Back Crack Chiropractic and Sports Clinic

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EIN # 00-04555555
NP # 199999999

Date of Service_____

NEW PATIENT	CPT	FEE
☐ Problem Focused-10 min	99201	_____
☐ Exp. Problem Focused-20 min	99202	_____
☐ Detailed Hist & Exam-30 min	99203	_____
☐ Comp. Hist & Exam-45 min	99204	_____
☐ Comp. Hist & Exam-60 min	99205	_____

ESTABLISHED PATIENT	CPT	FEE
☐ Problem Focused-10 min	99212	_____
☐ Exp. Problem Focused-15 min	99213	_____
☐ Detailed Hist & Exam-25 min	99214	_____
☐ Comp. Hist & Exam-40 min	99215	_____

MANUAL PROCEDURES	CPT	FEE
☐ Chiropractic Manip. (1-2 spinal regions)	98940	_____
☐ Chiropractic Manip. (3-4 spinal regions)	98941	_____
☐ Manual Therapy (Myofascial Release, mobilization and manual traction)	97140	_____
☐ Massage Therapy (stroking, compression, percussion)	97124	_____
☐ Therapeutic Exercises (1 or more areas)	97110	_____

MEDICAL NUTRITION THERAPY	CPT	FEE
☐ Initial assessment and intervention, individual, each 15 min.	97802	_____
☐ Re-assessment and intervention, individual, each 15 min.	97803	_____

MODALITY PROCEDURES	CPT	FEE
☐ Elect. Muscle Stim (unattended)	97014	_____
☐ Ultrasound	97035	_____
☐ Cold Laser (Class IV)	97139	_____
☐ Hot / Cold Pack	97010	_____
☐ Other	_____	_____
☐ Other	_____	_____

DIAGNOSIS

☐ Abdominal Pain:	789.0	☐ Common cold	460.0	☐ Neuralgia	729.2	☐ Back pain (sciatica)	724.3
☐ Allergies	995.3	☐ Constipation	564.0	☐ Radiculopathy	729.2	☐ Pain, Chest	786.50
☐ Anxiety	300.0	☐ Contusion	924.9	☐ Sciatic Neuralgia	724.3	☐ Pain, Shoulder	719.41
☐ Arthritis	716. 9	☐ Cystitis	595.0	☐ Sinusitis	473.9	☐ Pain, Elbow	719.42
☐ Brachial Neuritis	723.4	☐ Dysmenorrhea	625.3	☐ Tendonitis	726.90	☐ Pain, Wrist/Hand	719.44
☐ Bursitis	727.3	☐ Headache	784.0	☐ Pain, Foot/Ankle	719.47	☐ Pain, symptoms involving head and neck	784.0
☐ Carpal Tunnel Syndrome	354.0	☐ Lumbago	724.2	☐ Pain, Knee	719.46		
☐ Cervical Disc Displacement	722.0	☐ Malaise / fatigue	780.7	☐ Pain, Hip	719.45	☐ Pain, Neck/Cervicalgia	723.1
☐ Cervical Spondylosis	738.4	☐ Myalgia	729.1	☐ Back Pain (unspecified)	724.5	☐ Pain, Face or Head	784.0
☐ _____	_____	☐ _____	_____	☐ _____	_____	☐ _____	_____

Patient Name:_____ D.O.B. _____ Soc. Sec. #_____

Address:_____ Subscriber#:_____Group#_____

Work Phone: _____ Return Visit _____

Physician's statement: I certify that I personally rendered the above services and that the charges shown represent my usual charges.

Signature_____ Date:_____

❑ If Box Is Checked Please Remit Payment Directly To Patient

$	$
Today's Charge	Payment