

# **Baylor Institute for Rehabilitation Outpatient Services**

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## **PATIENT ACCOUNTS RECEIPT**

**Patient Name:** Plock, Robert

**Payment Date:** Feb 13, 2013 08:59 AM

**Payment Method:** Master Card

**Account Number:** 030R290071246

**Receipt Number:** 2013-017018

**Payment Rec'd By:** SELECT\ShEdwards

**Appointment Date Time**

Wednesday, Feb 13, 2013 09:00 AM

**Payment Category**

Clinical Services

**Amount**

\$ 55.00

**Total:**

\$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: Feb 13, 2013 08:59 AM

Thank you,

Baylor Institute for Rehabilitation Outpatient Services

1ST APPT.



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 2/13/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Feb 13 2013 9:00:34 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 451808

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X\_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

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## Proof of Appointment

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Patient Name

Robert Plock

Patient was seen at our facility on 2/13/13 for Outpatient Therapy.

If you have any questions please feel free to contact us at 214-820-7457

Thank You,

Shanene E.

# Patient Information Form

Registration AP  
TS \_\_\_\_\_  
RT \_\_\_\_\_  
Revised Form 08/07/2012

Page 1 of 2

Date of Call/Registration: <u>1/15/13</u>		Patient Account Number: <u>290071240</u>	
Past Patient: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Medical Record Number: _____	
Discipline: <input checked="" type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST		Patient Information verified DL/photo i.d.: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Last Name/Suffix: <u>Plock</u>		First Name: <u>Robert</u> Middle Initial: _____	
Address: <u>6827 Latta Pkwy</u>		City: <u>Dallas</u>	State: <u>TX</u> Zip Code: <u>75227</u>
Home Phone: <u>214-275-4195</u>	Mobile Phone: <u>214-799-7775</u>	Email Address: <u>robplock@gmail.com</u>	
Contact Method: Ph <input type="checkbox"/> E-m <input type="checkbox"/> Mob <input type="checkbox"/> Txt <input type="checkbox"/>		Text Enabled <input type="checkbox"/> No Appointment Reminders <input type="checkbox"/>	
Date of Birth: <u>7/26/68</u>	SSN: <u>456533292</u>	Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Status: <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown
<b>Employer Information</b>			
Employer Name: <u>Spencer Air Conditioning</u>		Employment Status: <input checked="" type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> None <input type="checkbox"/> Retired <input type="checkbox"/> Student	
Address: <u>3600 Skyway Dr S, Irving</u>		City: _____	State: <u>TX</u> Zip Code: _____
Work Phone Number: <u>214-687-7426</u>		Patient Occupation: <u>Service Technician</u>	
<b>Emergency Contact Information</b>			
Contact Name: <u>Frank Adner</u>		Phone #: <u>214-799-7774</u>	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input checked="" type="checkbox"/> Other
<b>Physician Information</b>			
Name of Referring Physician: <u>Bill Christensen MD</u>		Telephone #: <u>214-828-5775</u>	RX Date: <u>1/2/13</u> Eval/Treat: <input type="checkbox"/> # of visits: _____
<b>Additional Questions</b>			
Date of Injury Onset Date: <u>1/25/2013</u>	Auto Related: <input checked="" type="checkbox"/> Yes-State? <u>TX</u> <input type="checkbox"/> No Adjuster name: <u>Mary Anne Vinson</u> Phone #: <u>888-257-6077</u>	Work Related: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Accident Related: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis/Body Part: <u>lumbar strain</u>			
Post Surgical: <input type="checkbox"/> Yes / <input checked="" type="checkbox"/> No / <input type="checkbox"/> Unknown		Surgery Description: _____	
Surgery Date (if applicable): _____		How did you hear about us? <u>Dr. Christensen</u>	
<b>MEDICARE ONLY- Additional Questions</b>			
If Medicare, are you currently receiving Home Health Service? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Agency? _____ Last Date of Service _____			
Are you currently residing in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Name of Facility? _____			
If Yes, are you on/in the "Medicare Unit"? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Medicare, have you received PT, OT or Speech services since the first of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
• If Yes, do you know if you have exceeded your Medicare Therapy Cap amount? <input type="checkbox"/> Yes <input type="checkbox"/> No			
• Are you aware of any partial amount used since the first of the year? \$ _____			
If Yes, please bring in any billing information from your previous therapy, or contact your previous provider for the information. Please bring the Medicare benefit summary you receive from Medicare.			
Appointment Date: <u>1/28/13</u>		Time: <u>8:00</u>	Therapist: <u>April</u>
Intake Completed By: <u>April</u>		Date: <u>1/15/13</u>	Patient, Please initial here if the above information is complete and correct: <u>RD</u> Date: <u>02/13/2013</u> Time: <u>8:30 AM</u>

Patient Name: <u>Robert Plocl</u>		Account Number: <u>290071246</u>	
7-26-68		Insurance Information	
Only complete the following if the Primary or Secondary policy holder is not the patient. Primary <input type="checkbox"/> Secondary <input type="checkbox"/>			
Last Name:	First Name:	Middle Initial	SSN
Patient Relationship to Policy Holder: <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name:		Employer Phone #:	
Primary Insurance Section # <u>090593</u>		Secondary Insurance Section	
Payor/Plan <u>UMR UHC Options PPO</u> Code:		Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Policy/ID #: <u>13280912</u>	Group #: <u>76-410892</u>	Policy/ID #:	Group #:
Insurance Phone #: <u>877 233-1800</u>		Insurance Phone #:	
Verification AT: FSC:		Verification	
Date: <u>1-23-13</u>	Spoke with: <u>Maria</u>	Date:	Spoke with:
Verify Plan: Effective Date: <u>1-1-11</u>		Verify Plan: Effective Date:	
Is this a Federally Funded Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Cal year</u> <u>LTm UL</u>			
Does patient have PT <input checked="" type="checkbox"/> OT <input checked="" type="checkbox"/> Speech <input checked="" type="checkbox"/> coverage?		Does patient have PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> coverage?	
Informed payor this is outpatient-hospital based benefits(billed on UBO4) <input checked="" type="checkbox"/>		Informed payor this is outpatient-hospital based benefits(billed on UBO4) <input type="checkbox"/>	
Visit Limitation: <u>new opt. 25 v</u>	Coverage: <u>70/30</u>	Visit Limitation:	Coverage:
Limitations on Modalities or Units?		Limitations on Modalities or Units?	
Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___		Home Program/97535 ___ Anodyne/97026 ___ Aquatic/97113 ___	
E-Stim/ 97014 ___ ST Tx/92507 ___ Ionto/97033 ___		E-Stim/ 97014 ___ ST Tx/92507 ___ Ionto/97033 ___	
Comments/Special Instructions: <u>Rep unable to look up codes</u> <u>- slw pt. apt. benefits -</u>		Comments/Special Instructions:	
Deductible: \$ <u>1000.00</u>	Out Of Pocket: \$ <u>3000.00</u>	Deductible: \$	Out Of Pocket: \$
Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Met: <input type="checkbox"/> Yes <input type="checkbox"/> No	Met: <input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient have a co-pay? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, amount: \$		Does patient have a co-pay? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$	
Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>		Per Visit? <input type="checkbox"/> IE/Re-eval only? <input type="checkbox"/>	
Required for therapy? <input checked="" type="checkbox"/> Referral <input checked="" type="checkbox"/> Authorization <input checked="" type="checkbox"/> Pre-Cert		Required for therapy? <input type="checkbox"/> Referral <input type="checkbox"/> Authorization <input type="checkbox"/> Pre-Cert	
If any of the above is required, verify that it is on file? <input type="checkbox"/>		If any of the above is required, verify that it is on file? <input type="checkbox"/>	
Auth #: # of Auth Visits:		Auth #: # of Auth Visits:	
Auth Start Date: Auth Exp Date:		Auth Start Date: Auth Exp Date:	
Claims Address: <u>POB 30541 SLC UT 84130</u>		Claims Address:	
Our office is unable to guarantee an amount as your insurance makes the final decision on the total applied towards your coinsurance/Deductible. Estimated amount to apply towards coinsurance/Deductible balance: \$ <u>55.00</u> / visit			
The Proceeding Benefits are what your Insurance Company has communicated to us. This is not a guarantee; therefore you will be responsible for any remaining balance. Patient Acknowledgement Initials: <u>RP</u> Date: <u>02/13/2013</u> Time: <u>8:30 AM</u>			
Verified By: <u>MU 1-23-13</u>			

# Statement of Financial Responsibility

Patient Name: Robert Pluck

Date: 2/13/13

Acct #: 290071246

BIR JV, LLP appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment system @ <https://select7.accelpayonline.com> once a statement is received from the billing office, or by calling our customer service department at 1-866-889-9968.

I have read the above policy regarding my financial responsibility to BIR JV, LLP for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to BIR JV, LLP. I agree to pay BIR JV, LLP the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. I understand I am financially responsible to BIR JV, LLP for charges not covered by this authorization. **MEDICARE PATIENTS:** I understand that this BIR JV, LLP facility is a provider-based location of the main hospital located in Dallas, Texas and that I may be responsible for a separate and additional coinsurance payment if I am seen by a physician at any BIR JV, LLP hospital, which I would not incur if this outpatient facility was not a provider based location of the hospital. The actual liability will depend on the actual services furnished by the hospital based on the current charge master. The estimated charges for visits to the facility are \$275. - \$400. (MEDICARE: Amount based upon typical or average charges. Please note that your final costs may be higher or lower, as this is only an estimate).

