Demo Physical Therapy
email@email.com
123 Test St, suite 3, email@email.com
Demo, LA 85024-1144
Phone: (602)555-4879
Fax: (602)555-4880
www.webpt.com

Daily Note / Billing Sheet

Patient Name: "Little", Corky Jaysonx
Date of Birth: 02/04/1945
Referring Physician(s): Baggins, Bilbo location test MD / Baggins, Bilbo location test MD
Date of Original Eval: 03/27/2012
Treatment Diagnosis: 000.00: Unknown
Secondary Insurance Name: Gieco

Date of Daily Note: 01/23/2013
Injury/Onset Date/Change of Status Date: 11/16/2010
Diagnosis: 726.32: Lateral epicondylitis

Visit No.: 4
Primary Insurance Name: Self Pay

Subjective

History of Falls: No
Mental Status/Cognitive Function Appears Impaired? No

Objective

CPT® Code	Untimed Codes	*Units*
97012	Mechanical Traction	*1*
90901	Biofeedback Training	*1*

CPT® Code	Direct Timed Codes	*Units*
97032	E-Stim Manual See Flowsheet	*1*
97035	Ultrasound/Phonophoresis See Flowsheet	*1*
97110	Therapeutic Exercise See Flowsheet	*1*

Assessment

Rehab Potential: Good

Plan

Instructions: Continue per Plan of Care

Certification of Medical Necessity: It will be understood that the treatment plan mentioned above is certified medically necessary by the documenting therapist and referring physician mentioned in this report. Unless the physician indicates otherwise through written correspondence with our office, all further referrals will act as certification of medical necessity on the treatment plan indicated above.

Thank you for this referral. If you have questions regarding this plan of care, please contact me at (602)555-4879.

Please sign and return: Fax#: (602)555-4880

I certify the need for these services furnished under this plan of treatment and while under my care.

_____
Scottie L. Pippen
License #4564
Completed by Scottie L. Pippen on January 23, 2013 at 2:16 pm

__I have no revisions to the plan of care.
__Revise the plan of care as follows_____
_____

Physician Signature_____
B. Baggins test, MD
Date:_____