SOTERIA HEALTHCARE NETWORK CHIROPRACTIC TREATMENT PLAN FORM.

Initial 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 Patients condition requires care beyond one visit. Please note, be as detailed/accurate as possible. If not, additional information may be required upon request. Copies of this form and more are at www.SoteriaHealthcare.com/downloads.*** *Questions, 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 Type ___ *New to my office or* ___ *Est. Patient (If Est. Patient, select type):* __ *New episode* __ *New injury*

Patient/Member Last Name: _____ Member First Name: _____

Member ID#: _____ Patient/Member Date of Birth: _____ Sex: _____

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

LINE 1. Has the Doctor treated this Patient within the past 12-mos. (for any condition). (check one) __Yes __ No

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

LINE 2.

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

LINE 3. Date when current condition began? _____ Date of first visit for current course of treatment? _____

LINE 4.

Current Diagnoses	ICD-10 Code

LINE 5. Etiology or cause of current condition: _____

LINE 6. Current subjective complaints:

A. _____ C. _____

B. _____ D. _____

LINE 7. Positive test(s) which confirm you diagnosis:

A. _____ C. _____

B. _____ D. _____

SECTION 4. VISIT ESTIMATE TO COMPLETE ACUTE PHASE OF TREATMENT

LINE 1. *"Treating Doctor estimates a total of ____ # of visits over _____ days or _____ weeks."*

LINE 2. Prognosis: _____ On a scale of 1 to 10 what is Patients pain level? ____

LINE 3. Additional Treating Doctor Comments (Optional) _____

Treating Doctor's Signature _____ Date _____

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

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