Signature: Robert Pluck

Date: 02/13/2013

Time: 8:30am

(Relationship to patient: self - guardian - - other: \_\_\_\_\_)

PSS Initials: WM

## BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize BIR JV, LLP to disclose my health information that is directly related to my current treatment at BIR JV, LLP to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP
Clarence Abner	Domestic Partner

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP
N/A	

I acknowledge that the **Notice of Privacy Practices** is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: Robert Pluck

Date: 02/13/2013

Time: 8:30am

(Relationship to patient: self - guardian - - other: \_\_\_\_\_)

**Statement of Financial Responsibility**Patient Name: Robert D. BlockDate: 2-13-13Acct #: 2900-71246**CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize BIR JV, LLP through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature: Robert D. BlockDate: 02/13/2013Time: 8:30am(Relationship to patient: self - guardian - other: \_\_\_\_\_)

I further authorize BIR JV, LLP to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: Robert D. BlockDate: 02/13/2013Time: 8:30am(Relationship to patient: self - guardian - other: \_\_\_\_\_)

**RESEARCH:** Research to improve patient care is conducted at this hospital and is approved and monitored by the Institutional Review Board. This review and monitoring assures strict confidentiality with regard to who may view medical records. I consent to the use of information in my record for research purposes. I understand that I might subsequently be asked if I would be willing to participate in research projects if they require activities outside of normal clinical care, and that I have the right to decline participation.

Signature: N/A

Date: \_\_\_\_\_

Time: \_\_\_\_\_

(Relationship to patient: self - guardian - other: \_\_\_\_\_)

**Medical and Surgical Consent:** I consent to BIR JV, LLP to provide me with necessary medical services, treatments and diagnostic tests. My consent to treat includes any examinations, X-rays, laboratory procedures, tests, medications, medical treatment, and/or other services rendered by the attending physician or other treating or consulting physicians, their associates, technical assistants and other healthcare providers including nurses and other hospital personnel, which in the judgment of such practitioners, are advisable during the course of evaluation, diagnosis and treatment. I consent to allow medical residents, students and authorized individuals to observe or participate in the care provided as determined by the treating physicians and as permitted by hospital policy.

**Physicians and Independent Contractors:** I understand that the physicians participating in my care at BIR JV, LLP are not employees or agents of BIR JV, LLP and are not acting for or on behalf of BIR JV, LLP. They are either independent physicians who are engaged in the private practice of medicine and who have been granted privileges to use this facility to care for their patients or they are licensed physicians who are engaged in a post-graduate medical education program. I understand that all such medical decisions regarding my care and treatment at BIR JV, LLP are made by such physicians and not by BIR JV, LLP.

**Accidental Exposure of the Healthcare Worker:** I understand that Texas law provides, if any healthcare worker is exposed to the patient's blood or other bodily fluid, that BIR JV, LLP may perform test(s) on the patient's blood or other bodily fluid to determine the presence of human immunodeficiency virus (HIV, the virus associated with AIDS). I consent to the testing for other communicable diseases, including but not limited to hepatitis and syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient while a patient of BIR JV, LLP.

**Authorization to Photograph:** I grant permission to photograph the Patient for the purpose of patient identification.

Signature of Patient: Robert D. BlockDate: 02/13/2013Time: 8:30amWitness: LinolaDate: 2/13/13Time: 9am

Or Legally Authorized Representative

**Outpatient Medical History/Screening Form**

*To be completed by the patient*

Patient Name: Robert Plock Spoken Language: English  
Emergency Contact: Clarence Abne Telephone #: 214 799 7774  
Referring Physician: William Christensen Telephone #: 214 828 5775  
Primary Care Physician: William Christensen Telephone #: 11  
Religious/Cultural Needs: NO ☐ YES ☐ Please Explain: \_\_\_\_\_  
Special Learning Needs: NO ☐ YES ☐ Please Explain: \_\_\_\_\_  
Date of Injury: 01/25/2013  
Why are you here? Headache, Neck pain, Back Pain, Knee Sprain

**Medical Information:**

	YES	NO		YES	NO
Hypertension (high blood pressure)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Skin Sensitivity <u>Finger</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hypotension (low blood pressure)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diminished Sensation <u>Right Arm</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Alzheimers	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Emphysema /Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Bleeding / Bruising (recent history)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chest Pain /Angina /Heart Attack	<input type="checkbox"/>	<input checked="" type="checkbox"/>
History of diabetes <u>Family -</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Urinary Urgency / Incontinence	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Are You Pregnant?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cancer / Tumors / Growths	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Have you had/have a Stroke	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Active seizure disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Swelling Of Extremities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Fractures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	History of pressure sores	<input type="checkbox"/>	<input checked="" type="checkbox"/>
DATE: _____ AREA: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other _____		
DATE: _____ AREA: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Are you in pain?		
Artificial Joints	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Location of pain <u>Lower back, Neck, Knee</u>		
Light-Headedness / Dizziness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	If you answered yes to any of the above:		
Anxiety / Panic Attacks (recent)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Are you under the care of a	YES	NO
Depression(recent)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	physician for these conditions?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Allergies: Poison Ivy  
Surgery(s) within last 3 months - Include Dates: NO  
What are your treatment goals?: get back to my active self.  
If you need information regarding Advanced Directives, please contact the site Admission/Office Assistant.  
Advanced Directives are not honored in the Outpatient Setting.



## OSWESTRY BACK DISABILITY INDEX

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer **every** question by placing a mark in the **one** box that best describes your condition today. We realize that you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

<b>Section 1: Pain Intensity</b>					
I can tolerate the pain I have without having to use pain medication <input type="checkbox"/>	The pain is bad, but I can manage without having to take pain medication <input type="checkbox"/>	Pain medication provides me with complete relief from pain <input type="checkbox"/>	Pain medication provides me with moderate relief from pain <input type="checkbox"/>	Pain medication provides me with little relief from pain <input checked="" type="checkbox"/>	Pain medication has no effect on my pain <input type="checkbox"/>
<b>Section 2: Personal Care (Washing, Dressing, etc.)</b>					
I can take care of myself normally without causing increased pain <input type="checkbox"/>	I can take care of myself normally, but it increases my pain <input checked="" type="checkbox"/>	It is painful to take care of myself, and I am slow and careful <input type="checkbox"/>	I need help, but I am able to manage most of my personal care <input type="checkbox"/>	I need help every day in most aspects of my care <input type="checkbox"/>	I do not get dressed, wash with difficulty, and stay in bed <input type="checkbox"/>
<b>Section 3: Lifting</b>					
I can lift heavy weights without increased pain <input type="checkbox"/>	I can lift heavy weights, but it causes increased pain <input checked="" type="checkbox"/>	Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table) <input type="checkbox"/>	Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned. <input type="checkbox"/>	I can lift only very light weights <input type="checkbox"/>	I cannot lift or carry anything at all <input type="checkbox"/>
<b>Section 4: Walking</b>					
Pain does not prevent me from walking any distance <input type="checkbox"/>	Pain prevents me from walking more than 1 mile <input type="checkbox"/>	Pain prevents me from walking more than 1/2 mile <input checked="" type="checkbox"/>	Pain prevents me from walking more than 1/4 mile <input type="checkbox"/>	I can only walk with crutches or a cane <input type="checkbox"/>	I am in bed most of the time and I have to crawl to the toilet <input type="checkbox"/>
<b>Section 5: Sitting</b> - <i>Change positions often - discomfort</i>					
I can sit in any chair as long as I like <input type="checkbox"/>	I can only sit in my favorite chair as long as I like <input type="checkbox"/>	Pain prevents me from sitting for more than one hour <input checked="" type="checkbox"/>	Pain prevents me from sitting for more than 1/2 hour <input type="checkbox"/>	Pain prevents me from sitting for more than 10 minutes <input type="checkbox"/>	Pain prevents me from sitting at all <input type="checkbox"/>
<b>Section 6: Standing</b>					
I can stand as long as I want without increased pain <input type="checkbox"/>	I can stand as long as I want, but it increases my pain <input checked="" type="checkbox"/>	Pain prevents me from standing more than 1 hour <input type="checkbox"/>	Pain prevents me from standing more than 1/2 hour <input type="checkbox"/>	Pain prevents me from standing more than 10 minutes <input type="checkbox"/>	Pain prevents me from standing at all <input type="checkbox"/>
<b>Section 7: Sleeping</b>					
Pain does not prevent me from sleeping well <input type="checkbox"/>	I can sleep well only by using pain medication <input type="checkbox"/>	Even when I take medication, I sleep less than 6 hours <input type="checkbox"/>	Even when I take medication, I sleep less than 4 hours <input checked="" type="checkbox"/>	Even when I take medication, I sleep less than 2 hours <input type="checkbox"/>	Pain prevents me from sleeping at all <input type="checkbox"/>
<b>Section 8: Social Life</b>					
My social life is normal and does not increase my pain <input type="checkbox"/>	My social life is normal, but it increases my pain <input type="checkbox"/>	Pain prevents me from participating in more energetic activities (e.g., sports, dancing) <input checked="" type="checkbox"/>	Pain prevents me from going out very often <input type="checkbox"/>	Pain has restricted my social life to home <input type="checkbox"/>	I have hardly any social life because of my pain <input type="checkbox"/>
<b>Section 9: Traveling</b>					
I can travel anywhere without increased pain <input type="checkbox"/>	I can travel anywhere, but it increases my pain <input type="checkbox"/>	My pain restricts my travel over 2 hours <input checked="" type="checkbox"/>	My pain restricts my travel over 1 hour <input type="checkbox"/>	My pain restricts my travel to short necessary journeys under 1/2 hour <input type="checkbox"/>	My pain prevents all travel except for visits to the physician, therapist, or hospital <input type="checkbox"/>
<b>Section 10: Employment/Homemaking</b>					
My normal homemaking/job activities do not cause pain <input type="checkbox"/>	My normal homemaking/job activities increase my pain, but I can still perform all that is required of me <input checked="" type="checkbox"/>	I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming) <input checked="" type="checkbox"/>	Pain prevents me from doing anything but light duties <input type="checkbox"/>	Pain prevents me from doing even light duties <input type="checkbox"/>	Pain prevents me from performing any job or homemaking chores <input type="checkbox"/>

Robert Plock IE  
00011545619047



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 2/18/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Feb 18 2013 8:00:50 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 225403

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

2ND ACT

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## PATIENT ACCOUNTS RECEIPT

**Patient Name:** Plock, Robert

**Payment Date:** Feb 18, 2013 07:59 AM

**Payment Method:** Master Card

**Account Number:** 030R290071246

**Receipt Number:** 2013-017167

**Payment Rec'd By:** SELECT\ShEdwards

**Appointment Date Time**

Monday, Feb 18, 2013 08:00 AM

**Payment Category**

Clinical Services

**Amount**

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**Total:**

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Thank you,

Baylor Institute for Rehabilitation Outpatient Services

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411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## PATIENT ACCOUNTS RECEIPT

**Patient Name:** Plock, Robert

**Payment Date:** Feb 27, 2013 08:11 AM

**Payment Method:** Master Card

**Account Number:** 030R290071246

**Receipt Number:** 2013-017534

**Payment Rec'd By:** SELECT\ShEdwards

**Appointment Date Time**

Wednesday, Feb 27, 2013 08:00 AM

**Payment Category**

Clinical Services

**Amount**

\$ 55.00

**Total:**

\$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: Feb 27, 2013 08:11 AM

Thank you,

Baylor Institute for Rehabilitation Outpatient Services

3rd AppT.



