Patient Better®

The Treatment Plan Calculator

Name: ___________________________ __________ ***D.O.B.*** _______________________________

Option # ___	Title: ______________________			Total Annual Deductible			
Projected Length of Time: ______________________				Ins. Coverage $ ________			
DOCTOR VISITS	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
MEDICATION	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
DIAGNOSTIC IMAGING	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
LAB TESTS	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
SURGERY	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
THERAPY	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
EQUIPMENT	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______
IN-HOME CARE	___________	EVERY	DD / WK / MO / YR	Y	N	OOP:	$_______

PROJECTED HOURS: ________________ EVERY	DD / WK / MO / YR	Total: $ _______

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COMMENTS: ____
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Filled out by: ___________________________________ Date: _______________________

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