

S.O.A.P. NOTES

PRE-BILLING VERIFICATION STATUS:

MEDICARE/INSURANCE # _____ D.O.B. ____/____/____

Pre-Billing Verification: Date of Verification: _____ Medicare Primary: Yes No

Patient has Part B: Yes No #: _____ Deductible Has Been Met: Yes No

Patient had **Same or Similar** Treatment this year: Yes No Last Date of Service: _____

PATIENT NAME: _____ DOB: ____/____/____

.....
S (SUBJECTIVE COMPLAINTS)

.....
O (OBJECTIVE EVALUATION)

.....
A (ASSESSMENT/TREATMENT)

.....
P (PLAN of CARE)

Name of Person Charting _____ Date: ____/____/____