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 2/27/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Feb 27 2013 8:11:54 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 523924

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas, TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

VM 214-820-7539

## Appointment list for Plock, Robert

April Manint

Thank you for visiting Baylor Institute for Rehabilitation Outpatient Services. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Mon, Feb 18, 2013	08:00 AM	Daily Visit	Manint, PT, April	0.00
<del>Wed, Feb 27, 2013</del>	<del>08:00 AM</del>	<del>Daily Visit</del>	<del>Manint, PT, April</del>	<del>0.00</del>
Wed, Mar 06, 2013	08:00 AM	Daily Visit	Manint, PT, April	0.00
Wed, Mar 13, 2013	08:00 AM	Daily Visit	Manint, PT, April	0.00
Wed, Mar 20, 2013	08:00 AM	Daily Visit	Manint, PT, April	0.00

### Additional Instructions:

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## PATIENT ACCOUNTS RECEIPT

**Patient Name:** Plock, Robert  
**Payment Date:** Mar 04, 2013 09:05 AM  
**Payment Method:** Visa

**Account Number:** 030R290071246  
**Receipt Number:** 2013-017693  
**Payment Rec'd By:** SELECT\ShEdwards

**Appointment Date Time**  
Monday, Mar 04, 2013 09:00 AM

**Payment Category**  
Clinical Services

**Amount**  
\$ 55.00

**Total:** \$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES  
Printed: Mar 04, 2013 09:05 AM

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

4th App't



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 3/4/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Mar 4 2013 9:05:52 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 307663

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X  
\_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

BIR JV,LLP  
PO Box 677466  
Dallas, TX 752677466  
866-889-9968

## Amount Receipt Voucher

---

**PATIENT ID:** 290071246 - Plock,Robert

**CHECK #:** 962262

**AMOUNT:** \$6.50

**DATE REC'D:** 03-04-2013

**COMMENTS:** Patient: paid \$6.50 via check # 962262;  
Batch# 19230030420133: [3/4/2013] pt  
supply/yellow theraband

---

Date

Signature

(Ref #16500.36420.ShEdwards.19230)

---



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 3/4/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Mar 4 2013 10:06:20 AM

Card Type : VISA  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*7727

Auth Amount : \$6.50  
Auth Code : 962262

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas, TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## PATIENT ACCOUNTS RECEIPT

**Patient Name:** Plock, Robert  
**Payment Date:** Mar 20, 2013 09:08 AM  
**Payment Method:** Master Card

**Account Number:** 030R290071246  
**Receipt Number:** 2013-018237  
**Payment Rec'd By:** SELECT\ShEdwards

Appointment Date/Time	Payment Category	Amount
Wednesday, Mar 20, 2013 08:00 AM	Clinical Services	\$ 55.00
	<b>Total:</b>	<b>\$ 55.00</b>

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES  
Printed: Mar 20, 2013 09:08 AM

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

5<sup>th</sup> Apt



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 3/20/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Mar 20 2013 9:09:41 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 684259

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

411 North Washington Ave  
Suite 4000  
Dallas, TX USA 75246  
Phone: (214) 820-7457 Fax: (214) 820-1654

<b>Patient:</b>	<b>Robert Plock</b>	<b>Visit Date:</b>	<b>Mar 20, 2013</b>
<b>Acct #:</b>	<b>030R290071246</b>	<b>FSC:</b>	<b>HMO/PPO</b>
<b>DOB:</b>	<b>Jul 26, 1968</b>	<b>Payor:</b>	<b>UMR/UHC</b>
<b>Clinician:</b>	<b>April S. Manint, PT</b>	<b>Pol/Claim#:</b>	<b>13280912</b>
<b>Prim Phy:</b>	<b>William T. Christensen</b>	<b>Insured:</b>	<b>Plock,Robert</b>
<b>Phy Phone:</b>	<b>(214) 828-5775</b>	<b>Employer:</b>	<b>Spencer Air Cond</b>
<b>Phy Fax:</b>	<b>(214) 828-5777</b>	<b>Case Mgr:</b>	<b>Not Specified</b>
<b>Sec Phy:</b>	<b>Not Specified</b>	<b>Visits:</b>	<b>5</b>
<b>Inj. Date:</b>	<b>1/2/2013</b>	<b>Cxl/Ns:</b>	<b>1</b>
<b>Surg. Date:</b>	<b>Not Specified</b>		

## Re-Evaluation

<b>Diagnoses</b>	<b>Spine</b>	<b>7242</b>	<b>LUMBAGO</b>
		<b>7231</b>	<b>CERVICALGIA</b>
		<b>72887</b>	<b>MUSCLE WEAKNESS-GENERAL</b>
		<b>78192</b>	<b>ABNORMAL POSTURE</b>

## Subjective Examination

### ADL / Functional Status:

- Current Status: Pt. hasn't been working the last 3 weeks secondary to his low back and neck pain. Pt. is an air conditioning technician. Pt. has difficulty sleeping, sitting, walking, heavy household ADLs. Pt. will go back to work next week with lifting restrictions.

### Chief Complaint:

- Pt. reports on Thanksgiving day he was riding his mountain bike pretty fast and overpressed his left brake and went over his handlebars. Pt. reports neck and low back pain since then. Pt. reports he went to the physician and didn't have any xrays. Pt. reports he had a car wreck 25th of January and he was rear-ended and that flared up his low back and neck. Pt. went back to the doctor and pt. had an xray of the neck with open mouth xray and CAT scan of his head (no hemorrhaging.) Pt. reports he can't remember if they x-rayed his low back. Pt.'s script is for low back. Pt. is currently on Tramadol and the corticosteroids for his neck (last one today.) (Pt. also complains numbness/tingling right arm.) Pt. reports with the pain medication low back pain about 3/10, and 7/10 low back pain without medication. Pt. reports pain goes down to his sacrum at the lowest. Pt. reports pain with sleeping (wakes up frequently secondary to pain), pt. reports pain with prolonged sitting, walking, heavy household ADLs, pain with his job as an air conditioning technician. Pt. does installs, repairs, requires a lot of lifting, bending, working in attic. Pt. has not been working the last 3 weeks secondary to the pain.

### Daily Comments:

- 5/10 low back and 4/10 neck pain with pain medication--pt. reports pain level was 8/10 low back without pain medication, 5-6/10 neck

### Mechanism of Injury:

- fell off bike and car wreck.

## Objective Examination

### Flexibility:

- Iliopsoas(pain in low back)
- Iliotibial Band
- Hamstrings(SLR on the right)
- Rectus Femoris

### Left

Moderate Restriction  
Mild Restriction  
Moderate Restriction  
Mild Restriction

### Right

Moderate Restriction  
Mild Restriction  
Moderate Restriction  
Mild Restriction

### Feb 13, 2013

### Mar 20, 2013

### Muscle Testing: Lower Extremity MMT:

- Hip Abduction
- Hip Flexion
- Knee Extension
- Knee Flexion
- Ankle Dorsiflexion

### Left

+4/5  
5/5  
5/5  
5/5  
5/5

### Right

4/5  
5/5  
5/5  
5/5  
5/5

### Left

5/5  
5/5  
5/5  
5/5  
5/5

### Right

5/5  
5/5  
5/5  
5/5  
5/5

### Muscle Testing: Upper Extremity MMT:

- Scapular Retraction
- Scaption
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation
- Shoulder Internal Rotation
- Elbow Extension
- Elbow Flexion

### Left

+4/5  
+4/5  
5/5  
5/5  
5/5  
5/5  
5/5  
5/5

### Right

4/5  
4/5  
-5/5  
5/5  
5/5  
5/5  
5/5  
5/5

### Muscle Testing: Grip/Pinch: Dynamometer II Elbow

### Left

83.0 Pounds

### Right

80.0 Pounds

### Extended: Measures:

- Trial 1.(right handed)

### Palpation:

**Patient:** Robert Plock  
**Acct #:** 030R290071246  
**DOB:** Jul 26, 1968

**Visit Date:** Mar 20, 2013

• Pt. has increased kyphosis lower thoracic. Lumbar extension irritates a little, but no major motion preference. Pt. has tenderness to PA L1-L5, and right SI (right SI appears slightly anteriorly rotated.) Right unilateral mob more hypomobile on the right side.

