at the above fax number.

When requesting additional visits, the physician or therapy provider will need to submit progress notes and current, objective clinical data (i.e., strength, active and passive range of motion, functional capabilities, etc.) that address both the patient's response to therapy and the progress made towards outlined goals. For services denied, additional information must be received within 30 days of this notice.

Please note that benefit payments for this health care request depend on the member's eligibility status and the terms and provisions of the health care contract that are in effect when the member received these services. To verify eligibility and benefit coverage contact PCIP customer service at (800) 220-7898.

Sincerely,

OrthoNet Medical Management

cc: UNSPECIFIED PROVIDER , GEHA
GEHA_PCIP_PARA99201201

**Facsimile Transmission Cover Sheet****Transmit to FAX Number:****Date:** 07/23/2012 2:02 PM**Total Number of Pages** (Including this sheet): 2**TO:****FROM:**

Name: FLORIDA ORTHO INSTITUTE	Name: GEHA/ ORTHONET, LLC
Department: PHYSICAL/OCCUPATIONAL/SPEECH THERAPY DEPT.	Department: MEDICAL MANAGEMENT DEPT.
Company:	2
Phone:	Phone: (877) 304-4399
RE:	

Comments:

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FLORIDA
ORTHOPAEDIC
INSTITUTE

Keeping you active.

This transmission contains personal health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

**HAND SURGERY
and MICROSURGERY**
M. Ellen Beatty, M.D.
Alfred V. Hess, M.D.
Jeffrey Stone, M.

TRAUMA
Roy W. Sanders, M.D.
Thomas G. DiPasquale, D.O.
Dolfi Herscovici, Jr., D.O.
Anthony Infante Jr., D.O.
MUSCULOSKELETAL ONCOLOGY
Arthur K. Walling, M.D.
PHYSIATRY
Jodi Shields, M.D.

**ADULT RECONSTRUCTION
and ARTHRITIS SURGERY**
Kenneth A. Gustke, M.D.
Steven T. Lyons, M.D.
Thomas L. Bernasek, M.D.
Mark A. Frankle, M.D.
Mark A. Mighell, M.D.
SPINE SURGERY
Antonio E. Castilvi, M.D.
John M. Small, M.D.
Marc A. Weinstein, M.D.

SPORTS MEDICINE
David Leffers, M.D.
Seth I. Gasser, M.D.
Adam Morse, D.O.

RAIN MANAGEMENT
David M. Herson, M.D.
FOOT and ANKLE SURGERY
Arthur K. Walling, M.D.
Roy W. Sanders, M.D.
Dolfi Herscovici, Jr., D.O.
MUSCULOSKELETAL ONCOLOGY
Arthur K. Walling, M.D.
INTERVENTIONAL SPINE
Howard Jackson, M.D.

FAXED
07/18/2012

DATE: July 18, 2012

TO: Authorizations Department

PHONE

FAX:

FROM: Tia W. 13020 N. Telecom Parkway Temple
Terrace Fl. 33637

PHONE: (813) 978-9779x7109

FAX: (813) 558-6415

SUBJECT:

PAGES:

MESSAGE:

(Last 4 Social) or (Policy Number)

5443

Medical Record #: 1027888

This patient was given a prescription on

7/19/12 by Dr. Hilgert

We are seeking authorization for our facility to start
Therapy. Please review for authorization.

Duration

Requested

2XS x 4wks = 8vts

FLORIDA ORTHOPAEDIC INSTITUTE

Keeping you active.

This transmission contains personal health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

HAND SURGERY and MICROSURGERY

M. Ellen Beatty, M.D.
Alfred V. Hess, M.D.
Jeffrey Stone, M.

TRAUMA

Roy W. Sanders, M.D.
Thomas G. DiPasquale, D.O.
Dolfi Herscovici, Jr., D.O.
Anthony Infante Jr., D.O.

MUSCULOSKELETAL ONCOLOGY

Arthur K. Walling, M.D.

PHYSIATRY

Jodi Shields, M.D.

ADULT RECONSTRUCTION and ARTHRITIS SURGERY

Kenneth A. Gustke, M.D.
Steven T. Lyons, M.D.
Thomas L. Bernasek, M.D.

Mark A. Frankle, M.D.

Mark A. Mighell, M.D.

SPINE SURGERY

Antonio E. Castellvi, M.D.
John M. Small, M.D.
Marc A. Weinstein, M.D.

SPORTS MEDICINE

David Leffers, M.D.
Seth I. Gasser, M.D.
Adam Morse, D.O.

PAIN MANAGEMENT

David M. Herson, M.D.

FOOT and ANKLE SURGERY

Arthur K. Walling, M.D.
Roy W. Sanders, M.D.
Dolfi Herscovici, Jr., D.O.

MUSCULOSKELETAL ONCOLOGY

Arthur K. Walling, M.D.

INTERVENTIONAL SPINE

Howard Jackson, M.D.

SHOULDER and ELBOW SURGERY

Mark A. Frankle, M.D.

Seth I. Gasser, M.D.

Alfred V. Hess, M.D.

David Leffers, M.D.

Mark A. Mighell, M.D.

GENERAL ORTHOPAEDICS

Thomas Davison, M.D.
Anthony Infante Jr., D.O.
Christian Foglar, M.D.

FAXED
JUL 18 2009

DATE: JUL 18, 2009

TO: Authorizations Department

PHONE: 813 558-6415

FAX: 877 304-1398

FROM: Tia W. 13020 N. Telecom Parkway Temple
Terrace Fl. 33637

PHONE: (813) 978-9779x7109

FAX: (813) 558-6415

SUBJECT: Otto Snow / physical
Therapy

PAGES: 2, including cover.

MESSAGE: Patient Name: Otto Snow

(Last 4 Social) or (Policy Number)

#: 5743

Medical Record #: 10027883

This patient was given a prescription on
7/19/09 by Dr. Hilgers

We are seeking authorization for our facility to start
Therapy. Please review for authorization.

Duration

Requested: 2XS x 4wks = 8vts

Physical Occupational Splint

Provider # 59159991008

CPT Codes in need of authorization (circle all that
apply):

97001 97002 97003 97004 97010
97012 97014 97022 97033 97035
97039 97110 97112 97140 97530
97535

Patient is scheduled to start EVAL DONE 7/17

☐ Please review and contact me.

☒ Script and notes are attached.

☒ Requesting for Continuation.

THANK YOU!

Warning: This message is intended only for the person listed above. The attached information is confidential and considered privileged by law. If the reader of this fax is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you are not the intended recipient, please notify us and shred this information. Thank you for your cooperation.

FLORIDA ORTHOPAEDIC INSTITUTE REHABILITATION CENTER

Medical History Summary

Patient Name: OTTO SNOW MR#: 1027882 Cell Phone #: _____

Please complete this brief history form of alert your therapist to your current medical condition. Completing this form enables the therapist to proceed immediately with your evaluation in the absence of your full medical record. We appreciate your cooperation.

Date of Injury/Illness: _____ Date of Surgery: N/A

Job Title: Publisher

Description of Job Duties: Typing, moving boxes

Please circle your response below and list any additional information:

Do you have any metal, plates, pins, screws or joint replacements?	Yes	<u>No</u>
If yes, please list: _____		
Do you have any broken bones?	<u>Yes</u>	<u>No</u>
Are you currently taking any medication(s)?	<u>Yes</u>	No
If yes, please list: <u>Lorazepam 1mg 4x/day Metoprolol 50mg</u>		
Are you allergic to anything?	<u>Yes</u>	No
If yes, please list: <u>Corticosteroids, Anything constipating</u>		
Have you had heart surgery?	Yes	<u>No</u>
If yes, please indicate what type: _____		
Do you have a hearing aide?	Yes	<u>No</u>
Do you wear dentures?	Yes	<u>No</u>
For women: Are you pregnant?	Yes	<u>No</u>

Please check if you have any of the following conditions?

<input type="checkbox"/> Heart condition or disease	<input type="checkbox"/> Pacemaker
<input checked="" type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke (TIA or CVA)
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis (Osteoarthritis)	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Osteoporosis	Other: <u>Hepatic Hemangioma Liver</u>
	<u>Gilbert's syndrome</u>

ALL Patients: (please complete)

Are you currently receiving Home Health Therapy or Therapy in a Skilled Nursing facility? ☐ Yes ☐ No

☐ I have had previous Physical Therapy/Occupational Therapy for this condition / different condition in 2012.

Condition Treated: _____ Approximate visits: _____

Condition Treated: _____ Approximate visits: _____

Patient's Signature: OTTO E SNOW Date: 7/17/12

Therapist's Signature: Joy Moulton Date: 7/17/12

FLORIDA ORTHOPAEDIC INSTITUTE REHABILITATION CENTER
Patient Financial Responsibility Acknowledgement

The following information was provided to us by your insurance company. Please review and sign below to confirm your acknowledgement and understanding.

PATIENT NAME: Otto Snow MR# 11057885
 PRIMARY INSURANCE First Health ☐ Out of Network Benefits
 SECONDARY INSURANCE - ☐ Out of Network Benefits

	PRIMARY INS.	SECONDARY INS.	SPLINT/ORTHOTICS
Deductible Amount	\$ <u>2000</u>	\$	\$
Amount Met	\$ <u>2000</u>	\$	\$
Amount Owed	\$ <u>-</u>	\$	\$
Co-pay	\$ <u>-</u> /visit	\$ /visit	\$
Co-Insurance	<u>0</u> %/visit	%/visit	
Maximum out of pocket	\$ <u>4000</u>	\$	\$
Amount Met	\$ <u>4000</u>	\$	\$
Benefits expire	<u>100 comorbid</u> <u>per cal</u>		
Authorization required	<u>(YES)</u> / NO	YES / NO	YES / NO
FOI has obtained authorization	<u>(YES)</u> / NO	YES / NO	YES / NO
# visits authorized	<u>RX</u>		Splint code:

PRIMARY Ins. Limitations

☐ - consecutive days per calendar year/diagnosis
☒ 100 visits per calendar year/diagnosis
☒ 100 modalities per (mths) /diagnosis
☐ \$ - Daily/per visit maximum
☒ other: CVD 100 /

SECONDARY Ins. Limitations

☐ - consecutive days per calendar year/diagnosis
☐ - visits per calendar year/diagnosis
☐ - modalities per (mths) /diagnosis
☐ \$ - Daily/per visit maximum
☐ other: -

Insurance Benefit Information Notice: (Patient please read fully)

This does not constitute a guarantee of payment or an exact amount of your co-pay or co-insurance. This is a description of benefits from your insurance company given to us at this time. Should a dispute arise between this estimation and your Insurance Company Explanation of Benefits (EOB), the Patient Responsibility noted on your insurance Explanation of Benefits (EOB) shall prevail. We urge you to contact your insurance company, at the phone number listed on your insurance card, and confirm these benefits, and review your Insurance EOB's as they come to you. In this way we can work together to ensure accuracy of your financial responsibility.

SIGNATURE Otto E Snow DATE 7/17/12
 WITNESS [Signature] DATE 7.17.12

FLORIDA ORTHOPAEDIC INSTITUTE



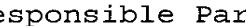
Account #: 1027882
Today's Date: 07/12/12
Recall: 062012

Appt Date: 07/17/12
Patient Bal: .00
Insurance Bal: 961.00

-----Patient Information-----Employer Information-----

Name: OTTO SNOW
Addr: 9177 JENA RD
SPRING HILL FL 34608-4765

Name: SELF EMPLOYED
Addr:

Phone: 
Dob: 
SS#: 
Sex: M MS: S EMAIL:

Phone: 999-999-9999

-----Responsible Party Information-----Emergency Contact-----

Name: OTTO SNOW
Addr: 9177 JENA RD
SPRING HILL FL 34608-476

Name:
Phone: -

-----Referring Physician-----Primary Care Provider-----

Name: MUKESH H MEHTA, MD
Addr: STE 250
17222 HOSPITAL BLVD
BROOKSVILLE FL 34601
Phone: 352-754-7222

Name: MUKESH H MEHTA, MD
Addr: STE 250
17222 HOSPITAL BLVD
BROOKSVILLE FL 34601
Phone:

-----Primary Insurance-----Secondary Insurance-----

FIRST HEALTH/PPO (Y) HEALTH INS
Ins Type: I
Policy: 24128472
Group:
Subscriber: OTTO SNOW
1. AF02 2. 3. 4. 5.

