

SVASSAMA DAILY NOTE / CHARGE SHEET

Name _____ Service Date _____
 Diagnosis(s)/ICD-9 _____ Start Time _____
 _____ End Time _____

S: _____

O: CERVICAL: FLX < 5 15 30 45 60 90 **PROM @ TISSUE SPEED** _____
 EXT < 5 15 30 45 60 90 _____
 ROT **R** < 5 15 30 45 60 90 **L** < 5 15 30 45 60 90 _____
 SB **R** < 5 15 30 45 60 90 **L** < 5 15 30 45 60 90 _____
 SH ABD **R** < 5 15 30 45 60 90 **L** < 5 15 30 45 60 90 _____
 PELVIC ROT **R** < 5 15 30 45 60 **L** < 5 15 30 45 60 _____

CPT	PROCEDURE	FEE (PER UNIT)	X	= CHARGE
EVALUATION				
<input type="checkbox"/> 97001	Initial evaluation	110.	_____	_____
<input type="checkbox"/> 97002	Re-evaluation	75.	_____	_____
<input type="checkbox"/> 97750	Manual Muscle Testing	40.	_____	_____
MODALITIES				
<input type="checkbox"/> 97010	Hot, Cold Pack	15.	_____	_____
<input type="checkbox"/> 97012	Traction, mechanical	20.	_____	_____
<input type="checkbox"/> 97014	Elect. Stim (unattended)	20.	_____	_____
<input type="checkbox"/> 97016	Vasopneumatic Device	20.	_____	_____
<input type="checkbox"/> 97032	Elect. Stim (attended)	30.	_____	_____
<input type="checkbox"/> 97035	Ultrasound	25.	_____	_____
THERAPEUTIC PROCEDURES				
<input type="checkbox"/> 97110	Therapeutic exercise, activity	40.	_____	_____
<input type="checkbox"/> 97112	Neuromuscular re-education	40.	_____	_____
<input type="checkbox"/> 97113	Aquatic therapy	40.	_____	_____
<input type="checkbox"/> 97116	Gait Training	35.	_____	_____
<input type="checkbox"/> 97140	Manual Therapy techniques	45.	_____	_____
<input type="checkbox"/> 97530	Functional Activities (one-on-one)	45.	_____	_____
MISCELLANEOUS				
<input type="checkbox"/> _____	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____
<input type="checkbox"/> _____	Missed Appt. (NCNS)	25.	_____	_____

A: Decrease Increase No change ⇄ In primary complaint
 Progress No apparent progress ⇄ Toward goals
 Tolerated Did not tolerate ⇄ Exercise / Activity
 Noticed improvement other than primary complaint

P: Continue with current treatment plan See plan of care
 Refer patient to: _____
 Discharge patient: Goals met Per patient
 Goals partially met Per insurance
 Goals not met Per physician

Signature: _____
 Eric Brummel, PT

PATIENT	OFFICE USE ONLY
I certify that: all dates of service are accurate; all itemized services were performed and necessary for my care; I am responsible for all charges above not covered by insurance; I have been informed and have given my consent for the treatments performed, understanding that ill effects are possible. PATIENT'S SIGNATURE _____	TOTAL CHARGE TODAY: _____ AMOUNT PAID: _____ CO-PAY <input type="checkbox"/> YES <input type="checkbox"/> NO PAYMENT: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK # _____ <input type="checkbox"/> HCFA entered <input type="checkbox"/> Charges submitted _____

SVASSAMA
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