**Range of Motion: Spine: Cervical Degrees:**

- Active Extension.(more pain extension)
- Active Flexion
- Active Rotation Left(discomfort)
- Active Rotation Right
- Active Side Bend Left
- Active Side Bend Right

**Mar 20, 2013**

45 Degrees  
40 Degrees  
60 Degrees  
60 Degrees  
35 Degrees  
35 Degrees

**Treatments**

**Exercise Activities: Stabilization Training: Supine Position:**

- Abdominal Brace(This visit)
- Air Bicycle(This visit)
- Bridging

- Stabilization Training 1

Did Not Perform: This visit

Did Not Perform: This visit

Time Elapsed: 6 Minutes, Additional Detail: 10s hold 10x each side--leg crossed over, Charge As: Therapeutic Exercise

Time Elapsed: 4 Minutes, Level: 10s hold 10x, Additional Detail: 90-90 holds-, Charge As: Therapeutic Exercise

**Exercise Activities: Flexibility(L. Quarter):**

- Hamstring Muscle(This visit)
- Piriformis Muscle(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

**Exercise Activities: Isotonics(L. Quarter):**

- Straight Leg Raises-Abduction(This visit)
- Wall Squats;(This visit)
- Isotonic Activity 1(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

**Exercise Activities: Pulleys: Spine:**

- Pulley 1(This visit)

Did Not Perform: This visit

**Exercise Activities: Isotonics(U. Quarter):**

- Prone Extension.(This visit)
- Prone External Rotation(This visit)
- Prone Horizontal Abduction.(This visit)
- Isotonic Activity 1(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Quadruped Position:**

- Alternating LE Lift(This visit)

Did Not Perform: This visit

**Exercise Activities: Tubing/Bands(U. Quarter):**

- ER Pullout(This visit)
- Pull Downs(This visit)
- Rows(This visit)
- Tubing/Bands 1(This visit)

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Prone Position:**

- Plank(This visit)

Did Not Perform: This visit

**Exercise Activities: Flexibility(U. Quarter):**

- Pectoralis Minor Muscle(This visit)

Did Not Perform: This visit

**Exercise Activities: Isometrics:**

- Isometric Activity 1(This visit)

Did Not Perform: This visit

**Manual Interventions: Vertebral Joint Segments:**

- Cervical Spine(This visit)

Did Not Perform: This visit

**Modalities:**

- Mechanical Traction

Time Elapsed: 20 Minutes, On/Off Ratio: 32:23, Traction Application: intermittent, Traction Placement: cervical, Additional Detail: 5 min assessment and adjustment, Clinical Use: Pre Activity, Charge As: Traction, Mechanical

**Therapy Session Time**

- Therapy Session Start Time
- Therapy Session Stop Time

08:10 AM

09:00 AM

**Documented Procedural Code Summary:**

Description	Code	Units	Minutes
• Physical Therapy Reevaluation	97002	1	n/a
• Therapeutic Procedure	97110	1	10

• Traction, Mechanical 97012 1 n/a

## Assessment

The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

### Evaluation Components:

- Pt. has improved in neck rotation ROM, but other ranges have gotten worse. Pt. has improved in UE strength. Pt. notes his right grip strength is still weak with continued numbness/tingling. Pt. objective measures were done following traction today. Pt. continues to have low back and neck pain, which is severe without the use of pain medication. Pt. will continue to benefit from skilled physical therapy 1-2x a week for another 6 weeks to continue to address these impairments.

### Recommendations: Skilled Intervention: Required To:

- Decrease Pain. Improve Function. Improve Motor Control. Increase Range of Motion. Increase Strength.

## Problems & Goals

**Problem #1 Chief Complaint:** Pt. reports on Thanksgiving day he was riding his mountain bike pretty fast and overpressed his left brake and went over his handlebars. Pt. reports neck and low back pain since then. Pt. reports he went to the physician and didn't have any xrays. Pt. reports he had a car wreck 25th of January and he was rear-ended and that flared up his low back and neck. Pt. went back to the doctor and pt. had an xray of the neck with open mouth xray and CAT scan of his head (no hemorrhaging.) Pt. reports he can't remember if they x-rayed his low back. Pt.'s script is for low back. Pt. is currently on Tramadol and the corticosteroids for his neck (last one today.) (Pt. also complains numbness/tingling right arm.) Pt. reports with the pain medication low back pain about 3/10, and 7/10 low back pain without medication. Pt. reports pain goes down to his sacrum at the lowest. Pt. reports pain with sleeping (wakes up frequently secondary to pain), pt. reports pain with prolonged sitting, walking, heavy household ADLs, pain with his job as an air conditioning technician. Pt. does installs, repairs, requires a lot of lifting, bending, working in attic. Pt. has not been working the last 3 weeks secondary to the pain.

LTG Achieve by Apr 17, 2013. Progress: Some progress. pt. still has a lot of pain without medication

#### Symptomatic Improvements:

- Pt. will report no more than 1/10 low back pain without using pain medication, with work activities.

### Problem #2 Muscle Testing: Lower Extremity MMT.

LTG Achieve by Apr 17, 2013. Progress: Good progress.

#### Musculoskeletal Improvements In: Lower Extremity Strength to:

- Hip Abduction(improve lumbopelvic stability with walking)

Left

Right

5/5

5/5

### Problem #3 Muscle Testing: Upper Extremity MMT.

LTG Achieve by Apr 17, 2013. Progress: Good progress.

#### Musculoskeletal Improvements In: Upper Extremity Strength to:

- Scapular Protraction(to decrease upper trap recruitment with overhead)
- Scapular Retraction
- Shoulder Abduction
- Shoulder Flexion

Left

Right

+4/5

+4/5

+4/5

+4/5

5/5

5/5

5/5

5/5

### Problem #4 Range of Motion: Spine: Cervical Degrees.

LTG Achieve by Apr 17, 2013. Progress: Some progress. rotation better, others worse, post traction

#### Range of Motion Improvements to: Cervical:

- Active Rotation Left(decrease limitation with driving) 75 Degrees
- Active Rotation Right 75 Degrees

## Plan

### Amount, Frequency and Duration:

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 2 visits a week with an expected duration of 6 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

### Therapeutic Contents:

- Active Assistive Range of Motion Activities. Active Range of Motion Activities. Client Education. Home Exercise Program. Joint Mobilization Techniques. Manual Range of Motion Activities. Manual Therapy Techniques. Neural Mobilization Techniques. Neuromuscular Re-education. Passive Range of Motion Activities. Proprioceptive/Closed Kinetic Chain Activities. Soft Tissue Mobilization Techniques. Stretching/Flexibility Activities. Therapeutic Activities. Therapeutic Exercise.

Patient: Robert Plock  
Acct #: 030R290071246  
DOB: Jul 26, 1968

Visit Date: Mar 20, 2013

---

• Modalities:

- Moist Hot Pack. Mechanical Traction.



---

April S. Manint, PT, PT(TX Lic: 1203237)  
Signed on Mar 20, 2013 10:38:58

---

## Proof of Appointment

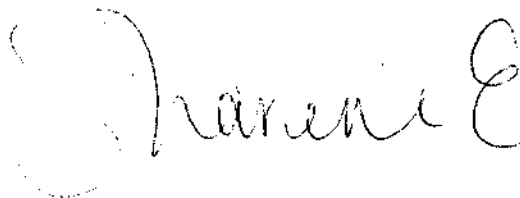
---

Patient Name Robert Plock

Patient was seen at our facility on 3/20/13 for Outpatient Therapy.

If you have any questions please feel free to contact us at 214-820-7457

Thank You,



# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## Appointment list for Plock, Robert

Thank you for visiting Baylor Institute for Rehabilitation Outpatient Services. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Mon, Mar 04, 2013	09:00 AM	Daily Visit	Manint, PT , April	0.00
Wed, Mar 13, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
Wed, Mar 20, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00

### Additional Instructions:

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 2971246  
Date of Service : 3/29/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Mar 29 2013 9:09:54 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 193711

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

6th Appx

# **Baylor Institute for Rehabilitation Outpatient Services**

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## **PATIENT ACCOUNTS RECEIPT**

<b>Patient Name:</b>	Plock, Robert	<b>Account Number:</b>	030R290071246
<b>Payment Date:</b>	Mar 29, 2013 09:08 AM	<b>Receipt Number:</b>	2013-018549
<b>Payment Method:</b>	Master Card	<b>Payment Rec'd By:</b>	SELECT\JacASmith

<b>Appointment Date Time</b>	<b>Payment Category</b>	<b>Amount</b>
Friday, Mar 29, 2013 08:00 AM	Clinical Services	\$ 55.00
	<b>Total:</b>	\$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES  
Printed: Mar 29, 2013 09:08 AM

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

**Baylor Institute for Rehabilitation Outpatient Services**

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

**PATIENT ACCOUNTS RECEIPT**

**Patient Name:** Plock, Robert

**Payment Date:** Apr 02, 2013 09:16 AM

**Payment Method:** Master Card

**Account Number:** 030R290071246

**Receipt Number:** 2013-018637

**Payment Rec'd By:** SELECT\ShEdwards

**Appointment Date Time**  
Tuesday, Apr 02, 2013 08:00 AM

**Payment Category**  
Clinical Services

**Amount**  
\$ 55.00

**Total:** \$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: Apr 02, 2013 09:17 AM

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

7th Apt



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 4/2/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Apr 2 2013 9:17:00 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 695988

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Account # : 290071246  
Date of Service : 4/12/2013  
Last : PLOCK

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

Apr 12 2013 9:14:07 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 242855

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

8<sup>th</sup> Appt

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## PATIENT ACCOUNTS RECEIPT

**Patient Name:** Plock, Robert

**Payment Date:** Apr 12, 2013 09:12 AM

**Payment Method:** Master Card

**Account Number:** 030R290071246

**Receipt Number:** 2013-019029

**Payment Rec'd By:** SELECT\JacASmith

**Appointment Date Time**

Friday, Apr 12, 2013 08:00 AM

**Payment Category**

Clinical Services

**Amount**

\$ 55.00

**Total:**

\$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: Apr 12, 2013 09:12 AM

Thank you,

Baylor Institute for Rehabilitation Outpatient Services

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## Appointment list for Plock, Robert

