The following Macro's are not intended to imply advice on jurisprudence or compliance. The following samples are for illustration purposes only. Providers are cautioned to use their clinical judgment along with appropriate professional advice to determine the appropriateness and legality of using this information.

Normal Physical Exam

The patient was cooperative, alert and in apparent good health. No masses were palpated on the head. Lung sounds were clear bilaterally; auscultation of the heart demonstrated a regular rate and rhythm. The patient's abdomen was symmetrical with no masses or tenderness palpated. No bruit was auscultated over the abdominal aorta. There was no palpable lymph gland swelling in the cervical or supraclavicular areas. Distal pulses were palpable and equal bilaterally. Neurologically, gross motor and sensory functions are intact. Cranial nerves 2 through 12 are grossly intact. Carotid artery auscultation was negative for bruit, and George's functional maneuver was negative for elicitation of an ischemic response when held for 30 seconds.

Normal Neuro

The patient has good muscle symmetry and tone. Myotomal strength is graded at 5/5. Sensation to pinwheel is equal and normal bilaterally and unrevealing for any dermatomal deficiency. Deep tendon reflexes are graded at 2+ bilaterally.

Treatment plan

Treatment goals include decreasing spasm and edema while increasing range of motion and function. The patient will be treated three times a week for two to four weeks based on evaluations and progress. Modalities for pain control, treatment methods, and treatment frequency may be modified based on progress. As symptoms improve, the patient will be transitioned from passive in-office care toward active care including stretching, strengthening and stabilization exercises. Upon completion of the initial care plan, the patient will be formally reevaluated to determine need for further care.

Medicare AT Plan

The patient has a significant musculoskeletal problem, painfully limiting their activities of daily living. Chiropractic treatment, including spinal manipulation, is expected to have a direct positive impact on their condition. Treatment goals include decreasing spasm and edema while increasing range of motion and function. The patient will be treated three times a week for two to four weeks based on evaluations and progress. As symptoms improve, the patient will be transitioned from passive in-office care toward active care including stretching, strengthening and stabilization exercises. Upon completion of the initial care plan, the patient will be formally reevaluated to determine need for further care. Since both subjective and objective improvement would be expected from this treatment, this care plan will be considered active treatment.

Report of Findings

The report of findings consisted of a detailed explanation of my diagnosis, treatment plan, treatment length, outcome goals and cost of care. The risks associated with the proposed treatment plan were explained. I informed the patient that I expected a favorable outcome through treatment, but I could not guarantee success. Furthermore, I explained that there was also a chance of aggravating the existing condition or creating new injuries. Alternative treatment options were covered. An opportunity to ask questions was offered. The patient is in agreement with my proposed treatment plan and wishes to proceed. Informed consent was verbally obtained. Treatment was initiated.

Orthotic Prescription

After careful orthopedic and biomechanical reevaluation, it is apparent that the patient is predisposed to chronic aggravation of their spinal condition due to structural instability of the feet. This instability is a perpetuating factor for the patient's spinal and lower extremity complaints. In an effort to reduce

and stabilize this permanent structural instability, prescribed custom fitted orthotics are required. The patient has been cast for orthotics and will be instructed in the proper use and care of the orthotics when they arrive.

Smoker ADL

The patient and I had a discussion about the risks of tobacco use and the health benefits of cessation. We discussed methods to quit smoking and I provided resources to help. The patient was given a "smoking cessation" handout summarizing these concepts.

Weight ADL

The patient and I discussed the health risks associated with being overweight. I explained the importance of proper diet and beginning exercise. I provided suggestions for losing weight.
The patient was given a "healthy weight" handout summarizing these points.

First reassessment

Upon reassessment, the patient is making progress toward treatment goals. Updated treatment goals include restoring full range of motion and reducing the residual hypertonicity of the affected muscles. The patient will be treated for 6 times over the next 4-8 weeks based on evaluations and progress. I will continue to transition the patient toward active care reinforcing the home stretching and strengthening program. Upon completion of this updated care plan the patient will again be reevaluated to determine need for further care.