Ins Type: P
Policy:
Group:
Subscriber:
6. 7. 8.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. ARE YOU BEING SEEN TODAY FOR AN AUTO RELATED ACCIDENT? YES _____ NO 9
2. ARE YOU BEING SEEN TODAY FOR A WORK RELATED ACCIDENT? YES _____ NO 9
3. IN THE PAST YEAR (SINCE 1/1/12), HAVE YOU HAD OR ARE YOU CURRENTLY PARTICIPATING IN OUTPATIENT PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY SERVICES, INCLUDING IN HOME HEALTH SETTING? YES _____ NO 9

FIRST HEALTH PPO
P O BOX 4665
INDEPENDENCE MO 64051

ADJ NAME:
ADJ PHONE:
DATE OF INJ:
INS PHONE#:

Comments:

PATIENT SERVICE REP INITIALS: Mer

Clinic: Telecom

FLORIDA
ORTHOPAEDIC
INSTITUTE

MR #: 1087882

Patient: OTO SNOW

Next MD Visit 8/7/12

Diagnosis: unequal leg length (SIJ + inguinal p.) Keeping you active.
Sig Medical HX: Gilbert's syn.
NBP, Liver hemangioma

Restricted Modalities/Procedures:

- ☐ 97039 (Anodyne) ☐ 97014 (E stim) ☐ 97124 (massage) ☐ 97140 (Manual) ☐ 97010 (Hot/Cold pack)
☐ 97112 (Neuro Re-ed) ☐ 97535 (ADI) ☐ 97026 (Infrared) ☐ 97033 (Tonto) ☐ other: _____

4 MODS

90001

LOW REPS

4 (R)

Visit #	1/	2/	3/	4/	5/	6/	7/	8/	9/	10/	11/	12/
(continuation)	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
Date:	7/17/12	7/26	8/2	8/8	8/15	8/22	8/29					
Modality/Exercise												
MWP or US to (R) SIJ		5'	5'	5'	5'	5'	5'					
MFR to (R) QL, upper glutes, piriformis + psoas (prn)		✓	✓	✓	✓	✓	✓					
MET's (prn)	see note	✓	✓	✓	✓	✓	✓					
Ball/Belt Piriformis (S)	10x5"	20x5" 2x30"	20x5"	20x5" 3x30"	30" ea.		NEP NEP					
HSS Thomas (S) (R) 30"	on chain 2x30"			3x30"		3x30"	30" NEP					
PPT - E marches		10"x5"	10x10"	10x10"	dema.		NEP					
- E heel slides			2x10	2x10	2x10	2x10	2x10					
90/90 TA iso. (if tol)			10x	2x10	10x	10x	10x					
Bridges												
Clams												
S/L IR 45° Kicks												
Mod. Planks: (f) + (s)												
Bird Dogs QL (S) (R=L)												
astim +/- CP (prn)												
Therapist Initials	JM	JM	JM	JM	JM	JM	JM					

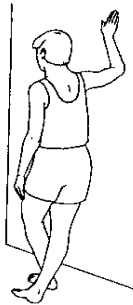
CHART COPY

HIP OBLIQUE - 9 Iliotibial Band

Cross right leg behind the left. Lean right hip toward wall while bending left knee and keeping right knee straight. Hold 30 seconds. Repeat with left leg behind right.

For a variation of this stretch, cross right leg *in front of* the left leg.

Repeat 3 times.
Do 1 sessions per day.



SPINAL MOBILIZATION - 34 Pelvic Rotation (Standing)

Right knee behind on chair, gently lower body by bending other knee until stretch is felt. Do not allow back to arch. Hold 30 seconds. Relax.

Repeat 3 times per set.
Do 1 sets per session.
Do 1 sessions per day.

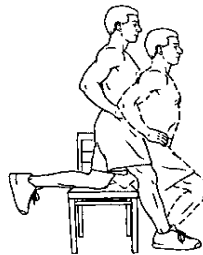


CHART COPY

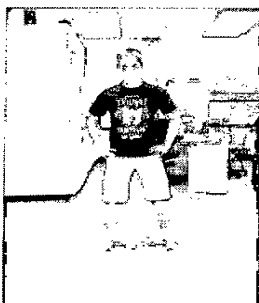
FLORIDA
ORTHOPAEDIC
INSTITUTE
Keeping you active.

Routine For:
Created By: Joy Moulton DPT

Aug 22, 2012

Crab Walk

With tubing loop wrapped around your shoes, slightly bend your knees and make sure your feet are facing forward. Side step across the room (____ feet) keeping knees bent and maintaining feet forward. Then side step back across the room, leading with opposing leg. Repeat this ____ times.



Monster Walk

Place tubing loop around ankles. Keep feet facing forward and knees straight, walk across the room, swinging each leg out and around to take a step. Maintain feet facing forward and knees straight. Walk ____ feet. Repeat this exercise ____ times.

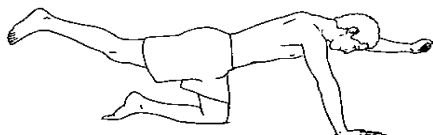


Standing hip flexion/march

Holding on to something stable (kitchen counter or bathroom counter), raise your knee towards your chest, alternating legs as if you are marching in place. Repeat this exercise ____ times, alternating legs.



TRUNK STABILITY - 20 Upper / Lower Extremity Extension (All-Fours)



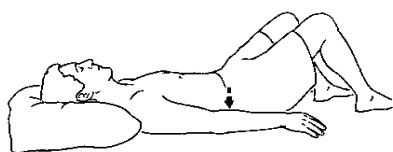
Tighten stomach and raise right leg and opposite arm. Keep trunk rigid.
Repeat 10 times per set. Do 2 sets per session.
Do 1 sessions per day.

CHART COPY

Routine For:
Created By: Joy Moulton DPT

Aug 02, 2012
Lumbar Stab Routine

TRUNK STABILITY - 4 Isometric Abdominal



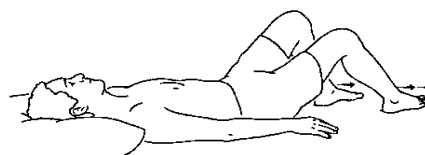
Lying on back with knees bent, tighten stomach by pressing elbows down. Hold 10 seconds.
Repeat 10 times per set. Do 1 sets per session.
Do 1 sessions per day.

TRUNK STABILITY - 6 Bent Leg Lift (Hook-Lying)



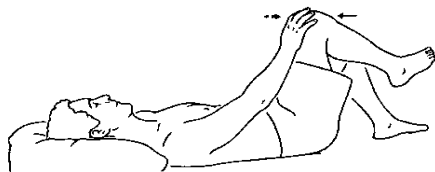
Tighten stomach and slowly raise right leg 10-15 inches from floor. Keep trunk rigid. Hold 1-2 seconds.
Repeat 10 times per set. Do 3 sets per session.
Do 1 sessions per day.

TRUNK STABILITY - 8 Heel Walk (Hook-Lying)



Tighten stomach and slowly slide 1 foot away from torso. Don't lose abdominal contraction. Slide foot back toward torso. Repeat with other foot. Then relax abdominals.
Repeat 10 times per set. Do 1 sets per session.
Do 1 sessions per day.

TRUNK STABILITY - 10 Unilateral Isometric Hip Flexion



Tighten stomach and raise right knee to outstretched arm. Push gently, keeping arm straight, trunk rigid. Hold 5 seconds. Repeat with Left leg.
Repeat 10 times per set. Do 1 sets per session.
Do 1 sessions per day.



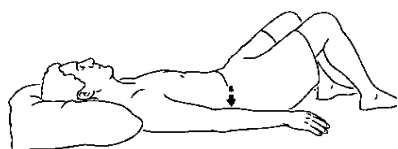
CHART COPY

FLORIDA
ORTHOPAEDIC
INSTITUTE
Keeping you active.

Routine For:
Created By: Joy Moulton, DPT

Jul 26, 20

TRUNK STABILITY - 4 Isometric Abdominal



Lying on back with knees bent, tighten stomach by pressing elbows down. Hold 10 seconds.

Repeat 10 times per set. Do 1 sets per session.
Do 1-2 sessions per day.

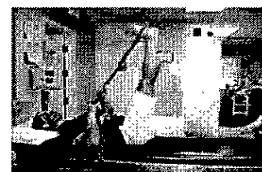
HIP / KNEE - 48 Piriformis (Supine)



Cross legs, right on top. Gently pull other knee toward chest until stretch is felt in buttock/hip of top leg. Can also pull across midline a little to enhance stretch. Hold 30 seconds.

Repeat 3 times per set. Do 1 sets per session.
Do 1-2 sessions per day.

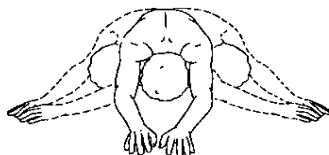
Supine Hamstring Stretch with rope



Lying on your back, attach a stretching rope around your foot. Using your arms to pull the rope, slowly raise your leg towards the ceiling, keeping your knee straight, until a stretch is felt on the back of the knee. Hold for _____ seconds.

Repeat _____ times. Perform _____ times per day.

BACK - 21 Mid-Back Rotation Stretch

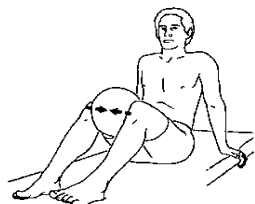


Reach to each side as far as possible, keeping chest low to floor. Hold 30 seconds.

Repeat 2-3 times per set. Do 1 sets per session.
Do 1-2 sessions per day.

CHART COPY

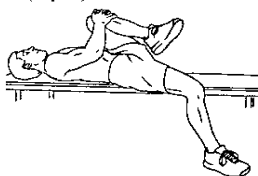
HIP / KNEE - 16 Strengthening: Hip Adduction – Isometric



With ball or folded pillow between knees, squeeze knees together. Hold 5 seconds.

Repeat 10 times per set. Do 2 sets per session.
Do 1-2 sessions per day.

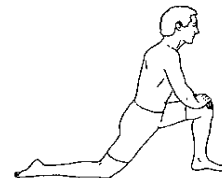
SPINAL MOBILIZATION - 32 Pelvic Rotation: Knee-to-Chest (Supine)



With right leg hanging over side of bench, other knee to chest, relax leg as much as possible. Hold 30 seconds. Relax.

Repeat 3 times per set. Do 1 sets per session.
Do 1-2 sessions per day.

HIP / KNEE - 34 Stretching: Hip Flexor



Kneeling on right knee, slowly push pelvis down while slightly arching back until stretch is felt on front of hip. Hold 30 seconds.

Repeat 3 times per set. Do 1 sets per session.
Do 1-2 sessions per day.

QL ⑤ ②

FOI Therapy Billing Guidelines

Aetna: Cannot Bill: 1) 95831/95851 together MMT Ext.&Trunk/ROM Ext& Trunk 2) 95832/95852 together MMT hand/Rom hand 3) 97033 ionto		Auto: General: 1) First visit require signed GREEN D&A Form 2) Therapist and Patient sign bottom of charge ticket daily 3) Must have secondary insurance which FOI is a provider	
Blue Cross Blue Shield of Florida General: Cannot Bill Hot/cold pack 97010 Infrared 97026 Out of State: varies by state confirm benefits Iontophoresis 97033 ADL 97535		Managed Care: General: 1) Consult Arrival Log to identify insurance restrictions 2) No ROM/MMT's procedures w/in 30 days of each other 3) No Eval/Re-eval w/in 30 days of each other	
Medicare: General: 1) Complete billing worksheet for time/service based units 2) Modifiers: GP: by all Physical Therapy charges GO: by all Occupational Therapy charges -59: distinct separate site/procedure/time period KX: when \$1860 cap reached and patient has valid exception 3) 8 min rule guideline: 0-7 min 0 units 8-22 min 1 unit 23-37 min 2 units 38-52 min 3 units 53-67 min 4 units 68-82 min 5 units 83-97 min 6 units 4) Medicare Special codes: Electric Stim (97014) bill as G0283 5) Cannot bill Hot/cold pack 97010 Anodyne Infrared 97039 * Infrared 97026: Cannot bill on Diabetic wounds, ulcers, neuropathies			
Tricare: 1) Cannot Bill Hot/Cold pack 97010		United: 1) Cannot Bill Hot/Cold pack 97010 2) Electrical Stim use G0283 3) Cannot Bill Anodyne 97039 , Bill Infrared 97026	
US Dept of Labor: Cannot Bill 1) Hot Pack/ Coldpack 97010 MMT 97752 2) Can Bill: PT Eval * 97001 OT Eval * 97003 * 1 per claim every 6 mths.		Modifiers: 97140 97530 (59) 97012 97140 (59) all 97002 (59) all 97004 (59)	
Work Comp: General: 1) 4 procedures per visit (only) unless special written auth. to bill more ie) 2 Dx or body parts. 2) Supplies do not count as a procedure ie) can do 4 units plus a supply, (attach invoice) 3) No ROM/MMT procedures w/in 30 days of each other 4) Can Bill Initial Evaluation PT or OT 97001/97003 Follow up MMT= 97752 Follow up MMT+ROM= 97752 Follow up ROM= 95851 or 95852 HOT PACK 97010		Supplies: electrodes 2x2 \$4.00 electrodes 2x4 \$5.75 45 cm Ball \$14.00 \$23.00 55 cm Ball \$16.75 \$27.50 65 cm Ball \$19.50 \$32.00 75 cm Ball \$31.00 \$41.00 9" Overball \$8.50 \$14.00 Hybresis Patch \$10.00 \$10.00 home pulley \$10.00 \$16.00 cerv/std ice pack \$15.50 \$25.00 lumbar ice pack \$23.00 \$38.00 putty 4oz. \$4.50 \$7.00 otoform 2 oz. \$5.00 \$8.50 otoform 4 oz. \$10.00 \$16.25 otoform 6 oz. \$15.00 \$24.50 silicone 1/4 \$9.00 \$14.50 silicone 1/2 \$17.00 \$28.25 coban 1" (per roll) \$1.50 \$2.00 digital gel tube (ea) \$5.00 \$8.50 digital gel cap (ea) \$4.50 \$7.50 buddy strap \$2.50 \$3.75 Biofreeze 3 oz \$8.00 \$12.75 Biofreeze 16 oz \$25.00 \$41.00 Lumbar Roll \$9.50 \$15.50 Ex. Handle \$5.00 \$8.50 Mini Vibrator \$15.00 \$24.00 Oedema Glove \$5.50 \$8.50	
VA: 1) Modifiers: GP: by all Physical Therapy charges GO: by all Occupational Therapy charges			