Thank you for visiting Baylor Institute for Rehabilitation Outpatient Services. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Fri, Mar 29, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
Tue, Apr 02, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
<del>Tue, Apr 09, 2013</del>	08:00 AM	Daily Visit Apr 12	Manint, PT , April	0.00
Wed, Apr 17, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
Wed, Apr 24, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
Wed, May 01, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00

### Additional Instructions:

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

# **Baylor Institute for Rehabilitation Outpatient Services**

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## **PATIENT ACCOUNTS RECEIPT**

**Patient Name:** Plock, Robert

**Payment Date:** Apr 24, 2013 09:12 AM

**Payment Method:** Master Card

**Account Number:** 030R290071246

**Receipt Number:** 2013-019352

**Payment Rec'd By:** SELECT\ShEdwards

### **Appointment Date Time**

Wednesday, Apr 24, 2013 08:00 AM

Wednesday, Apr 17, 2013 08:00 AM

### **Payment Category**

Co-Ins/Deductible

Co-Ins/Deductible

### **Amount**

\$ 55.00

\$ 55.00

**Total:** \$ 110.00

Please Note: The payments included on this receipt are an estimate of your responsibility. Payments may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: Apr 24, 2013 09:12 AM

Thank you,

Baylor Institute for Rehabilitation Outpatient Services



## Baylor Institute for Rehab - Landry 4th Floor

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Last : PLOCK  
Account # : 290071246  
Date of Service : 4/24/2013  
Comments : PT CO INS FOR DOS 4/17/13

Credit Card - Sale

--- APPROVED ---

Response Message : Approval (00)  
Response Code : 000

Apr 24 2013 9:13:35 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 722172

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)



## Baylor Institute for Rehab - Landry 4th Floor

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Last : PLOCK  
Account # : 290071246  
Date of Service : 4/24/2013  
Comments : PT CO INS 30%

Credit Card - Sale

--- APPROVED ---

Response Message : Approval (00)  
Response Code : 000

Apr 24 2013 9:10:30 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 721719

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X

(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

**Baylor Institute for Rehabilitation Outpatient Services**

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

**PATIENT ACCOUNTS RECEIPT****Patient Name:** Plock, Robert**Account Number:** 030R290071246**Payment Date:** May 01, 2013 09:14 AM**Receipt Number:** 2013-019543**Payment Method:** Master Card**Payment Rec'd By:** SELECT\ShEdwards**Appointment Date Time**

Wednesday, May 01, 2013 08:00 AM

**Payment Category**

Co-Ins/Deductible

**Amount**

\$ 55.00

**Total:**

\$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: May 01, 2013 09:14 AM

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services



**Baylor Institute for Rehab - Landry 4th Floor**

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Last : PLOCK  
Account # : 290071246  
Date of Service : 5/1/2013  
Comments : PT CO INS 30%

Credit Card - Sale

**--- APPROVED ---**

Response Message : Approval (00)  
Response Code : 000

May 1 2013 9:14:34 AM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$55.00  
Auth Code : 207990

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X  
\_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)



## Baylor Institute for Rehab - Landry 4th Floor

411 North Washington Avenue  
Suite 4000  
Dallas, TX 75246

First : ROBERT  
Last : PLOCK  
Account # : 290071246  
Comments : PT COINS 30%

Credit Card - Sale

**--- Approved ---**

Response Message : Approval (00)  
Response Code : 000

Jun 10 2013 9:11:43 AM

Card Type : VISA  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*2677

Auth Amount : \$55.00  
Auth Code : 010278

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X \_\_\_\_\_  
(Signature)

For billing questions please call 866-889-9968 or email [rehabcbocs@selectmedical.com](mailto:rehabcbocs@selectmedical.com)

# **Baylor Institute for Rehabilitation Outpatient Services**

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## **PATIENT ACCOUNTS RECEIPT**

<b>Patient Name:</b>	Plock, Robert	<b>Account Number:</b>	030R290071246
<b>Payment Date:</b>	Jun 10, 2013 09:10 AM	<b>Receipt Number:</b>	2013-020690
<b>Payment Method:</b>	Visa	<b>Payment Rec'd By:</b>	SELECT\ODunn

<b>Appointment Date Time</b>	<b>Payment Category</b>	<b>Amount</b>
Monday, Jun 10, 2013 08:00 AM	Co-Ins/Deductible	\$ 55.00
	<b>Total:</b>	\$ 55.00

Please Note: The payment included on this receipt is an estimate of your responsibility. Payment may be adjusted in the future based on additional information received from your insurance carrier.

PLEASE RETAIN YOUR RECEIPT FOR TAX PURPOSES

Printed: Jun 10, 2013 09:10 AM

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave  
Suite 4000  
Dallas, TX USA 75246  
Phone: (214) 820-7457 Fax: (214) 820-1654

**Patient: Robert Plock**

**Acct #: 030R290071246**

**DOB: Jul 26, 1968**

**Clinician: April S. Manint, PT**

**Prim Phy: William T. Christensen**

**Phy Phone: (214) 828-5775**

**Phy Fax: (214) 828-5777**

**Sec Phy: Not Specified**

**Inj. Date: 1/2/2013**

**Surg. Date: Not Specified**

**Visit Date: Apr 17, 2013**

**FSC: HMO/PPO**

**Payor: UMR/UHC**

**Pol/Claim#: 13280912**

**Insured: Plock,Robert**

**Employer: Spencer Air Cond**

**Case Mgr: Not Specified**

**Visits: 9**

**Cxl/Ns: 1**

## Re-Evaluation

<b>Diagnoses</b>	Spine	7242	LUMBAGO
		7231	CERVICALGIA
		72887	MUSCLE WEAKNESS-GENERAL
		78192	ABNORMAL POSTURE

## Subjective Examination

### ADL / Functional Status:

- Current Status: Pt. hasn't been working the last 3 weeks secondary to his low back and neck pain. Pt. is an air conditioning technician. Pt. has difficulty sleeping, sitting, walking, heavy household ADLs. Pt. will go back to work next week with lifting restrictions.

### Chief Complaint:

- Pt. reports on Thanksgiving day he was riding his mountain bike pretty fast and overpressed his left brake and went over his handlebars. Pt. reports neck and low back pain since then. Pt. reports he went to the physician and didn't have any xrays. Pt. reports he had a car wreck 25th of January and he was rear-ended and that flared up his low back and neck. Pt. went back to the doctor and pt. had an xray of the neck with open mouth xray and CAT scan of his head (no hemorrhaging.) Pt. reports he can't remember if they x-rayed his low back. Pt.'s script is for low back. Pt. is currently on Tramadol and the corticosteroids for his neck (last one today.) (Pt. also complains numbness/tingling right arm.) Pt. reports with the pain medication low back pain about 3/10, and 7/10 low back pain without medication. Pt. reports pain goes down to his sacrum at the lowest. Pt. reports pain with sleeping (wakes up frequently secondary to pain), pt. reports pain with prolonged sitting, walking, heavy household ADLs, pain with his job as an air conditioning technician. Pt. does installs, repairs, requires a lot of lifting, bending, working in attic. Pt. has not been working the last 3 weeks secondary to the pain.

### Daily Comments:

- 3/10 neck, 2-3/10 low back--took pain medication today

### Mechanism of Injury:

- fell off bike and car wreck.

## Objective Examination

### Flexibility:

- Iliopsoas(pain in low back)
- Iliotibial Band
- Hamstrings(SLR on the right)
- Rectus Femoris

### Left

Moderate Restriction  
Mild Restriction  
Moderate Restriction  
Mild Restriction

### Right

Moderate Restriction  
Mild Restriction  
Moderate Restriction  
Mild Restriction

**Mar 20, 2013**

**Apr 17, 2013**

### Muscle Testing: Lower Extremity MMT:

- Hip Abduction
- Hip Flexion
- Knee Extension
- Knee Flexion
- Ankle Dorsiflexion

Left	Right
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5

Left	Right
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5

**Mar 20, 2013**

**Apr 17, 2013**

### Muscle Testing: Upper Extremity MMT:

- Scapular Retraction
- Scaption(protraction)
- Shoulder Abduction
- Shoulder Flexion
- Shoulder External Rotation
- Shoulder Internal Rotation
- Elbow Extension
- Elbow Flexion

Left	Right
+4/5	4/5
+4/5	4/5
5/5	-5/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5

Left	Right
+4/5	+4/5
+4/5	+4/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5
5/5	5/5

### Muscle Testing: Grip/Pinch: Dynamometer II Elbow

#### Extended: measures:

- Trial 1.(right handed)

**Left**  
110.0 Pounds

**Right**  
110.0 Pounds

**Palpation:**

- Pt. has increased kyphosis lower thoracic. Lumbar extension irritates a little, but no major motion preference. Pt. has tenderness to PA L1-L5, and right SI (right SI appears slightly anteriorly rotated.) Right unilateral mob more hypomobile on the right side.

