SOTERIA HEALTHCARE NETWORK CHIROPRACTIC TREATMENT PLAN FORM.

Follow Up Visit Form

Please complete/submit this form. ***If answers are not complete and/or accurate, this form may be returned without authorization. This form is required if the Patient's condition requires care beyond one visit. Please note, please be as detailed/accurate as possible. If not, additional information may be required upon request. Thank you.*** *Any questions/comments, please call 770-455-8190 ext 119 or fax # 404-341-9804*

SECTION 1. TREATING DOCTOR INFORMATION.

Date: ________________________ Treating Doctor: ________________________

Office Tel. ____________ Office Fax: ____________ Office Email: ________________________

SECTION 2. PATIENT AND INSURANCE INFORMATION.

Patient/Member Last Name: ______________________ Member First Name: ______________________

Patient/Member Date of Birth: ______________________ Sex: ____________

Member ID#: ________________ Is Patient a dependent? ___Yes ___ No Health Plan Name: ________________

THIS CASE IS ... ___ Group Health ___ Workers Comp ___Auto Liability

Is Kaiser Permanente the Patient's primary insurance carrier? ___ Yes ___ No

Please note: Member/Patient must complete & sign the "Primary Payor Information Form" at the beginning of each year or if Member/Patient health insurance has changed. You may download and have the Member complete this form here: www.SoteriaHealthcare.com/downloads

SECTION 3. TREATMENT INFORMATION

Please list all diagnoses for which you have treated this Patient in the past 12-months.

LINE 1.

All Diagnoses (Past 12 Mos)	ICD-10 Code(s)	# of Treatments	Start Date	End Date
______________	__________	__________	__________	________
______________	__________	__________	__________	________
______________	__________	__________	__________	________

LINE 2.

CURRENT DIAGNOSES	ICD-10 CODE
______________________________	______________
______________________________	______________
______________________________	______________

LINE 3. Date When Current Condition Began? ________________

Please note: If submitting for continuing care of an acute episode, please use data collected at time of initial examination.

LINE 4. Etiology or cause of current condition: ______________________________

Please state reason (above) for request for additional visits, etiology, cause of current condition or exacerbation, if applicable.

LINE 5. Has "acute phase of treatment" been completed? (Yes/No) _____. If No, date projection of completion __________.

LINE 6. _______ % of recovery to date. **LINE 6.5.** Date of first visit for current course of treatment? ______________

LINE 7. On a scale of 1-10, what was/is the patient's Pain Level? ____ ***Initial Pain Level and*** ____ ***Current Pain Level***

LINE 8. Current subjective complaints:

A. ______________________________ C. ______________________________

B. ______________________________ D. ______________________________

LINE 9. Positive test(s) which support your request for additional treatment:

A. ______________________________ C. ______________________________

B. ______________________________ D. ______________________________

SECTION 4. VISIT ESTIMATE TO COMPLETE ACUTE PHASE OF TREATMENT ...

LINE 1. Treating Doctor requests a total of ____ # of visits over _______ days or ______ weeks.

LINE 2. Have you placed the Patient on specific recommendations/limitations? (Yes or No) If yes, please describe.

____

LINE 3. Has the Patient been compliant? (Yes or No) _______ Describe home exercise/therapy advised? __________

LINE 4. Additional comments and/or Is there anything about this case that makes it unusual or which may hinder your progress?

____

Treating Doctor's Signature ______________________________ **Today's Date** ______________

INSTRUCTIONS: Once signed and completed, please return this document to Soteria Healthcare Network's Utilization Management (UM) Department. Thank you. Office (770) 455-8190 ext 119 Fax # 404-341-9804

THIS SECTION IS FOR SOTERIA INTERNAL USE ONLY. Please do not write in this box.