OTTO SNOW

DOB: XXXXXXXXXX

SEX:

D/A: HEALTH INS
FIRST HEALTH/PPD (Y)ACCOUNT #: 1027882
CHARGE SLIP: 4757077

08/29/12 EF30 10:30A

LAST SEEN DT

INJ DATE:

INJ STATE:

THERAPY COPAY: .00

PT BALANCE: .00

AUTH #: AOVTSFPERCALYRMODMEDNECEDMTCDV100%

INS BALANCE: 2068.00

DX: 73681

DX:

DX:

DX:

REF PHYS: HIS MARC F HILGERS, MD

INS PCP: M33 MUKESH H MEHTA, MD

POS: PTF01

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			See PN ↓		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation			↓		
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	<input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase flexibility		
97113	Aquatic Therapy	1 2 3 4 5		To ↑ core stable		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5		<input checked="" type="checkbox"/> MANUAL THERAPY: <input checked="" type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
97110	Therapeutic Exercise	1 2 3 4 5		MER to (R) QL, MET for (R) ant. innom		
97140	Manual Therapy Techniques	1 2 3 4 5		(R) psoas not tight today		
97116	Gait Training	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97033	Iontophoresis (No Aetna)	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: MNP to Lv. 5' to tx.		
97032	Electrical Stimulation (Manual)	1 2 3 4 5		CP to (R) psoas 5' p tx.		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated			ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	See PN updated NER ↓		
97598	Active wound care > 20 cm			PLAN:		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)			THERAPIST SIGNATURE: Joy Moulton SCHEDULING GUIDE: D/C SUPPLY PAYMENT INFORMATION: Amt Pd: \$ COPAY/CO INS. INFORMATION: DATE: 8/29/12		
97018	Paraffin					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)					
SPLINTING/ ORTHOTICS/ SUPPLIES	QTY	L Code	MOD	1 2 3 4 5 times per week for week(s).		
SPLINT/ORTHOTIC #:				Schedule w/ TEAM: D/C		
97760	Orthotics man. and training	1 2 3 4 5		SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		
97762	C/O for orthotic/prosthetic	1 2 3 4 5		SPECIAL SCHEDULING INSTRUCTIONS:		
Supply 99070				<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code			<input type="checkbox"/> Medicare Schedule ME30 ME60 MP60		
-59	Distinct separate site/procedure			<input checked="" type="checkbox"/> # authorized visits left: 0		
GP/GO	GP Medicare Phys. Therapy/ GO Medicare Occ. Therapy			<input type="checkbox"/> Expiry Date:		
KX	MC Annual Benefit Cap exceeded and qualifies for exception			POOL THERAPY SCHEDULING: Pool Visits: Land Visits:		

Patient Signature: _____
(Auto Related Injuries)

OTTO SNOW

DOB: XXXXXXXXXX

SEX: XXXXXX

D/A: HEALTH INS

FIRST HEALTH/PPD (Y)

ACCOUNT #: 1027882

CHARGE SLIP: 4748893

08/22/12 EF30 10:30A

INJ DATE:

THERAPY COPAY: .00

LAST SEEN DT

INJ STATE:

PT BALANCE: .00

AUTH #: 60VTSFPERCALYRMODMEDNECEDMTCDV100XT

INS BALANCE: 2202.00

DX: 73681

DX:

DX:

DX:

REF PHYS: HIS MARC F HILGERS. MD

INS PCF: M33

MUKESH H MEHTA. MD

POS: PTF01

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			pt. reports feeling much better lately, able to control spasms now		
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation			Pain Level: /10		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE:		
97799	Func. Capacity Evaluation			slight tightness in @ psoas p marches		
95831	MMT Extremity, Trunk			= TB		
95851	ROM Meas. Extremity, Trunk			@ ASIS slightly lower, @ P555 slightly higher		
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	<input checked="" type="checkbox"/> THER EX (SEE FLOW) <input type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase flexibility		
97113	Aquatic Therapy	1 2 3 4 5		to core str.		
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5		<input checked="" type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other:		
97750	PPT/Isokinetic Test	1 2 3 4 5		MET to correct @ ant. innom.		
97530	Therapeutic Activities	1 2 3 4 5		XF + Tr. Pt. Release to @ psoas p ther ex.		
97110	Therapeutic Exercise	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: MNP to Lx. a tx. 5'		
97032	Electrical Stimulation (Manual)	1 2 3 4 5		CP to @ psoas p tx. 8'		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated			ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	updated NRP, pt. progressing well, however needs cont. core str. to prevent recurrence of pathology		
97598	Active wound care > 20 cm					
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)			PLAN: Reassess nv for MD		
90283	Elec Stim. (MC & United)			if all well nv, may dic to @ NRP		
97018	Paraffin			THERAPIST SIGNATURE: <i>[Signature]</i> DATE: 8/22/12		
97026	Infrared			<input type="checkbox"/> D/C IN VISITS <input type="checkbox"/> COPAY/CC INS. INFORMATION		
97010	Hot/Cold Pack (WC and Auto only)			SCHEDULING GUIDE: 1 2 3 4 5 times per week for <i>168</i> week(s)		
SPLINTING: ORTHOTICS/ SUPPLIES				Schedule w/ TEAM: <i>168</i>		
CODE	SPLINT/ORTHOTIC #:	QTY	MOD	SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		
97760	Orthotics man. and training	1 2 3 4 5		SPECIAL SCHEDULING INSTRUCTIONS:		
97762	C/O for orthotic/prosthetic	1 2 3 4 5		<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		
Supply 99070				<input type="checkbox"/> Medicare Schedule ME30 ME60 MP60		
MODIFIER	MODIFIER EXPLANATION-list modifier next to CPT code			<input checked="" type="checkbox"/> # authorized visits left: <i>1</i>		
-59	Distinct separate site/procedure			<input type="checkbox"/> Expiry Date:		
GP/GO	GP Medicare Phys. Therapy/ GO Medicare Occ. Therapy			POOL THERAPY SCHEDULING:		
KX	MC Annual Benefit Cap exceeded and qualifies for exception			<input type="checkbox"/> Pool Visits <input type="checkbox"/> Land Visits		
				Amt Pd: \$ _____		
				Payment Method: (circle one)		
				VISA MC CASH DISC AMEX		
				CHECK/ CC # _____		
				Initials: _____		

Patient Signature: _____
(Auto Related Injuries)

DOB: [REDACTED]

SEX

ACCOUNT #: 1027882
CHARGE SLIP: 4740770

LAST SEEN DT

INJ DATE:

INJ STATE: 24

THERAPY COFAY: .00

FT BALANCE:	-00
-------------	-----

AUTH # 1 ADUTSPERCALYRMDDMEDNECEDMTCDVD100%T

INS BALANCE: 1940.00

DX: 73691

DX 4

ΔX_{eff}

DX 5

REF PHYS: HIS MARC P. HILGERS, MD

INS FCP:

M33 MUKESH H MEHTA

FOS: FTFOZ

Patient Signature: _____
(Auto Related Injuries)

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: pt. reports MD thinks he has psas bursitis; pt. c/o persistent psas spasm, esp in a.m. but confessed to sleeping prone & RLE in fkg position		
97001	PT Evaluation					
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE: (R) psas not TTP, only mildly tight (R) ASIS lower, (R) PSIS higher		
97799	Func. Capacity Evaluation					
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)			TREATMENT: <input checked="" type="checkbox"/> THER EX SEE FLOW <input type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase flexibility to ↑ core stable		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD			
97113	Aquatic Therapy	1 2 3 4 5				
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5		<input checked="" type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> To improve circulation <input type="checkbox"/> Other: MET to correct (R) ant. innom. MFR to (R) QL		
97530	Therapeutic Activities	1 2 3 4 5				
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97032	Electrical Stimulation (Manual)	1 2 3 4 5				
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY): pt. progressing in core stable however still demo. confusion & HEP ex. needs cont. PT to ↑ core str. to ↓ recurrence of SIJ pathology advised pt. to keep (R) leg straight while sleeping PLAN: cont. POC		
97598	Active wound care > 20 cm					
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)			THERAPIST SIGNATURE: <i>Joy Mouton DPT</i> DATE: 8/9/12 SCHEDULING GUIDE SUPPLY PAYMENT INFORMATION		
60283	Elec Stim. (MC & United)					
97018	Paraffin					
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)					
SPLINTING/ ORTHOTICS/ SUPPLIES				1 2 3 4 5 times per week for _____ week(s). Schedule w/ TEAM: <i>P68/R20</i> SPECIAL SERVICES: <input type="checkbox"/> Whirlpool SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1:1 w/ _____ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input checked="" type="checkbox"/> # authorized visits left: <i>3</i> <input type="checkbox"/> Expiry Date: _____ POOL THERAPY SCHEDULING: <input type="checkbox"/> Pool Visits _____ <input type="checkbox"/> Land Visits _____		
SPLINT/ORTHOTIC #:				Amt Pd: \$ _____ Amt. Pd: \$ _____ Payment Method: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # _____ CHECK/ CC # _____ Initials: _____ Initials: _____		
97760	Orthotics man. and training	1 2 3 4 5				
97762	C/O for orthotic/prosthetic	1 2 3 4 5				
Supply 99070						
MODIFIER				MODIFIER EXPLANATION -list modifier next to CPT code -59 Distinct separate site/procedure GP/GO GP Medicare Phys. Therapy/ GO Medicare Occ. Therapy KX MC Annual Benefit Cap exceeded and qualifies for exception		

Patient Signature: _____
 (Auto Related Injuries)