**Range of Motion: Spine: Cervical Degrees:**

	Mar 20, 2013	Apr 17, 2013
• Active Extension.(more pain extension)	45 Degrees	50 Degrees
• Active Flexion	40 Degrees	50 Degrees
• Active Rotation Left(discomfort)	60 Degrees	55 Degrees
• Active Rotation Right	60 Degrees	65 Degrees
• Active Side Bend Left(feels tight)	35 Degrees	40 Degrees
• Active Side Bend Right	35 Degrees	40 Degrees

**Treatments**

**Exercise Activities: Stabilization Training: Supine Position:**

- Abdominal Brace(This visit)
- Air Bicycle(This visit)
- Bridging(This visit)
- Stabilization Training 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit

**Exercise Activities: Flexibility(L. Quarter):**

- Hamstring Muscle(This visit)
- Piriformis Muscle(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit

**Exercise Activities: Isotonics(L. Quarter):**

- Straight Leg Raises-Abduction(This visit)
- Wall Squats;(This visit)
- Isotonic Activity 1

Did Not Perform: This visit  
Did Not Perform: This visit  
Time Elapsed: 6 Minutes, Additional Detail: yellow med ball 5s hold  
10x in front, 10x overhead, Description: retrosquats, Charge As:  
Therapeutic Exercise

**Exercise Activities: Pulleys: Spine:**

- Pulley 1(This visit)

Did Not Perform: This visit

**Exercise Activities: Isotonics(U. Quarter):**

- Prone Extension.
- Prone External Rotation
- Prone Horizontal Abduction.
- Supine Punch(This visit)
- Isotonic Activity 1

Time Elapsed: 7 Minutes, Weight - Pounds: 3 Pounds, Repetitions:  
15, Sets: 2, 5s hold, Charge As: Neuromuscular Reeducation  
Time Elapsed: 7 Minutes, Weight - Pounds: 1 Pounds, Repetitions:  
15, Sets: 2, Charge As: Neuromuscular Reeducation  
Time Elapsed: 7 Minutes, Repetitions: 15, Sets: 2, Additional Detail:  
5s hold, Charge As: Neuromuscular Reeducation  
Did Not Perform: This visit  
Time Elapsed: 7 Minutes, Repetitions: 15, Sets: 2, Additional Detail:  
5s hold, Description: low trap, Charge As: Neuromuscular  
Reeducation

**Exercise Activities: Stabilization Training: Quadruped Position:**

- Alternating LE Lift(This visit)

Did Not Perform: This visit

**Exercise Activities: Tubing/Bands(U. Quarter):**

- ER Pullout(This visit)
- Pull Downs(This visit)
- Rows(This visit)
- Tubing/Bands 1(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit

**Exercise Activities: Stabilization Training: Prone Position:**

- Plank

Time Elapsed: 6 Minutes, Body Position: 1 min, 2x forward, 30s, 2x  
side each, Elevation: instruction time, modifications %, Additional  
Detail: forward, short lever, Charge As: Therapeutic Exercise

**Exercise Activities: Flexibility(U. Quarter):**

- Pectoralis Minor Muscle(This visit)

Did Not Perform: This visit

**Exercise Activities: Isometrics:**

- Isometric Activity 1(This visit)
- Isometric Activity 2(This visit)
- Isometric Activity 3(This visit)

Did Not Perform: This visit  
Did Not Perform: This visit  
Did Not Perform: This visit

**Manual Interventions: Vertebral Joint Segments:**

Patient: Robert Plock  
Acct #: 030R290071246  
DOB: Jul 26, 1968

Visit Date: Apr 17, 2013

• Cervical Spine(This visit)

Did Not Perform: This visit

**Modalities:**

• Mechanical Traction(This visit)

Did Not Perform: This visit

**Pt./Family Education:**

• Written Home Exercise Program

Time Elapsed: 2 Minutes, Activity: Provided & Reviewed, Additional Detail: wrote out planks and retrosquats, Description: Diagnosis Specific, Charge As: Therapeutic Exercise

**Therapy Session Time**

• Therapy Session Start Time

08:00 AM

• Therapy Session Stop Time

09:00 AM

**Documented Procedural Code Summary:**

Description	Code	Units	Minutes
• Neuromuscular Reeducation	97112	2	28
• Physical Therapy Reevaluation	97002	1	n/a
• Therapeutic Procedure	97110	1	14

**Assessment**

The patient was educated regarding their diagnosis, prognosis, related pathology & plan of care. The patient demonstrates a good understanding of the risks, benefits, precautions/contraindications, & prognosis of their skilled rehabilitation program.

**Evaluation Components:**

- Pt. has improved in grip strength, UE strength, slightly in neck ROM, and pt. notes improvements in neck and low back pain, but pt. still has to take pain medication to control pain levels. Pt. will continue to benefit from skilled physical therapy 1x a week for another 6 weeks to continue to address these impairments, as well as possible additional intervention as determined by the physician.

**Recommendations: Skilled Intervention: Required To:**

- Decrease Pain. Improve Function. Improve Motor Control. Increase Range of Motion. Increase Strength.

**Problems & Goals**

**Problem #1 Chief Complaint:** Pt. reports on Thanksgiving day he was riding his mountain bike pretty fast and overpressed his left brake and went over his handlebars. Pt. reports neck and low back pain since then. Pt. reports he went to the physician and didn't have any xrays. Pt. reports he had a car wreck 25th of January and he was rear-ended and that flared up his low back and neck. Pt. went back to the doctor and pt. had an xray of the neck with open mouth xray and CAT scan of his head (no hemorrhaging.) Pt. reports he can't remember if they x-rayed his low back. Pt.'s script is for low back. Pt. is currently on Tramadol and the corticosteroids for his neck (last one today.) (Pt. also complains numbness/tingling right arm.) Pt. reports with the pain medication low back pain about 3/10, and 7/10 low back pain without medication. Pt. reports pain goes down to his sacrum at the lowest. Pt. reports pain with sleeping (wakes up frequently secondary to pain), pt. reports pain with prolonged sitting, walking, heavy household ADLs, pain with his job as an air conditioning technician. Pt. does installs, repairs, requires a lot of lifting, bending, working in attic. Pt. has not been working the last 3 weeks secondary to the pain.

LTG Achieve by May 15, 2013. Progress: Good progress. still requires pain medication

**Symptomatic Improvements:**

- Pt. will report no more than 1/10 low back pain without using pain medication, with work activities.

**Problem #2 Muscle Testing: Lower Extremity MMT.**

Goal Achieved Apr 17, 2013.

**Musculoskeletal Improvements In: Lower Extremity Strength to:**

- Hip Abduction(improve lumbopelvic stability with walking)

Left

Right

5/5

5/5

**Problem #3 Muscle Testing: Upper Extremity MMT.**

LTG Achieve by May 15, 2013. Progress: Excellent progress.

**Musculoskeletal Improvements In: Upper Extremity Strength to:**

- Scapular Protraction(to decrease upper trap recruitment with overhead)
- Scapular Retraction
- Shoulder Abduction
- Shoulder Flexion

Left

Right

+4/5

+4/5

+4/5

+4/5

5/5

5/5

5/5

5/5

---

**Problem #4 Range of Motion: Spine: Cervical Degrees.**

*LTG Achieve by May 15, 2013. Progress: Some progress.*

**Range of Motion Improvements to: Cervical:**

- Active Rotation Left(decrease limitation with driving) 75 Degrees
- Active Rotation Right 75 Degrees

**Plan**

**Amount, Frequency and Duration:**

- Frequency and Duration: It is recommended that the patient attend rehabilitative therapy for 1 visit a week with an expected duration of 6 weeks. The outlined therapeutic procedures and services in the plan of care will address the problems and goals identified.

**Therapeutic Contents:**

- Active Assistive Range of Motion Activities. Active Range of Motion Activities. Client Education. Group Therapy. Home Exercise Program. Manual Range of Motion Activities. Manual Therapy Techniques. Neural Mobilization Techniques. Neuromuscular Re-education. Passive Range of Motion Activities. Proprioceptive/Closed Kinetic Chain Activities. Soft Tissue Mobilization Techniques. Stretching/Flexibility Activities. Therapeutic Activities. Therapeutic Exercise.
- Modalities:
  - Moist Hot Pack. Mechanical Traction.



---

April S. Manint, PT, PT(TX Lic: 1203237)  
Signed on Apr 17, 2013 09:03:07

Short lever planks - linear, 2x forward  
side plank, 30s, 2x each side

---

retrosguards - yellow back - 516  
in front + overhead

Post on heels, knees behind toes  
5s hold, 10x each

# Baylor Institute for Rehabilitation Outpatient Services

411 North Washington Ave

Suite 4000

Dallas , TX 75246

Phone: (214) 820-7457

Fax: (214) 820-1654

## Appointment list for Plock, Robert

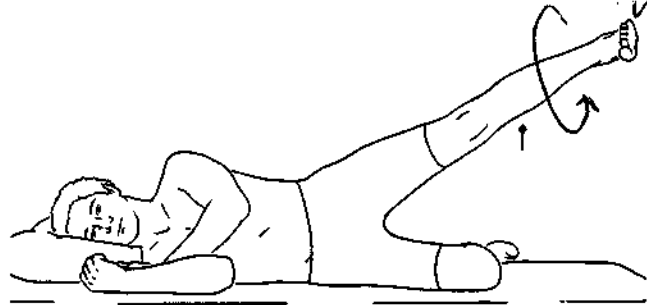
Thank you for visiting Baylor Institute for Rehabilitation Outpatient Services. If we can be of any further assistance, please let us know.

Date	Time	Appointment Type	Clinician	Copay
Wed, Apr 24, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
Wed, May 01, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00
Wed, May 15, 2013	08:00 AM	Daily Visit	Manint, PT , April	0.00

### Additional Instructions:

Thank you,  
Baylor Institute for Rehabilitation Outpatient Services

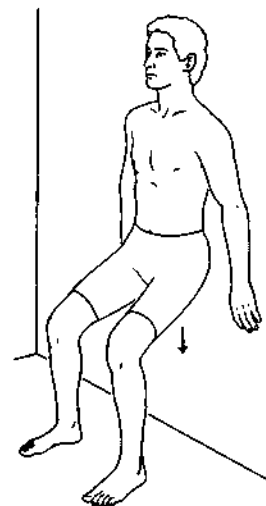
HIP / KNEE - 21 Strengthening: Hip Abduction  
(Side-Lying)



Tighten muscles on front of left thigh, then lift leg  
\_\_\_\_\_ inches from surface, keeping knee locked.  
Repeat \_\_\_\_\_ times per set. Do \_\_\_\_\_ sets per session.  
Do \_\_\_\_\_ sessions per day.

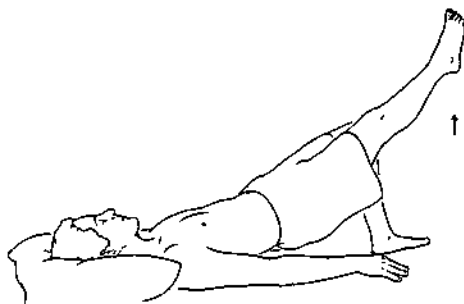
HIP / KNEE - 25 Strengthening: Wall Slide

Leaning on wall, slowly lower  
buttocks until thighs are parallel  
to floor. Hold 5 seconds.  
Tighten thigh muscles and return.