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE: pt. has been researching more about T.P.T. & is concerned about a T.P.T. in his rectus abdominis causing the paraspinal spasms.		
97001	PT Evaluation					
97002	PT Re-Evaluation					
97003	OT Evaluation					
97004	OT Re-Evaluation					
CODE	TESTS AND MEASURES	UNITS (1)	MOD	OBJECTIVE: Supine: (R) med. mal. slightly lower (R) ASIS slightly lower		
97799	Func. Capacity Evaluation			TREATMENT: <input checked="" type="checkbox"/> THER EX SEE FLOW <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase flexibility to ↑ ankle ROM to ↑ core stability		
95831	MMT Extremity, Trunk					
95851	ROM Meas. Extremity, Trunk					
64550	TENS Eval/Checkup					
97752	MMT (WC ONLY)					
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	MANUAL THERAPY: <input checked="" type="checkbox"/> MFR to (R) Thx, paraspinals, QL, upper glutes; MET to correct @ ant innom		
97113	Aquatic Therapy	1 2 3 4 5				
97535	Patient Education/ADL	1 2 3 4 5				
97112	Neuromuscular Reeducation	1 2 3 4 5				
97750	PPT/Isokinetic Test	1 2 3 4 5				
97530	Therapeutic Activities	1 2 3 4 5		NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97110	Therapeutic Exercise	1 2 3 4 5				
97140	Manual Therapy Techniques	1 2 3 4 5				
97116	Gait Training	1 2 3 4 5				
97033	Iontophoresis (No Aetna)	1 2 3 4 5				
97032	Electrical Stimulation (Manual)	1 2 3 4 5		OTHER: MNP to Lx. 5' & tx.		
97035	Ultrasound	1 2 3 4 5				
97039	Anodyne Infrared (No MC)	1 2 3 4 5				
NOTRMT	Pt. arrived but not treated					
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD			
97598	Active wound care > 20 cm			ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY): I addressed concerns about T.P.T. & re-eg. pt. about primary issue of core weakness.		
97597	Active wound care < 20 cm					
97012	Mechanical Traction					
97022	Whirlpool/Fluidotherapy					
97014	Elec Stim. (No MC & United)					
97018	Paraffin			PLAN: cont. POC		
97026	Infrared					
97010	Hot/Cold Pack (WC and Auto only)					
SP/INT/GO	ORTHOTICS/ SUPPLIES	37	L-Code			
SP/INT/GO	SPLINT/ORTHOTIC #:					
97760	Orthotics man. and training	1 2 3 4 5		THERAPIST SIGNATURE: <i>Joe M...</i> SCHEDULING GUIDE: 1 2 3 4 5 times per week for _____ week(s). SPECIAL SERVICES: <input type="checkbox"/> Whirlpool SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 31:1 w/ _____ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min <input type="checkbox"/> Medicare Schedule ME30 ME60 MP60 <input checked="" type="checkbox"/> # authorized visits left: 4 <input type="checkbox"/> Expiry Date: _____ POOL THERAPY SCHEDULING: Pool Visits _____ Land Visits _____		
97762	C/O for orthotic/prosthetic	1 2 3 4 5				
Supply 99070			FEE:			
MODIFIER	MODIFIER EXPLANATION-List modifier next to CPT code					
-59	Distinct separate site/procedure					
GP/GO	GP Medicare Phys. Therapy/ GO Medicare Occ. Therapy					
KX	MC Annual Benefit Cap exceeded and qualifies for exception					
				AMT PD: \$ _____ PAYMENT METHOD: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # _____ INITIALS: _____		
				AMT. PD: \$ _____ PAYMENT METHOD: (circle one) VISA MC CASH DISC AMEX CHECK/ CC # _____ INITIALS: _____		

Patient Signature: _____
(Auto Refiled Injuries)

736.81

H7

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
CODE	DESCRIPTION	UNITS (1)	MOD	SUBJECTIVE:		
97001	PT Evaluation			pt. reports feeling somewhat better, he has been sitting on a therapy ball & keeping up w/ his HEP		
97002	PT Re-Evaluation			Pain Level: /10		
97003	OT Evaluation			OBJECTIVE:		
97004	OT Re-Evaluation			① ASIS lower in supine		
CODE	TESTS AND MEASURES	UNITS (1)	MOD	TREATMENT:		
97799	Func. Capacity Evaluation			<input checked="" type="checkbox"/> THER EX <u>SEE FLOW</u> <input checked="" type="checkbox"/> To Increase Rom <input checked="" type="checkbox"/> To Increase Endurance/Activity Tolerance		
95831	MMT Extremity, Trunk			<input checked="" type="checkbox"/> To Increase Strength <input checked="" type="checkbox"/> To Increase flexibility		
95851	ROM Meas. Extremity, Trunk			to ↑ core stabil.		
64550	TENS Eval/Checkup			<input checked="" type="checkbox"/> MANUAL THERAPY: <input type="checkbox"/> To Increase Joint Mobility <input type="checkbox"/> To Improve circulation		
97752	MMT (WC ONLY)			<input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
CODE	TIME BASED PROCEDURES	UNITS (Circle)	MOD	MET to ⑧ QL, upper glutes, piriformis, & ⑧ psoas XFM; prone passive hip MET to correct ⑧ ant. innom.		
97113	Aquatic Therapy	1 2 3 4 5		<input type="checkbox"/> NEUROMUSCULAR RE-ED: <input type="checkbox"/> Balance <input type="checkbox"/> Posture		
97535	Patient Education/ADL	1 2 3 4 5		<input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
97112	Neuromuscular Reeducation	1 2 3 4 5		<input checked="" type="checkbox"/> OTHER: MNP to Lx 5' to tx.		
97750	PPT/Isokinetic Test	1 2 3 4 5		ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):		
97530	Therapeutic Activities	1 2 3 4 5		pt. seems a bit anxious about his condition but was able to tol. all new thera. today		
97110	Therapeutic Exercise	1 2 3 4 5		updated HEP		
97140	Manual Therapy Techniques	1 2 3 4 5		needs cont. PT to ↑ core stabil.		
97116	Gait Training	1 2 3 4 5		PLAN:		
97033	Iontophoresis (No Aetna)	1 2 3 4 5		cont. PDC		
97032	Electrical Stimulation (Manual)	1 2 3 4 5		THERAPIST SIGNATURE: <i>[Signature]</i> DATE: 7/26/12		
97035	Ultrasound	1 2 3 4 5		SCHEDULING GUIDE: 1 2 3 4 5 times per week for 1 week(s)		
97039	Anodyne Infrared (No MC)	1 2 3 4 5		SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		
NOTRMT	PL arrived but not treated			SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		
CODE	SERVICE BASED PROCEDURES	UNITS (1)	MOD	Medicare Schedule ME30 ME60 MP60		
97598	Active wound care > 20 cm			<input checked="" type="checkbox"/> # authorized visits left: 5		
97597	Active wound care < 20 cm			<input type="checkbox"/> Expiry Date: _____		
97012	Mechanical Traction			POOL THERAPY SCHEDULING: _____		
97022	Whirlpool/Fluidotherapy			Land Visits: _____		
97014	Elec Stim. (No MC & United)			AMT Pd: \$ _____		
G0283	Elec Stim. (MC & United)			Payment Method: (circle one) VISA MC CASH DISC AMEX		
97018	Paraffin			CHECK/ CC # _____		
97026	Infrared			Initials: _____		
97010	Hot/Cold Pack (WC and Auto only)			AMT Pd: \$ _____		
SPLINTING/ ORTHOTICS, SUPPLIES				COPAY/CO-INS INFORMATION		
SPLINT/ORTHOTIC #:				Schedule w/ TEAM: P68/1820		
97760	Orthotics man. and training	1 2 3 4 5		SPECIAL SERVICES: <input type="checkbox"/> Whirlpool		
97762	C/O for orthotic/prosthetic	1 2 3 4 5		SPECIAL SCHEDULING INSTRUCTIONS: <input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min		
Supply 99070				Medicare Schedule ME30 ME60 MP60		
MODIFIER				MODIFIER EXPLANATION: not report or next to CPT code		
-59	Distinct separate site/procedure			<input checked="" type="checkbox"/> # authorized visits left: 5		
GP/GO	GP Medicare Phys. Therapy/ GO Medicare Occ. Therapy			<input type="checkbox"/> Expiry Date: _____		
KX	MC Annual Benefit Cap exceeded and qualifies for exception			POOL THERAPY SCHEDULING: _____		

Patient Signature: _____
(Auto Related Injuries)

SNOW [REDACTED] SEX: M A: HEALTH INS ACCOUNT #: 1081042
EST HEALTH/PPD (Y) LARGE BLIP: 4727367
1715 NP60 2:30P INT DATE: THE AFY COARY: .00
ST BEEN IT INT STATE: PT BALANCE: .00
730.81 DX: DX: INE BALANCE: 594.00
HIS MARC F HILGERS, MD INS PCF: M33 MUKESH H MEHTA, MD 59

PHYSICAL MEDICINE AND REHABILITATION				DAILY NOTE	PHYSICAL THERAPY	OCCUPATIONAL THERAPY
SUBJECTIVE:				see eval		
OBJECTIVE:				↓		
TREATMENT:				<input type="checkbox"/> THER EX SEE FLOW <input type="checkbox"/> To Increase Rom <input type="checkbox"/> To Increase Endurance/Activity Tolerance <input type="checkbox"/> To Increase Strength <input type="checkbox"/> To Increase flexibility		
MANUAL THERAPY:				<input checked="" type="checkbox"/> To increase Joint Mobility <input type="checkbox"/> To improve circulation <input type="checkbox"/> To decrease tightness/spasm <input type="checkbox"/> Other:		
NEUROMUSCULAR RE-ED:				<input type="checkbox"/> Balance <input type="checkbox"/> Posture <input type="checkbox"/> Proprioception <input type="checkbox"/> Coordination		
OTHER:						
ASSESSMENT: (PROGRESS/ REASON TO CONTINUE THERAPY):				See eval pt. responded well to MET today		
PLAN:				↓		
THERAPIST SIGNATURE:				[Signature] DATE: 7/17/12		
SCHEDULING GUIDE				SUPPLY PAYMENT INFORMATION		
1 2 3 4 5 times per week for 41 week(s).				Amt Pd: \$		
Schedule w/ TEAM: P68				Payment Method: (circle one)		
SPECIAL SCHEDULING INSTRUCTIONS:				VISA MC CASH DISC AMEX		
<input type="checkbox"/> 1:1 w/ <input type="checkbox"/> not cons days <input type="checkbox"/> 60 min				CHECK/ CC #		
<input type="checkbox"/> Medicare Schedule ME30 ME60 MP60				Initials:		
<input type="checkbox"/> # authorized visits left: NEED AUTH				Initials:		
<input type="checkbox"/> Expiry Date:						
POOL THERAPY SCHEDULING:						
Pool Visits				Land Visits		

CODE	DESCRIPTION	UNITS (1)	MOD
97001	PT Evaluation	1	
97002	PT Re-Evaluation		
97003	OT Evaluation		
97004	OT Re-Evaluation		
TESTS AND MEASURES			
97799	Func. Capacity Evaluation		
95831	MMT Extremity, Trunk		
95851	ROM Meas. Extremity, Trunk		
64550	TENS Eval/Checkup		
97752	MMT (WC ONLY)		
TIME BASED PROCEDURES			
97113	Aquatic Therapy	1 2 3 4 5	
97535	Patient Education/ADL	1 2 3 4 5	
97112	Neuromuscular Reeducation	1 2 3 4 5	
97750	PPT/Isokinetic Test	1 2 3 4 5	
97530	Therapeutic Activities	1 2 3 4 5	
97110	Therapeutic Exercise	1 2 3 4 5	
97140	Manual Therapy Techniques	1 2 3 4 5	
97116	Gait Training	1 2 3 4 5	
97033	Iontophoresis (No Aetna)	1 2 3 4 5	
97032	Electrical Stimulation (Manual)	1 2 3 4 5	
97035	Ultrasound	1 2 3 4 5	
97039	Anodyne Infrared (No MC)	1 2 3 4 5	
NOTRMT	Pt. arrived but not treated		
SERVICE BASED PROCEDURES			
97598	Active wound care > 20 cm		
97597	Active wound care < 20 cm		
97012	Mechanical Traction		
97022	Whirlpool/Fluidotherapy		
97014	Elec Stim. (No MC & United)		
G0283	Elec Stim. (MC & United)		
97018	Paraffin		
97026	Infrared		
97010	Hot/Cold Pack (WC and Auto only)		
SPLINTING/ ORTHOTICS/ SUPPLIES			
QTY	Code	MOD	
SPLINT/ORTHOTIC #:			
97760	Orthotics man. and training	1 2 3 4 5	
97762	C/O for orthotic/prosthetic	1 2 3 4 5	
Supply 99070		FEE:	
MODIFIER			
-59	Distinct separate site/procedure		
GP/GO	GP Medicare Phys. Therapy/ GO Medicare Occ. Therapy		
KX	MC Annual Benefit Cap exceeded and qualifies for exception		

Patient Signature: _____
(Auto Related Injuries)



Physical Therapy Discharge Summary

Patient: Otto Snow

Date: 8/30/12

Physician: Hilgers

MR Number: 1027882

Diagnosis: Unequal Leg Length

Visits ordered/ attended: 7/7

TREATMENT:

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Neuro-muscular Re-education |
| <input checked="" type="checkbox"/> Manual Therapy | <input type="checkbox"/> Gait Training | <input checked="" type="checkbox"/> Heat / Ice |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Traction | <input type="checkbox"/> Other: _____ |

The patient was taught a home exercise program: ☒ complete ☐ incomplete ☐ none

The pt. is independent with the HEP as instructed. ☒ yes ☐ no ☐ unknown

PHYSICAL EXAMINATION:

☒ Last noted objective measurements dated: 8/29/12

☐ The patient was not available to be examined for this discharge summary. Initial presentation and measurements can be found on the evaluation dated: _____.

GOALS: (based on observation and assessment during recent appointments)

Initial goals can be found on the evaluation.