Repeat 10 times per set.  
Do 2 sets per session.  
Do 1 sessions per day.

TRUNK STABILITY - 13 Bridging:  
with Straight Leg Raise



With legs bent, lift buttocks \_\_\_\_\_ inches from floor. Then  
slowly extend right knee, keeping stomach tight. (Hold 10s  
repeat 10 each side)  
Repeat \_\_\_\_\_ times per set. Do \_\_\_\_\_ sets per session.  
Do \_\_\_\_\_ sessions per day.

90-90 holds → toe taps

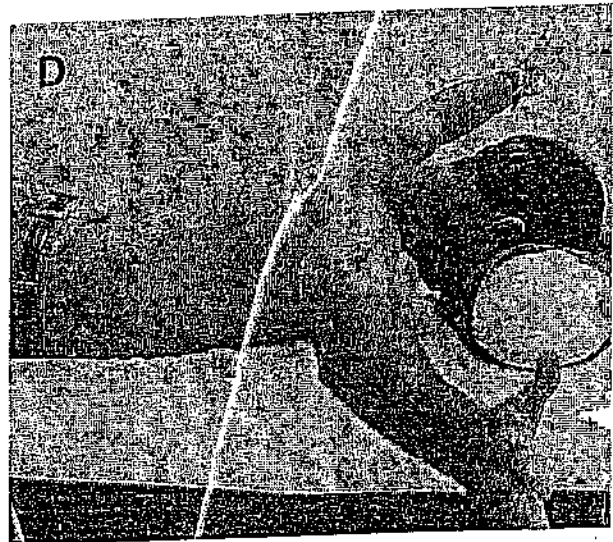
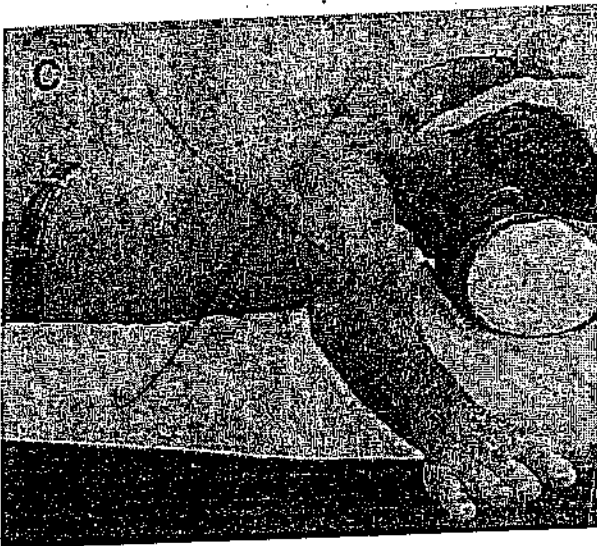
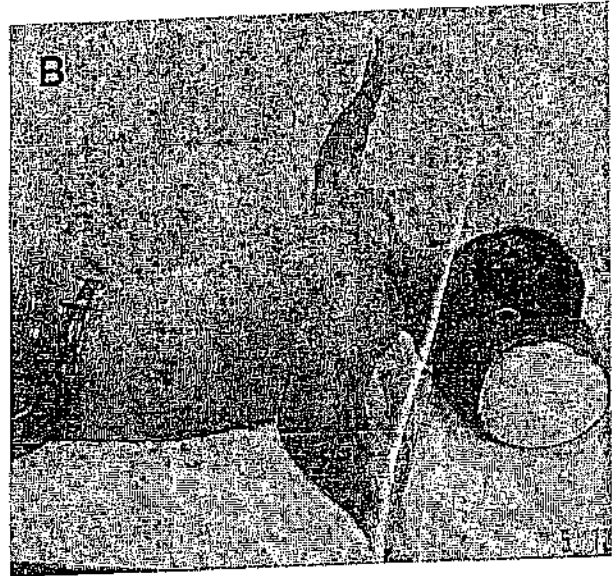
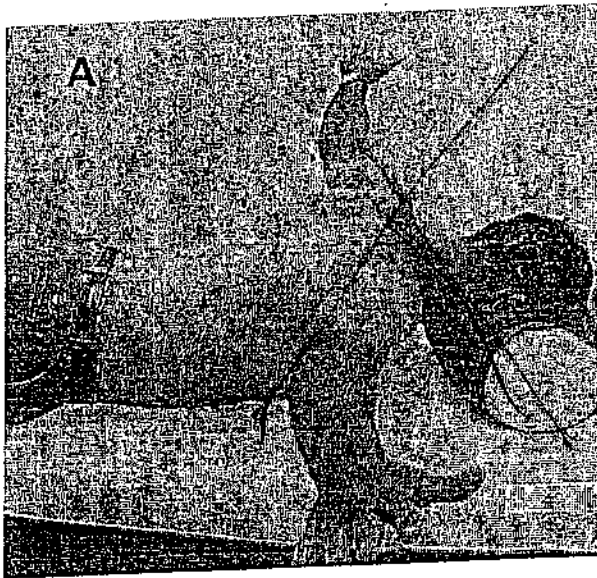
3 x 10  
back  
flat

Transverse abdominus  
w/ 30 heel slides  
each side

# THE DISABLED THROWING SHOULDER

659

2X15  
SS hold  
016



2X15  
016  
✓ SS hold

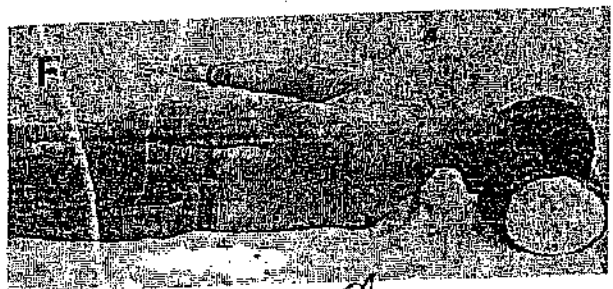
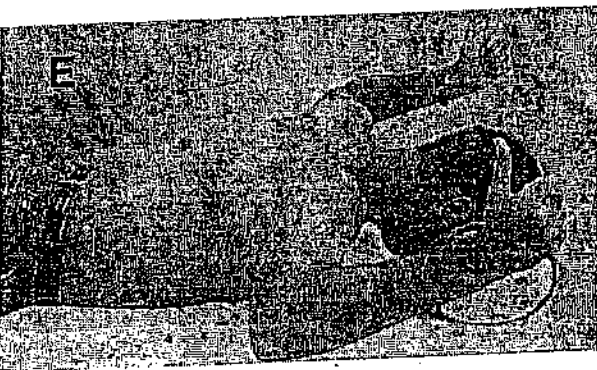


FIGURE 25. Blackburn exercises to strengthen scapular retractors and posterior rotator cuff. (A) Position 1, (B) position 2, (C) position 3, (D) position 4, (E) position 5, and (F) position 6.

2X15

216  
2X15  
SS hold

#### (4) HEALTHSOUTH

10 hold  
10 x  
2-3x/day

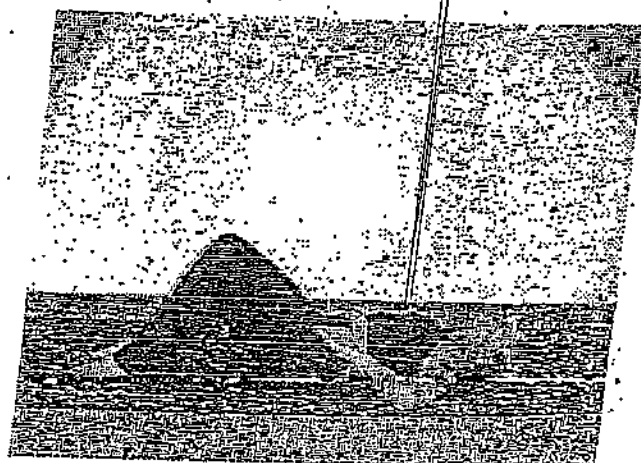
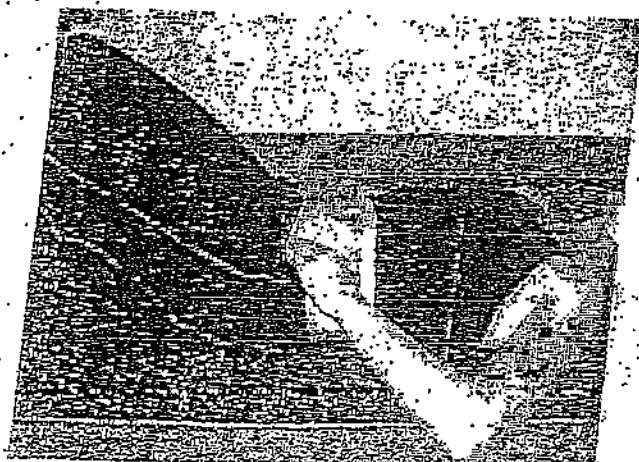
#### Transversus Abdominis Facilitation and Training

Palpate inside and slightly below the pelvic bones and to the side of your Rectus Abdominis. Allow your middle three fingers to sink deeply into the abdominal wall. Inhale slowly and exhale. Cease breathing and gently tighten the lower abdominal wall without lower back or pelvic movement. Do not recruit any other abdominal muscles. Inhale and resume normal breathing pattern. Hold the contraction with breathing for 10 seconds.