- | | | | | |
|---------------------|---|----------------------------------|----------------------------------|--|
| 1) ROM goals | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: _____ |
| 2) Strength goals | <input checked="" type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: _____ |
| 3) Functional goals | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input checked="" type="checkbox"/> Partially Met: _____ |
| 4) Other: _____ | <input type="checkbox"/> Met | <input type="checkbox"/> Not Met | <input type="checkbox"/> Unknown | <input type="checkbox"/> Partially Met: _____ |

ASSESSMENT AND PLAN:

The patient will be discharged at this time because:

- ☐ the patient was discharged by the physician.
- ☒ the patient met all goals; instructed to continue HEP for ROM/strength.
- ☒ the patient can continue on an independent basis to regain final ROM/strength.
- ☐ the patient does not want to return to therapy because their condition improved.
- ☐ the patient does not want to return to therapy because they feel therapy has not helped.
- ☐ the patient cannot be reached despite multiple attempts.
- ☐ the patient's benefits have been exhausted/expired; patient offered private pay, but denied..
- ☐ other: _____

Therapist's Signature: Jay Moulton, DPT Date: 8/30/12

MD Appointment: 9/4/12Clinic: Telecom
MR#: 1027882

Physical/Occupational Therapy Report (Lumbar)

☐ Progress ☒ DischargePatient: Otto Snow
Physician: Dr. Hilgers
Diagnosis: unequal leg lengthDate: 8/29/12
#Visits: 3

Current Treatment Modalities/Interventions

- ☒ Moist Heat/Cold Pack
☐ Fluidotherapy/Whirlpool
☐ Ultrasound
☒ MFR/STM
- ☐ Electrical Modalities
☐ Iontophoresis
☒ Therapeutic Exercise
☒ Joint Mobilization
- ☐ PROM
☐ AAROM
☐ AROM
☐ Anodyne
- ☒ Strengthening
☒ Patient Education
☐ Scar Management
☒ MET, NMR

Pain Rating: Initial: 10/10 worst Present: 7/10 @ worst during past wk. 2° constipationFunctional Level: pt. is able to control psoas spasms in the a.m., just has persistent spot specific p. @ ant. hip/inguinal lig. & hip v. mnts.

ROM: Initial:	Present:	Strength: Initial:	Present:
		R	L
Lmbr FB: <u>90-40 = 50°</u>	<u>95-65 = 30°</u>	Hip Flex: <u>5</u>	<u>5</u>
Lmbr Ext: <u>10-5 = 5°</u>	<u>10-5 = 5°</u>	Hip Abd: <u>5</u>	<u>5</u>
Lmbr SBR: <u>15-0 = 15°</u>	<u>25-15 = 10°</u>	Hip ER: <u>5</u>	<u>5</u>
Lmbr SBL: <u>25-10 = 15°</u>	<u>23-15 = 8°</u>	Hip IR: <u>4</u>	<u>5</u>
		Kn. Flex: <u>5</u>	<u>4+</u>
		Kn. Ext: <u>5</u>	<u>5</u>
		Ankle DF: <u>5</u>	<u>5</u>
		Ankle PF: <u>5</u>	<u>5</u>
		Ankle Ev:	
		Ankle Inv:	

Other: pt. is compliant & (I) = NER; still has p. = repetitive sit-stand transfers; able to sit indefinitely though

Goals:	STG <input type="checkbox"/> New <input type="checkbox"/> Updated
1. (I) = NER (met)	
2. demonstrate proper seated posture & sit = 1 hour w/ ↑ 5x5 (met)	
3. able to return to hiking for rec. (met) → in progress	
4. ↑ BLE Str. to 5/5 (met) → except (L) knee ✓	

Assessment: (reason for continuation/discharge of current therapy)

Pt's Lx. ROM is variable, however str. has improved. Pt. is compliant & (I) = NER. Pt. has L'd sx's overall, however still has concerns regarding p. @ ant. hip & wants to explore other tx options (injections, surgery, prolotherapy, etc.)

Plan/Recommendations: D/C pt. to (I) NER

- ☐ Patient discharged secondary to noncompliance with attempts made to reschedule remaining appointments
☐ Patient unavailable for current objective/subjective reassessment
☐ Patient's benefits have been exhausted/expired; patient was offered a private pay option to continue, but denied.
☐ Patient set up with HEP.

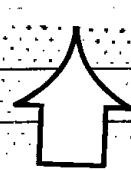
Therapist Signature: Jay Moulton, DPTDate: 8/29/12



Facility: Telecom
MR #: 1027882

Physical Therapy Evaluation

Patient: <u>Otto Snow</u>	Physician: <u>Dr. Hilgers</u>														
Diagnosis: <u>unequal leg length</u>	Onset/Surgery Date: <u>2007</u>														
Medical History: <u>HBP, Hemangioma Liver, Gilbert's syn. & ↑ fatigue 2° & mod. metal</u>	Occupation: <u>Publisher</u>														
History: <u>pt. lifted heavy book case while twisted to the (R), had p! in (R) groin, some surgeons think it might be a hernia; pt. also reports (R) SIJ p! & (R) knee swelling & p! ← knee p! since childhood</u>	Function: Patient is currently unable to: <u>hiking</u> <u>sitting to type</u> <u>prone lying</u>														
Pain: <u>(1) 1 2 3 4 5 6 7 8 9 10</u> Location: <u>(R) groin & SIJ</u> Type: <u>dull achy intense worse in a.m.</u> <u>pt. reports heel lift helps = SIJ & groin p! but p! keeps coming back</u>															
Observation: <u>(R) iliac crest</u> <u>(R) ASIS lower</u>	Supine: <u>(R) med. mal. lower, (R) ASIS lower</u>														
Range of Motion: <u>Lx</u> <u>✓ 90-40 = 50°</u> <u>✓ 10-5 = 5°</u> <u>R5B 15°</u> <u>L5B 25-10 = 15°</u>	Strength: <table border="0"><tr><td><u>B</u></td><td><u>L</u></td></tr><tr><td><u>hip ✓</u></td><td><u>5 5</u></td></tr><tr><td><u>abd 5</u></td><td><u>5 5</u></td></tr><tr><td><u>ER 6</u></td><td><u>5 5</u></td></tr><tr><td><u>IR 4</u></td><td><u>5 5</u></td></tr><tr><td><u>DF</u></td><td><u>5 5</u></td></tr><tr><td><u>PE</u></td><td><u>5 3</u></td></tr></table> <u>knee ✓</u> <u>5 5</u> <u>5 5</u> <u>5 5</u>	<u>B</u>	<u>L</u>	<u>hip ✓</u>	<u>5 5</u>	<u>abd 5</u>	<u>5 5</u>	<u>ER 6</u>	<u>5 5</u>	<u>IR 4</u>	<u>5 5</u>	<u>DF</u>	<u>5 5</u>	<u>PE</u>	<u>5 3</u>
<u>B</u>	<u>L</u>														
<u>hip ✓</u>	<u>5 5</u>														
<u>abd 5</u>	<u>5 5</u>														
<u>ER 6</u>	<u>5 5</u>														
<u>IR 4</u>	<u>5 5</u>														
<u>DF</u>	<u>5 5</u>														
<u>PE</u>	<u>5 3</u>														
Special Tests: <u>IS: (+) FB</u> <u>(+) BB (R)</u> <u>(+) Stork (R)</u> <u>sit-s slump = (0)</u> <u>Thomas = (+) (R)</u> <u>sup-sit = (+) (R) ant. innom.</u>	Neurologic:														
Skin/Soft Tissue/Palpation: <u>TTP (R) prox. rectus fem. & iliopsoas</u> <u>TTP (R) inginal reg., p! = cough but no palpable hernia</u>															
Accessory Movements: <u>↓ (R) passive hip IR = p! in (R) SIJ</u>															
PT Problems/ Functional Limitations: <u>SX's resemble (R) ant. innom.</u>	PT Goals: <u>8 visits:</u> <u>1. (1) = HEP</u> <u>2. able to demo proper seated posture + sit = 1 hour & ↑ SX's</u> <u>3. able to return to hiking for rec.</u> <u>4. ↑ (B) LE str. to 5/5</u>														
Plan: <input checked="" type="checkbox"/> ROM <input checked="" type="checkbox"/> Strengthening <input checked="" type="checkbox"/> HEP Instruction <input checked="" type="checkbox"/> Modalities PRN <input checked="" type="checkbox"/> Pt Edu. <input checked="" type="checkbox"/> NMR <input checked="" type="checkbox"/> Traction <input checked="" type="checkbox"/> Manual Rx	Frequency/Duration: <u>2 x/week for 4 weeks</u>														
Therapist's signature: <u>Joy Moulton, DPT</u>	Date: <u>7/17/12</u>														



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Fellowship Trained Subspecialists

**Adult Reconstruction
And Arthritis Surgery**
Thomas L. Bernasek, M.D.
Grant G. Garlick, M.D.
Kenneth A. Gustke, M.D.
Steven T. Lyons, M.D.
Michael A. Miranda, D.O.
David T. Watson, M.D.

Foot and Ankle Surgery
Michael P. Clare, M.D.
Dolfi Herscovici, Jr., D.O.
Roy W. Sanders, M.D.
Arthur K. Walling, M.D.

**Hand Surgery
And Microsurgery**
M. Ellen Beatty, M.D.
Michael J. Garcia, M.D.
Alfred V. Hess, M.D.
Jeffrey D. Stone, M.D.

Interventional Spine
Steven A. Bama, M.D.
Howard B. Jackson, M.D.

Musculoskeletal Oncology
Arthur K. Walling, M.D.

**Physical Medicine
And Rehabilitation**
Jodi A. Shields, M.D.

Shoulder and Elbow Surgery
Eddy L. Echols, Jr., M.D.
Mark A. Frankie, M.D.
Mikha A. Mighell, M.D.

Spine Surgery
James B. Bilyys, M.D.
Antonio E. Castellvi, M.D.
John M. Small, M.D.
Marc A. Weinstein, M.D.

Sports Medicine
Grant G. Garlick, M.D.
Seth L. Gasser, M.D.
Adam C. Morse, D.O.

Primary Care Sports Medicine
H. Wesley Dykes, D.O.
Marc P. Hilgers, M.D.

Trauma
Daniel S. Chan, M.D.
Dolfi Herscovici, Jr., D.O.
Anthony F. Infante, D.O.
Il. Claude Sagi, M.D.
Roy W. Sanders, M.D.
Anjan Shah, M.D.
David T. Watson, M.D.
Thomas G. DiPasquale, D.O.
(Consulting Physician)

General Orthopaedics
Thomas M. Davison, M.D.
Eddy L. Echols, Jr., M.D.
Anthony F. Infante, D.O.

Chiropractic Services
Jeffrey Langmaid, D.C.
David A. Reina, D.C.

FROM: FLORIDA ORTHOPAEDIC INSTITUTE
PROV: MARC HILGERS, M.D.
RE: OTTO SNOW
DOB: [REDACTED]
DATE: 7/10/2012
MR#: 1027882 (AF02)

Reason for Consult: Buttock and Right Lower Abdominal Pain

Mr. Snow is a 56 year old Caucasian male here for evaluation for buttock and right lower abdominal pain. The patient's condition is a result of an injury (/ /2006). The injury occurred at home. The patient has received previous treatment (physical therapy and chiropractic) for this problem. The patient describes the mechanism of his injury as lifting and hiking. At the time of the injury Mr. Snow states he felt pain.

CHIEF COMPLAINT: Buttock and right lower abdominal pain.

HISTORY OF PRESENT ILLNESS: This is a 56-year-old Caucasian male who presents today with pain in his right lower quadrant and in his right buttock. He states this has been going on since 2006.

Outcomes Instruments:

SF-12: In general, Mr. Snow feels that his health is fair. In the past four weeks, he was not limited at all in moderate activities. He accomplished less than he would like in the past four weeks, due to physical health. He accomplished less than he would like in the past four weeks, due to emotional health (feeling depressed or anxious). Pain interfered with the patient's normal work (including both work outside the home and housework) extremely, during the past four weeks.

Medical History:

1. Anxiety

Surgeries:

None.

Allergies:

1. Corticosteroids

Medications:

1. Lorazepam 1mg
2. Metoprolol 25mg

He takes the following medications on a regular basis: Prilosec

Zantac

He does not report any pertinent anti-inflammatory use or reaction

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2106 S. Lois Ave., 2nd Floor, Tampa, FL 33629 • 11373 Cortez Blvd., Suite 303, Brooksville, FL 34613
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Appointments: 813-978-9797 • General Information: 813-978-9700 • www.floridaortho.com

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history.

Family History:

No pertinent family health history reported. His father is deceased at age 74 (cause of death not specified). His mother is deceased at age 84 (cause of death not specified).

Social History:

He is single. He does not report any exercise frequency. Otto is a part time publisher. He denies current alcohol use, but previously drank alcohol. He currently uses tobacco. He smokes on average 1 pack of cigarettes a day.

ROS:

10 System Review of Systems is positive for difficulty sleeping, high blood pressure, gallbladder problems, anxiety, muscle pain, back pain and specifically negative for chest pain, shortness of breath, gross hematuria and melena.

PHYSICAL EXAMINATION: This is a 56-year-old Caucasian male, awake, alert and oriented x 3 and cooperative. He is well nourished, well developed and in no apparent distress. Height: 5 feet 9 inches. Weight: 142 pounds. Blood pressure: 118/82. Pulse: 76. He has full active and passive range of motion in both hips. The left leg is about half a centimeter shorter than the right leg.

PHYSICAL EXAMINATION:

Vital Signs: Ht:5ft.09in. Wt:145lbs.

General:

Healthy appearing stated age. Respiratory rate within normal limits.

Cognitive:

Oriented x 3 demonstrating normal mood and affect.

Lymphatics:

There is no evidence of adenopathy in affected extremity.

Skin:

Head, neck, and extremity skin is intact without rashes or lesions.

Musculoskeletal Exam

Leg length exam reveals the right longer by 0.5cm. Mild pelvic obliquity. Right knee demonstrates neutral alignment. Left knee demonstrates neutral alignment. Feet noted to be normal. Gait is normal. There is no quadriceps atrophy noted. No effusion present.

Motion

Right hip motion is normal.

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Left hip motion is normal.

Right Hip Tests
Trendelenburg test normal

Left Hip Tests
Trendelenburg test normal

Sensory exam is normal sensation normal sensation. Motor exam is symmetric. Strength exam demonstrates no motor deficits appreciated strength.

Right Vascular Exam
Dorsalis pedis pulse 2+.
Posteroir tibial pulse 2+.
No edema noted.

Left Vascular Exam
Dorsalis pedis pulse 2+.
Posteroir tibial pulse 2+.
No edema noted.

DIAGNOSTIC STUDIES: Today's bilateral lower extremity scanogram revealed true leg length discrepancy of 0.5 cm left shorter than the right, otherwise negative.

ASSESSMENT/PLAN: This is a 56-year-old Caucasian male with true leg length discrepancy of 0.5 cm left shorter than the right, poor core strength and slight pectus excavatum. He was also found to have bilateral pes planus. We gave him a prescription for Lynco arch supports with metatarsal pads as well as 0.5 cm heel lift for the left shoe. We discussed IntelliSkin shirts to help him with his posture. We discussed good choices for office chairs. He received a prescription for physical therapy. He will follow up with Dr. Mehta or us in four weeks or earlier if necessary.

PROCEDURE NOTE: The patient was found to have a leg length discrepancy of 0.5 cm. With the help of osteopathic manipulation techniques including muscle energy techniques targeting the lumbar spine, SI joint and pelvis, we attempted to correct this. Unfortunately, we were unable to do so in the office today.

Marc P. Hilgers, MD
MPH: sni/sir

cc: Mukesh H. Mehta, MD

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D: 07/10/2012
T: 07/11/2012

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00066859
0395906

PROTOCOL

HABILITATION PRESCRIPTION & PLAN OF CARE

Physical & Occupational / Hand Therapy

Preoperative Authorization is medically necessary

NAME: OTTO SNOW MRN: 1027882 DATE: 7/10/2012

DIAGNOSIS: 736.81 UNEQUAL LEG LENGTH DOI:

DOS:

PROCEDURE:

FREQUENCY: ☐ 5xWk ☐ 3xWk ☐ 6 Wks ☒ 4 Wks ☐ 2xWk ☐ 1xWk ☐ 3 Wks ☐ Other DURATION: WB ☐ FWB ☐ PWB
STATUS: ☐ TTWB ☐ WBAT
☒ EVALUATE AND TREAT ☒ HOME PROGRAM ☒ MODALITIES PRN ☐ %WB

TREATMENT	PROTOCOLS / PROGRAMS	
THERAPEUTIC EXERCISE <input type="checkbox"/> Range of Motion <input type="checkbox"/> Passive <input type="checkbox"/> Active - Assist <input type="checkbox"/> Active <input type="checkbox"/> Strengthening <input type="checkbox"/> Stabilization <input type="checkbox"/> Flexibility <input type="checkbox"/> Home Program Tband Free Wts <input type="checkbox"/> Closed Chain Stressloading	LOWER EXTREMITY <input type="checkbox"/> Ankle Program <input type="checkbox"/> Ankle Fusion <input type="checkbox"/> Meniscus Tear <input type="checkbox"/> Meniscus Repair <input type="checkbox"/> ACL Phase: <input type="checkbox"/> Anterior Knee Pain Protocol <input type="checkbox"/> Total Knee Replacement Protocol <input type="checkbox"/> Total Knee - Revision Protocol <input type="checkbox"/> Total Hip Replacement Protocol <input type="checkbox"/> Total Hip - Revision Protocol <input type="checkbox"/> Post Arthroscopy <input type="checkbox"/> Protonics	SPINE <input type="checkbox"/> Lumbar Stabilization Level: <input type="checkbox"/> Williams Flexion Exercises <input type="checkbox"/> MacKenzie Extension <input type="checkbox"/> Back School / Body Mech. Educ. <input type="checkbox"/> Postural Exercises <input type="checkbox"/> Cervical Stabilization
MANUAL THERAPY / PROCEDURES <input checked="" type="checkbox"/> Massage <input checked="" type="checkbox"/> Myofascial Release <input checked="" type="checkbox"/> Manual Mobilization <input type="checkbox"/> Traction <input type="checkbox"/> Proprioception <input type="checkbox"/> Balance <input type="checkbox"/> Gait Training WB Status: % <input type="checkbox"/> Edema Management <input type="checkbox"/> Coordination <input type="checkbox"/> Dexterity <input type="checkbox"/> Flicking <input type="checkbox"/> Desensitization <input type="checkbox"/> Sensorv Re-education	UPPER EXTREMITY <input type="checkbox"/> Rotator Cuff Impingement <input type="checkbox"/> Shoulder Impingement <input type="checkbox"/> Rotator Cuff Repair <input type="checkbox"/> Shoulder Stabilization <input type="checkbox"/> Shoulder Dislocation <input type="checkbox"/> Total Shoulder Arthroplasty Phase: ELBOW <input type="checkbox"/> Total Elbow <input type="checkbox"/> Radial Tunnel Syndrome <input type="checkbox"/> Epicondylitis <input type="checkbox"/> Lateral Epicondylitis Release <input type="checkbox"/> Cubital Tunnel Syndrome WRIST / HAND <input type="checkbox"/> Ulnar Nerve Transposition <input type="checkbox"/> Distal Radius Fracture <input type="checkbox"/> Flexor Tendon Repair - Zone <input type="checkbox"/> Extensor Tendon Repair - Zone <input type="checkbox"/> 1st Dorsal Compartment Release <input type="checkbox"/> Dupuytren's Release <input type="checkbox"/> Tenolysis <input type="checkbox"/> Trigger Finger Release <input type="checkbox"/> CMC Arthroplasty <input type="checkbox"/> MP Arthroplasty <input type="checkbox"/> Tendon Transfer <input type="checkbox"/> Carpal Tunnel Syndrome	ORTHOTICS / SPLINT <input type="checkbox"/> Type of Splint <input type="checkbox"/> Static Progressive <input type="checkbox"/> Dynamic <input type="checkbox"/> Static <input type="checkbox"/> Adjustment <input type="checkbox"/> Custom Foot Orthotic SPECIAL TESTS <input type="checkbox"/> Functional Capacity Evaluation FCE <input type="checkbox"/> Physical Capacity Assessment PCA <input type="checkbox"/> Isokinetic Testing (Biodex) SPECIAL PROGRAMS <input type="checkbox"/> Physical Reconditioning <input type="checkbox"/> Work Conditioning / Hardening <input type="checkbox"/> Aquatic Therapy OTHER Matt SPECIAL INSTRUCTONS / PRECAUTIONS
PATIENT EDUCATION / ADLs <input type="checkbox"/> Patient Education / ADL <input type="checkbox"/> Ergonomics Instruction <input type="checkbox"/> Work Simplification <input type="checkbox"/> Joint Protection		
WOUND CARE <input type="checkbox"/> Wound Debridement <input type="checkbox"/> Scar Management		
MODALITIES <input type="checkbox"/> Hot / Cold Packs <input type="checkbox"/> Iontophoresis / Phonophoresis <input type="checkbox"/> Contrast Baths <input type="checkbox"/> Fluidotherapy <input type="checkbox"/> Paraffin <input type="checkbox"/> Whirlpool <input type="checkbox"/> Ultrasound <input type="checkbox"/> Electrical Stimulation <input type="checkbox"/> US / Electrical Stimulation <input type="checkbox"/> TENS <input type="checkbox"/> Anodvne / Infrared		

☐ Verbal Order Date: Therapist Signature:

I certify that the above rehabilitation treatment and plan of care is medically necessary. The Plan of Care will be reviewed at least eve

PHYSICIAN'S SIGNATURE: Marc Hilgers, M.D. DATE: 7/10/2012

FOR OFFICE USE ONLY: DATE: TIME: PROVIDER:

FACILITY: LOCATION:

INS TYPE: NOTES:

4/11/11

Exercises

All w/ No Pain

Seated 1) sole of foot to opposite calf
3x10 reps 2-3x/day

2) Ly on back squeeze ball
(w/ feet together) between bent
knees. 2-3x/day

PT DX: 1) Right upslip of pelvis

2) Sacralitis

3) Weak piriformis (B)

4) decrease tone of Transverse abdominus

5) Pubis osteitis (Rectus Abdominal and (R)
Adductor Longus)

4/11/11 Dr Whelton



SEND TO: QUEST DIAGNOSTICS INCORPORATED
ATTN: REFERRAL TESTING
4225 EAST FOWLER AVENUE
TAMPA, FL 33617



Quest
Diagnostics

Quest Diagnostics Incorporated
33608 Ortega Hwy., San Juan Capistrano, CA 92675
CLIENT SERVICES - (800) 553-5445
Director: Jon Nakamoto, M.D., Ph. D.

Nichols Institute™

PATIENT NAME		PATIENT ID NO.		DATE		TIME
SNOW, OTTO		TMO34066R		COLLECTED 11/21/2011		11:13
ACCESSION NO.	AGE	SEX	SAMPLE ID NO	OTHER ID NO	RECEIVED	11/22/2011 04:40
83445072*	55	MALE	NOT GIVEN	60575693	REPORTED	11/29/2011 16:55
REMARKS				REFERRING PHYSICIAN	STATUS	
				FRANKENBERG	DUPLICATE	

TEST RESULT (= OUT OF RANGE) UNITS REFERENCE RANGE

UGT1A1 TA Repeat

SEE BELOW

RESULT: HOMOZYGOUS FOR THE TA7 POLYMORPHISM

Interpretation: Molecular analysis indicates that the tested individual is positive for two copies of the TA7 polymorphism in the UGT1A1 gene. The patient is expected to have diminished detoxification of the active metabolite of irinotecan, SN-38, leading to increased toxicity. He/she should be considered for reduced dosage of irinotecan.

Laboratory results and submitted clinical information reviewed by Franklin Quan, Ph.D., ABMG, CGMB.

Uridine diphosphate glucuronosyltransferase 1A1 (UGT1A1) is primarily responsible for the glucuronidation and detoxification of SN-38, the active metabolite of irinotecan (Camptosar). A polymorphic TA sequence in the promoter region of the UGT1A1 gene, TA7 (UGT1A1*28), is associated with reduced SN-38 glucuronidation. Thus, patients homozygous for the TA7 polymorphism have Gilbert syndrome with decreased detoxification capacity leading to a higher risk of the side effects such as neutropenia and diarrhea. These observations have prompted the FDA to mandate a change in the irinotecan package label.

The TA7 polymorphism in the UGT1A1 gene is detected by amplification of the gene region by polymerase chain reaction (PCR) in the presence of a fluorescently-labeled primer. The amplified product is detected on an automated DNA sequencer. Since genetic variation and other problems can affect the accuracy of direct mutation testing, the results should always be interpreted in light of clinical and familial data.

This does not detect other polymorphisms or mutations in the UGT1A1 gene which may impair irinotecan detoxification. Neither does it examine other modifiers of irinotecan metabolism, such as CYP3A4 activity. For assistance with the interpretation of these results, please contact your local Quest Diagnostics genetic counselor or call 1-866-GENEINFO (436-3463).

This test was developed and its performance characteristics have been determined by Quest Diagnostics Nichols Institute, San Juan Capistrano. Performance characteristics refer to the analytical performance of the test.