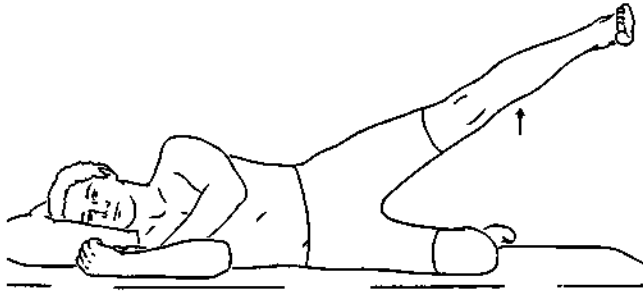
Cueing: Slowly draw your navel up and in towards your spine.  
Gently flatten your stomach below your bellybutton.  
Slowly tighten a seat belt low across your abdomen.  
Slowly develop a deep tension across the abdominal wall.  
Gently tighten the muscle below your fingertips.  
Imagine your lower abdomen is a corset tightening to protect your low back.  
Pelvic floor co-contraction - Imagine yourself stopping the flow of urine.

Watch For/Palpate Substitution: Posterior pelvic tilt, lower back flexion, rib cage depression, abnormal breathing, Rectus Abdominis or Obliquus Externus contraction, activation of Erector Spinae muscles.

Positions: Supine, four-point kneeling, prone, side-lying, sitting, standing, functional activities.



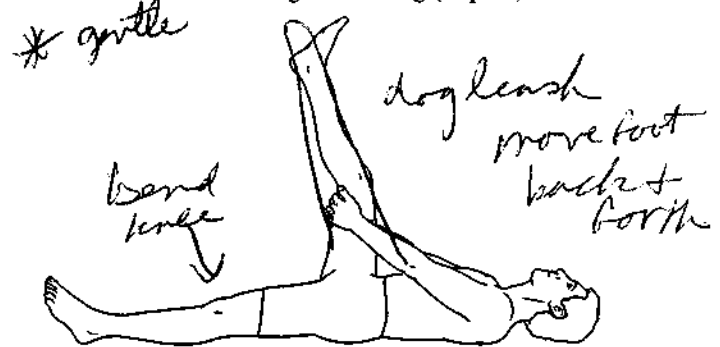
HIP / KNEE - 21 Strengthening: Hip Abduction  
(Side-Lying)



Tighten muscles on front of left thigh, then lift leg \_\_\_\_\_ inches from surface, keeping knee locked. Repeat both sides.

Repeat 15 times per set. Do 2 sets per session.  
Do \_\_\_\_\_ sessions per day.

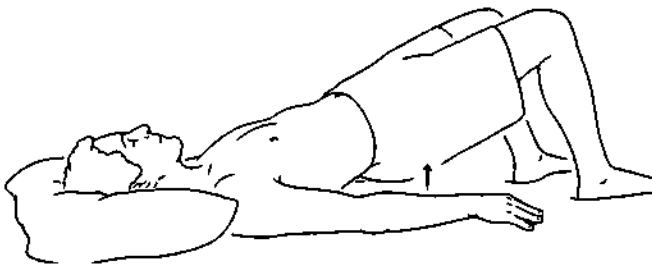
HIP / KNEE - 38 Stretching: Hamstring (Supine)



Supporting right thigh behind knee, slowly straighten knee until stretch is felt in back of thigh. Hold 30 seconds. Repeat opposite side.

Repeat 2 times per set. Do 1 sets per session.  
Do 2 sessions per day.

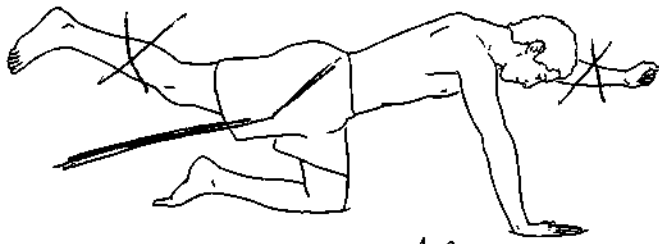
TRUNK STABILITY - 9 Bridging



Slowly raise buttocks from floor, keeping stomach tight.  
Hold 5s

Repeat 10 times per set. Do 2 sets per session.  
Do 1 sessions per day.

TRUNK STABILITY - 20  
Upper / Lower Extremity Extension (All-Fours)



*just legs*

Tighten stomach and raise right leg and opposite arm.  
Keep trunk rigid. Hold 5s

Repeat 10 times per set. Do 2 sets per session.  
Do 1 sessions per day.

HIP / KNEE - 48 Piriformis (Supine)



*use towel  
to stretch*

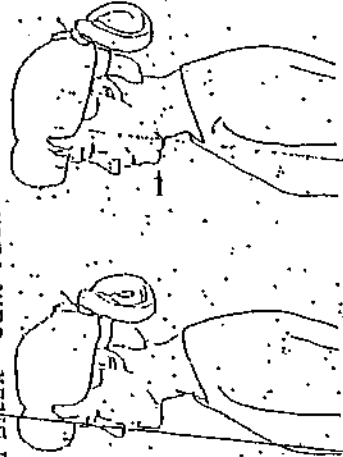
Cross legs, right on top. Gently pull other knee toward  
chest until stretch is felt in buttock/hip of top leg.  
Hold 30 seconds. both sides

Repeat 2 times per set. Do 1 sets per session.  
Do 2 sessions per day.



*90-90 holds  
10s hold 10x  
2 sets*

Stretch Break - Chin Tuck

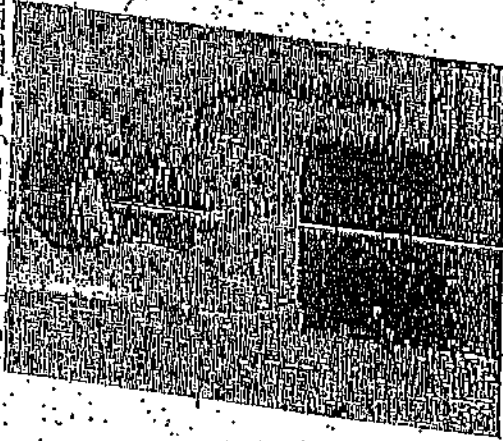


Looking straight forward,  
tuck chin and hold \_\_\_\_\_ seconds.  
Relax and return to starting position.  
Repeat \_\_\_\_\_ times every \_\_\_\_\_ hours.

10s hold 10x  
2-3x day

Arms Straight

Scapular Retraction - Keeping both your arms at your side, bend your elbows to 90 degrees. Squeeze your shoulder blades together.



10s hold 10x  
2-3x day

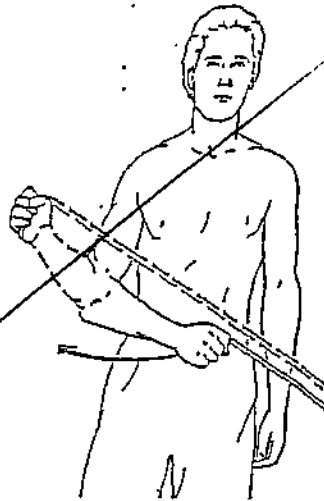
SHOULDER - 45 Strengthening Activities  
Active Resistive Extension



Using tubing, pull arm back. Be sure to keep elbow straight.

SHOULDER - 43 Strengthening: Resisted External Rotation

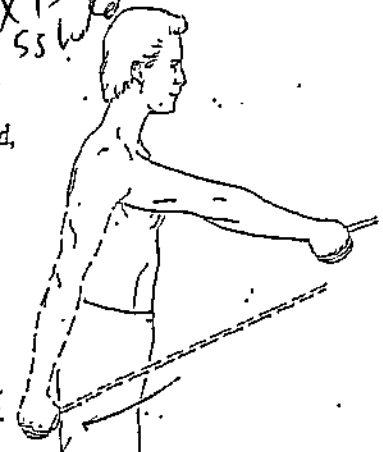
Hold tubing in right hand,  
elbow at side and forearm  
across body. Rotate  
forearm out.



Repeat \_\_\_\_\_ times per set.  
Do \_\_\_\_\_ sets per session.  
Do \_\_\_\_\_ sessions per day.

SHOULDER - 45 Strengthening: Resisted Extension

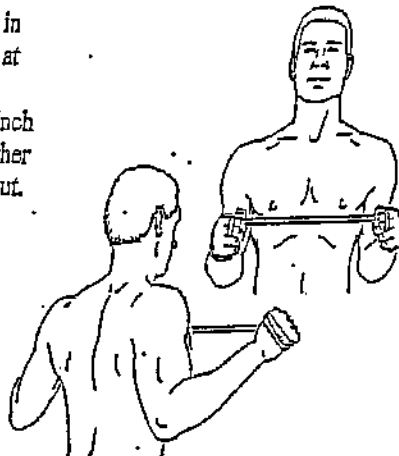
Hold tubing in right hand,  
arm forward. Pull arm  
back, elbow straight.



Repeat \_\_\_\_\_ times per set.  
Do \_\_\_\_\_ sets per session.  
Do \_\_\_\_\_ sessions per day.

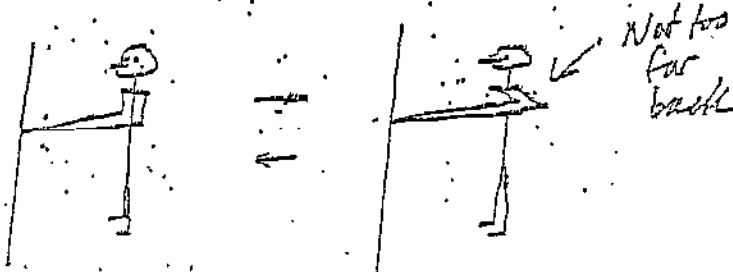
SHOULDER - 112 Resisted External Rotation in Neutral  
- Bilateral

Sit or stand, tubing in  
both hands, elbows at  
sides, bent to 90°,  
forearms forward. Pinch  
shoulder blades together  
and rotate forearms out.  
Keep elbows at sides.



Repeat \_\_\_\_\_ times  
per set.  
Do \_\_\_\_\_ sets  
per session.  
Do \_\_\_\_\_ sessions  
per day.

② Rowing: (squeeze shoulder blades together)



Green  
2X15  
55wld