Q. G. Hart's Signature
11/30/11

History=UNK
Exam=UNK / Complexity of MDM=UNK

<input type="checkbox"/> New <input checked="" type="checkbox"/> Est <input type="checkbox"/> PBC <input type="checkbox"/> Cons <input type="checkbox"/> Diet <input type="checkbox"/> Phys		Name: SNOW, OTTO SSN: 31182 Acct: 31182 Birthdate: [redacted] Age: 55 yrs. 0 mon. Visit Date: 01/22/2011 03:45 pm		Employer: Job Title: SunCoast Urgent Care 4112 Mariner Blvd, Spring Hill, FL 34609		Musculoskeletal PiVoT Ver. 3.0 09/01/04 PRACTICE VELOCITY <input type="checkbox"/> Cash <input checked="" type="checkbox"/> No Code <input type="checkbox"/> Discard	
* Main Problem (list only one) <input checked="" type="checkbox"/> pain <input type="checkbox"/> swelling <input type="checkbox"/> pressure <input type="checkbox"/> cut or laceration <input type="checkbox"/> itch <input type="checkbox"/> numbness <input type="checkbox"/> other (specify) Date of Onset (mm-dd-yy) 01-21-11 Time of Onset (hh-mm) [redacted] AM PM Where is it? Back Worse when... N/A Better when... N/A Timing is... <input type="checkbox"/> constant <input type="checkbox"/> constant, worse at times <input type="checkbox"/> comes & goes List related symptoms How severe? (check one) 0 1 2 3 4 5 6 7 8 9 10 0=no pain or symptoms worst of your life=10 Quality: Radiation? <input type="checkbox"/> no <input type="checkbox"/> yes, where? <input type="checkbox"/> sharp <input type="checkbox"/> ache <input type="checkbox"/> burn <input type="checkbox"/> other What caused this or was happening when this started? (describe below) Injury? <input type="checkbox"/> N <input type="checkbox"/> Y MVA? <input type="checkbox"/> N <input type="checkbox"/> Y Work-related? <input type="checkbox"/> N <input type="checkbox"/> Y				Recent Abnormal (for you) Symptoms Const <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> sweats <input type="checkbox"/> tired <input type="checkbox"/> weight loss Neuro <input checked="" type="checkbox"/> headache <input type="checkbox"/> weakness <input type="checkbox"/> poor balance or coordination Head <input checked="" type="checkbox"/> numb <input type="checkbox"/> tingling <input type="checkbox"/> urinary or bowel changes Eyes <input checked="" type="checkbox"/> pain in → <input type="checkbox"/> ear <input type="checkbox"/> mouth <input type="checkbox"/> tooth <input type="checkbox"/> throat Skin <input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> eye pain Musc-Skel <input type="checkbox"/> rash <input type="checkbox"/> itching <input type="checkbox"/> bites <input type="checkbox"/> sores <input type="checkbox"/> redness Cardio <input type="checkbox"/> muscle pain → <input checked="" type="checkbox"/> one area <input type="checkbox"/> many areas Resp <input type="checkbox"/> joint pain → <input type="checkbox"/> one joint <input type="checkbox"/> several joints G.I. <input type="checkbox"/> chest pain or pressure <input type="checkbox"/> light headed <input type="checkbox"/> fainting Genito-Urinary <input type="checkbox"/> fluttering in chest <input type="checkbox"/> swelling of legs or feet Psych <input type="checkbox"/> short of breath <input type="checkbox"/> cough <input type="checkbox"/> wheeze Heme <input type="checkbox"/> belly pain <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> vomiting Allergy <input type="checkbox"/> painful or frequent urination <input type="checkbox"/> waking up to urinate Where did injury occur? <input type="checkbox"/> industrial <input type="checkbox"/> mine/quarry <input type="checkbox"/> farm <input type="checkbox"/> home <input type="checkbox"/> residential institution <input type="checkbox"/> rec site <input type="checkbox"/> street/highway <input type="checkbox"/> public building <input type="checkbox"/> other(specify) Prev. injury to body part? <input type="checkbox"/> no <input type="checkbox"/> yes Seeing other doc for this? <input type="checkbox"/> no <input type="checkbox"/> yes			
Chronic / Inactive Conditions (status) <input type="checkbox"/> None <input type="checkbox"/> LR 1. Pcos Syndrome 2. 3. 4. 5.				Where did injury occur? <input type="checkbox"/> industrial <input type="checkbox"/> mine/quarry <input type="checkbox"/> farm <input type="checkbox"/> home <input type="checkbox"/> residential institution <input type="checkbox"/> rec site <input type="checkbox"/> street/highway <input type="checkbox"/> public building <input type="checkbox"/> other(specify) Prev. injury to body part? <input type="checkbox"/> no <input type="checkbox"/> yes Seeing other doc for this? <input type="checkbox"/> no <input type="checkbox"/> yes			
Meds <input type="checkbox"/> None <input type="checkbox"/> LR dose freq Lorazepam Zoloff		Surgeries <input type="checkbox"/> None <input type="checkbox"/> LR		History unobtainable because: <input type="checkbox"/> emergency condition <input type="checkbox"/> patient not alert Nurse Signature: [redacted] Allergies (Document in Boxes below) Corticosteroids "Pregnant?" <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure Last Menses [redacted] (mm-dd-yy) Last Pap [redacted] (mm-dd-yy)			
Family History <input type="checkbox"/> None <input type="checkbox"/> LR <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Sib <input type="checkbox"/> Other <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Sib <input type="checkbox"/> Other <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Sib <input type="checkbox"/> Other		Tobacco <input type="checkbox"/> never quit in (yr) [redacted] <input type="checkbox"/> cigars		Quality Verification [redacted] → [redacted] → [redacted] Sign in Complete Sign out Complete PiVoT Scanned Required Field			
Alcohol <input checked="" type="checkbox"/> never drinks per day <input type="checkbox"/> <1 <input type="checkbox"/> 1 <input type="checkbox"/> 1 1/2 <input type="checkbox"/> >2 <input type="checkbox"/> chew or snuff		Illlicit Drugs? <input checked="" type="checkbox"/> no <input type="checkbox"/> yes		100004614 0 63746			

Initials

T 975 P 8 T BP 162/97

V5x3

R 16 Wt. (lbs) Ht

abnormal

General appearance

Musculoskeletal

Gait & Station

	H&N	spine	ribs	LUE	RUE	LLE	RLE
Inspection & Palpation ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
ROM ²	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Stability ³	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Muscle strength & tone ⁴	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Skin

trunk

Inspection & Palpations

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

¹ Musculoskeletal Insp/Palp: alignment, asymmetry, crepitus, defect, tender, mass, effusion

² ROM: pain, crepitus, contracture

³ Stability: dislocation, subluxation, laxity

⁴ Muscle: flaccid, cog wheel, spastic, atrophy, abnormal movements

⁵ Skin Insp/Palp: rash, scar, lesion, cafe-au-lait spots, ulcers

Cardio

☒ ☐ i.e. peripheral vascular (swelling, pulses, varicosities, temp., edema, tenderness)

Neuro

☒ ☐ Coordination (e.g. finger nose, heel/knee/shin, rapid alternating movements in U&LE, fine motor in children)

☐ ☐ DTR's

☒ ☐ Sensation

Psych

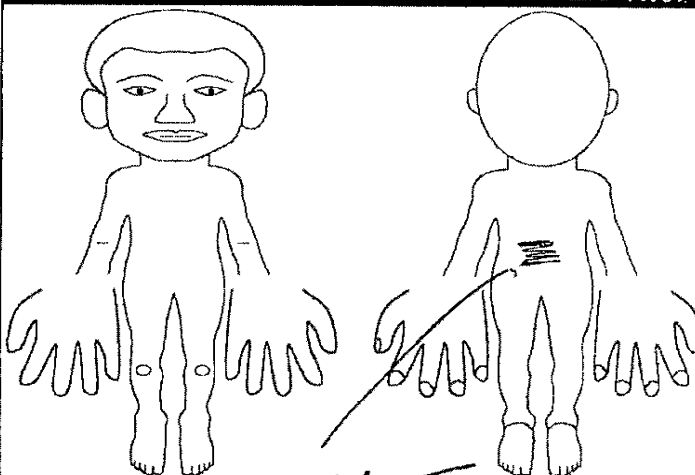
☒ ☐ O x 3

☒ ☐ Mood & Affect

	neck	axillae	groin	other
LN's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resp	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI/abd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Insp/Palp:	<input type="checkbox"/> swelling	<input type="checkbox"/> sm	<input type="checkbox"/> med	<input type="checkbox"/> lg
	<input type="checkbox"/> effusion	<input type="checkbox"/> sm	<input type="checkbox"/> med	<input type="checkbox"/> lg
	<input type="checkbox"/> tender palp.	<input type="checkbox"/> mid	<input type="checkbox"/> mod	<input type="checkbox"/> sev
ROM:	<input type="checkbox"/> tender on	<input type="checkbox"/> mid	<input type="checkbox"/> mod	<input type="checkbox"/> sev
	<input type="checkbox"/> crepitus on			
	<input type="checkbox"/> flexion			
<input type="checkbox"/> extension				
<input type="checkbox"/> abduction				
<input type="checkbox"/> adduction				
<input type="checkbox"/> int. rotation				
<input type="checkbox"/> ext. rotation				
Stability:	<input type="checkbox"/> laxity			
	<input type="checkbox"/> dislocation			

Praxi **Musculo**
PiVoT



Three
mushrooms
no BSE, both
acids
no more
no BSE

X = no Answer to
no relationship part

<input type="checkbox"/> day 0; 0-10d global	<input type="checkbox"/> complication	<input type="checkbox"/> routine f/u to global
<input type="checkbox"/> day 0; 90d global	<input type="checkbox"/> related procedure	<input type="checkbox"/> previous procedure
<input type="checkbox"/> day 0; sched. proc.	<input type="checkbox"/> unrelated problem	<input type="checkbox"/> different provider

63746

<http://www.practicevelocity.com>
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1000004614 0
63746



MUKESH MEHTA MD
7141 MARINER BLVD
SPRING HILL FL 34609

PATIENT: SNOW OTTO E
MED REC#: H951239
DOB: [REDACTED]
DATE OF EXAM: 02/14/2012

This study was performed in the West Hernando Spring Hill office.

02/14/2012: 09967 LOCM-300-349-mg/ml IODINE

02/14/2012: 74178 CT ABD/PEL W/WO CONTRAST

CLINICAL INDICATION: ABDOMINAL PAIN.

TECHNIQUE: Multiple axial images of the abdomen and pelvis were obtained before and after the infusion of intravenous contrast material.

CONTRAST: 100 cc Isovue-300.

The study was evaluated after review of a CT scan report dated March 26, 2004.

FINDINGS:

The lung bases are clear. Imaging below the diaphragm without contrast material reveals that there is a subtle but clearly identifiable area of hypo-attenuation seen in the inferior tip of the liver. The significance of this finding is unclear. The adrenal glands, kidneys, pancreas and spleen all appear to be within normal limits. It is noted that there is a tiny calcification within the lumen of the gallbladder without evidence of cholecystitis.

Imaging below the diaphragm after the infusion of IV contrast indicates that the inferior most aspect of the liver most likely features a hemangioma. The gallbladder, adrenal glands, pancreas and spleen all appear to be within normal limits. There are no remarkable findings involving the large or small bowel other than copious amounts of stool seen within the large bowel. I believe I see the appendix present on a limited basis. There is no indication of free air, free fluid or lymphadenopathy. Within the deep pelvis the prostate is enlarged measuring 5.4 x 3.5 mm.

IMPRESSION:

1. Hemangioma in the inferior aspect of the liver.
2. Small nonobstructing gallstone.
3. Prostatic hypertrophy.

Electronically Signed By:

MICHAEL K. HERRON MD
Diplomate, American Board of Radiology.
MKH/ SN

D: 02/16/12 T: 02/17/12 Date signed: 02/17/12

THE CENTER FOR BONE AND JOINT DISEASE RADIOLOGY DEPARTMENT

5319 Grand Blvd.
New Port Richey, FL 34652
727-848-1769

7544 Jacque Road
Hudson, FL 34667
727-697-2200
727-863-8774 Fax
(MRI Location)

11307 Cortez Blvd
Brooksville, FL 34613
352-596-0900
352-596-0440 Fax

SNOW, OTTO

Male - 56

MRN: 211961

03/30/2012

DOB:



CHRISTOPHER REYHER, MD

MRI OF THE THORACIC SPINE:

Clinical History: Back pain

Multiple pulse sequences were obtained through the thoracic spine in the axial and sagittal planes without the IV infusion of contrast material. All images were obtained on a 1.5 Tesla unit.

Findings: Sagittal images show the vertebral configuration and signal to be normal throughout. Alignment is maintained. The thoracic spinal cord as visualized appears normal. There is no significant disc bulging or herniation identified. There is mild disc space narrowing throughout the thoracic spine with some minimal spondylosis.

IMPRESSION: Minimal spondylosis.

MR thoracic spine is otherwise normal

A handwritten signature in black ink, reading "William L. Nyman".

WLN

WILLIAM L. NYMAN, MD
Diplomate, American Board of Radiology
Electronically Signed on 03/30/2012 04:38 PM

D: 03/30/2012 04:29 PM

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(MRI Location)

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Brooksville, FL 34613
352-596-0900
352-596-0440 Fax

SNOW, OTTO

Male - 56

MRN: 211961

04/02/2012

DOB:



CHRISTOPHER REYHER, MD

MRI OF THE LUMBAR SPINE

Clinical history: No Reason Given

Comparison: None

Technique: Sagittal turbo spin echo T1 and T2 weighted images were performed of the lumbar spine, as well as axial turbo spin echo T1 weighted images and T2 weighted images of the intervertebral disc spaces from L1 through S1. All images were performed on a 1.5 Tesla Siemens short bore magnet.

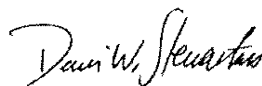
Findings: The vertebral bodies are normal in height and signal. The disc spaces are preserved. There no compression fractures, disc herniations, or spinal cord compression. There are no paravertebral masses, and the spinal cord is normal with the cauda equina at L2.

Axial images: There are no significant stenoses from L1 to S1.

IMPRESSION: Normal MR examination of the lumbar spine.

DWS

D: 04/02/2012 03:12 PM

A handwritten signature in cursive script that reads "Denis W. Stewart".

DENIS W. STEWART, MD

Diplomate, American Board of Radiology

Electronically Signed on 04/02/2012 03:21 PM

THE CENTER FOR BONE AND JOINT DISEASE RADIOLOGY DEPARTMENT

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Brooksville, FL 34613
352-596-0900
352-596-0440 Fax

SNOW, OTTO

Male - 56

MRN: 211961

04/06/2012

DOB 

CHRISTOPHER REYHER, MD

MR BRAIN WITHOUT CONTRAST

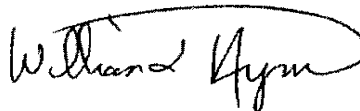
Clinical History: Neck pain

Comparison: None

Multiple axial, sagittal, and coronal images were obtained on a 1.5 T Siemens magnet with multiweighted sequences, FLAIR, and diffusion imaging without contrast.

Findings: There is no focal mass lesion. There is no hemorrhage or extra-axial collection. The basal cisterns and sulci of the convexities and ventricles have normal configuration.

IMPRESSION: Normal noncontrast MR of the brain



WLN

WILLIAM L. NYMAN, MD
Diplomate, American Board of Radiology
Electronically Signed on 04/06/2012 04:35 PM

D: 04/06/2012 04:25 PM

THE CENTER FOR BONE AND JOINT DISEASE RADIOLOGY DEPARTMENT

5319 Grand Blvd.
New Port Richey, FL 34652
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7544 Jacque Road
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727-697-2200
727-863-8774 Fax
(MRI Location)

11307 Cortez Blvd
Brooksville, FL 34613
352-596-0900
352-596-0440 Fax

SNOW, OTTO

Male - 56

MRN: 211961

04/06/2012

DOB: 

CHRISTOPHER REYHER, MD

MR BRAIN WITHOUT CONTRAST

Clinical History: Neck pain

Comparison: None

Multiple axial, sagittal, and coronal images were obtained on a 1.5 T Siemens magnet with multiweighted sequences, FLAIR, and diffusion imaging without contrast.

Findings: There is no focal mass lesion. There is no hemorrhage or extra-axial collection. The basal cisterns and sulci of the convexities and ventricles have normal configuration.

IMPRESSION: Normal noncontrast MR of the brain

WLN

D: 04/06/2012 04:25 PM



WILLIAM L. NYMAN, MD
Diplomate, American Board of Radiology
Electronically Signed on 04/06/2012 04:35 PM

THE CENTER FOR BONE AND JOINT DISEASE RADIOLOGY DEPARTMENT

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11307 Cortez Blvd
Brooksville, FL 34613
352-596-0900
352-596-0440 Fax

SNOW, OTTO

Male - 56

MRN: 211961

03/29/2012

DOB:



CHRISTOPHER REYHER, MD

MRI OF THE CERVICAL SPINE

Clinical History: Pain

Comparison: None

Technique: Sagittal turbo spin-echo T1 and T2-weighted images were performed of the cervical spine, as well as axial gradient-echo images from the inferior endplate of C3 to the upper endplate of T1. All images were performed on a 1.5 Tesla Siemens Symphony short bore MRI unit.

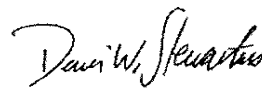
Findings: The vertebral bodies are normal in height and signal. The disc spaces are preserved. There is no evidence of fracture or prevertebral soft tissue swelling. The central canal, lateral recesses, and foramina are normal.

Axial Images: All levels are normal from C2 to T1.

IMPRESSION: Normal MR examination of the cervical spine.

DWS

D: 03/29/2012 03:19 PM

A handwritten signature in black ink that reads "Denis W. Stewart".

DENIS W. STEWART, MD

Diplomate, American Board of Radiology

Electronically Signed on 03/29/2012 03:37 PM



Report Status: F
SNOW, OT

Patient Information	Specimen Information	Client Information
SNOW, OTTO DOB: [REDACTED] AGE: 56 Gender: M Phone: [REDACTED] Patient ID: NG Health ID: 8573006440049697	Specimen: TM110174U Requisition: 0000940 Collected: 02/09/2012 / 13:33 EST Received: 02/10/2012 / 01:57 EST Reported: 02/10/2012 / 07:03 EST	Client #: 66001888 13NA999 MEHTA, MUKESH H MEHTA, MUKESH MD 7145 MARINER BLVD SPRING HILL, FL 34609-1048

Test Name	In Range	Out Of Range	Reference Range	L
BASIC METABOLIC PANEL				T
GLUCOSE		106 H	65-99 mg/dL	
Fasting reference interval				
UREA NITROGEN (BUN)	10		7-25 mg/dL	
CREATININE	0.77		0.70-1.33 mg/dL	
For patients >49 years of age, the reference limit for Creatinine is approximately 13% higher for people identified as African-American.				
eGFR NON-AFR. AMERICAN	101		> OR = 60 mL/min/1.73m2	
eGFR AFRICAN AMERICAN	118		> OR = 60 mL/min/1.73m2	
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 (calc)	
SODIUM	139		135-146 mmol/L	
POTASSIUM	4.1		3.5-5.3 mmol/L	
CHLORIDE	102		98-110 mmol/L	
CARBON DIOXIDE	25		21-33 mmol/L	
CALCIUM	9.6		8.6-10.3 mg/dL	
HEPATIC FUNCTION PANEL				T
PROTEIN, TOTAL	7.0		6.2-8.3 g/dL	
ALBUMIN	4.8		3.6-5.1 g/dL	
GLOBULIN	2.2		2.1-3.7 g/dL (calc)	
ALBUMIN/GLOBULIN RATIO		2.2 H	1.0-2.1 (calc)	
BILIRUBIN, TOTAL		1.6 H	0.2-1.2 mg/dL	
BILIRUBIN, DIRECT	0.2		< OR = 0.2 mg/dL	
BILIRUBIN, INDIRECT		1.4 H	0.2-1.2 mg/dL (calc)	
ALKALINE PHOSPHATASE	51		40-115 U/L	
AST	17		10-35 U/L	
ALT	16		9-60 U/L	
CBC (INCLUDES DIFF/PLT)				T
WHITE BLOOD CELL COUNT	7.1		3.8-10.8 Thousand/uL	
RED BLOOD CELL COUNT	4.90		4.20-5.80 Million/uL	
HEMOGLOBIN	15.2		13.2-17.1 g/dL	
HEMATOCRIT	44.3		38.5-50.0 %	
MCV	90.4		80.0-100.0 fL	
MCH	31.0		27.0-33.0 pg	
MCHC	34.2		32.0-36.0 g/dL	
RDW	13.6		11.0-15.0 %	
PLATELET COUNT	217		140-400 Thousand/uL	
ABSOLUTE NEUTROPHILS	4445		1500-7800 cells/uL	
ABSOLUTE LYMPHOCYTES	1825		850-3900 cells/uL	
ABSOLUTE MONOCYTES	547		200-950 cells/uL	
ABSOLUTE EOSINOPHILS	220		15-500 cells/uL	
ABSOLUTE BASOPHILS	64		0-200 cells/uL	
NEUTROPHILS	62.6		%	
LYMPHOCYTES	25.7		%	
MONOCYTES	7.7		%	
EOSINOPHILS	3.1		%	
BASOPHILS	0.9		%	
PSA, TOTAL	1.7		< OR = 4.0 ng/mL	T

This test was performed using the Siemens



Report Status: Final
SNOW, OTTO

Patient Information	Specimen Information	Client Information
SNOW, OTTO DOB: [REDACTED] AGE: 56 Gender: M Patient ID: NG Health ID: 8573006440049697	Specimen: TM110174U Collected: 02/09/2012 / 13:33 EST Received: 02/10/2012 / 01:57 EST Reported: 02/10/2012 / 07:03 EST	Client #: 66001888 MEHTA, MUKESH H

Test Name	In Range	Out Of Range	Reference Range	Lab
chemiluminescent method. Values obtained from different assay methods cannot be used interchangeably. PSA levels, regardless of value, should not be interpreted as absolute evidence of the presence or absence of disease.				
URINALYSIS REFLEX				TP
COLOR	YELLOW		YELLOW	
APPEARANCE	CLEAR		CLEAR	
SPECIFIC GRAVITY	1.012		1.001-1.035	
PH	6.5		5.0-8.0	
GLUCOSE	NEGATIVE		NEGATIVE	
BILIRUBIN	NEGATIVE		NEGATIVE	
KETONES		TRACE	NEGATIVE	
OCCULT BLOOD		1+	NEGATIVE	
PROTEIN	NEGATIVE		NEGATIVE	
NITRITE	NEGATIVE		NEGATIVE	
LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE	
WBC	NONE SEEN		< OR = 5 /HPF	
RBC	NONE SEEN		< OR = 3 /HPF	
SQUAMOUS EPITHELIAL CELLS	NONE SEEN		< OR = 5 /HPF	
BACTERIA	NONE SEEN		NONE SEEN /HPF	
HYALINE CAST	NONE SEEN		NONE SEEN /LPF	

PERFORMING SITE:

TP QUEST DIAGNOSTICS-TAMPA, 4225 E. FOWLER AVE, TAMPA, FL 33617 Laboratory Director: LUIS A DIAZ-ROSARIO,MD, CLIA: 16D0291120

MR# 1027082

SUMMIT IMAGING
12037 Cortez Boulevard
Brooksville 34613
Phone: (352)597-9008

Name: OTTO SNOW Exam Date: 9/19/2012
Patient ID: 5058006 Exam: NM BILIARY DUCT W RX
DOB: [REDACTED] Reason: 574.1 - CALCULUS OF
GALLBLADDER WITH OTHER
CHOLECYSTITIS
Phone: [REDACTED] Referrer: Donald Temple MD
Acc#: 80128269 Referrer 2: Mukesh Mehta MD

Results

Exam: HIDA SCAN

Indication: CALCULUS OF GALLBLADDER WITH OTHER CHOLECYSTITIS

Technique:

5.5 mCi of technetium 99m Choletec was injected intravenously. Dynamic anterior images of the abdomen were obtained. 1.6 mg of Kinevac were administered IV for gallbladder contraction.

Discussion: There is activity in the gallbladder extending into the common duct duodenum. The gallbladder ejection fraction was calculated at only 11%. This can be associated with so-called "biliary dyskinesia."

Impression:

Abnormally low gallbladder ejection fraction of only 11% as above.

Report Electronically Signed by: Albert Gutierrez
Report Signed on: 9/19/2012

Pt. Name:	OTTO SNOW	Exam:	NM BILIARY DUCT W RX
Patient ID:	5058006	Acc:	80128269
Completed Date:	9/19/2012 12:01:00 PM	Interpreting Rad:	Albert Gutierrez
Transcribed By:	RAID VR	Dictated Date:	9/19/2012 12:12 PM
Transcribed Date:	9/19/2012 12:12:41 PM	Finalized Date:	9/19/2012