

Healing Touch Massage Lmt
937.533.3354
healingtouchmassageimt.com
contactus@healingtouchmassageimt.com
1066 Reading Rd. Mason, Ohio 45040

PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE ____/____/____

PATIENT _____

PHYSICIAN _____ ADDRESS _____

PHONE _____ FAX: _____

REFERRED TO: _____ Phone: _____

Any of the following Physicians' *Current Procedural Terminology, CPT™* procedures and / or modalities, which are within this therapists' scope of practice training, & / or State & / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally four procedure units & 2 max modalities allowed per visit. A Unit = 15 - minutes. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

- | | |
|--|---|
| 97010 <input type="checkbox"/> HOT/COLD PACKS (as necessary) | 97036 <input type="checkbox"/> HYDROTHERAPY (full immersion) |
| 97014 <input type="checkbox"/> ELECTRIC STIMULATION, un-attended | 97039 <input type="checkbox"/> UNLISTED MODALITY, by report |
| 97018 <input type="checkbox"/> PARAFFIN BATH | 97124 <input type="checkbox"/> MASSAGE THERAPY |
| 97022 <input type="checkbox"/> WHIRLPOOL | 97139 <input type="checkbox"/> UNLISTED PROCEDURE, by report |
| 97026 <input type="checkbox"/> INFRA-RED | 97140 <input type="checkbox"/> MANUAL THERAPY TECHNIQUES |
| 97032 <input type="checkbox"/> ELECTRICAL STIMULATION, attended | 97799 <input type="checkbox"/> Unlisted Physical Medicine Rehab |
| 97034 <input type="checkbox"/> CONTRAST BATHS | Service or Procedure (By Report) (Initial or Re Assessment |
| 97035 <input type="checkbox"/> ULTRASOUND | ____ <input type="checkbox"/> OTHER _____ |

PHYSICIAN'S ICD- 10 DIAGNOSIS OF PATIENT

- | | |
|--|--|
| ____ <input type="checkbox"/> MIGRAINES | ____ <input type="checkbox"/> LUMBAR Sprain / Strain |
| ____ <input type="checkbox"/> HEADACHES | ____ <input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain |
| ____ <input type="checkbox"/> CERVICAL, Inc. Whiplash Injury Sprain / Strain | ____ <input type="checkbox"/> HIP & THIGH (unspecified site) |
| ____ <input type="checkbox"/> JAW (TMJ & Ligament) Sprain /Strain R ___ L ___ | ____ <input type="checkbox"/> SACROILIAC REGION (unspecified site) Spr/Str |
| ____ <input type="checkbox"/> CERVICALGIA (pain in neck) | ____ <input type="checkbox"/> SACRUM Sprain / Strain |
| ____ <input type="checkbox"/> INFRASPINATUS Sprain / Strain R ___ L ___ | ____ <input type="checkbox"/> LUMBOSACRAL RADICULITIS R ___ L ___ |
| ____ <input type="checkbox"/> SUBSCAPULARIS Sprain /Strain (muscle) R ___ L ___ | ____ <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R ___ L ___ |
| ____ <input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle) R ___ L ___ | ____ <input type="checkbox"/> KNEE OR LEG Sprain/Strain R ___ L ___ |
| ____ <input type="checkbox"/> SHOULDER & ARM (unspecified site) R ___ L ___ | ____ <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain R ___ L ___ |
| ____ <input type="checkbox"/> ELBOW & FOREARM (unspecified site) R ___ L ___ | ____ <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain R ___ L ___ |
| ____ <input type="checkbox"/> WRIST Sprain / Strain (unspecified site) R ___ L ___ | ____ <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia |
| ____ <input type="checkbox"/> CARPAL TUNNEL SYNDROME R ___ L ___ | ____ <input type="checkbox"/> SPASM OF MUSCLE _____ |
| ____ <input type="checkbox"/> HAND Sprain / Strain (unspecified site) R ___ L ___ | ____ <input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis) |
| ____ <input type="checkbox"/> PAIN IN THORACIC SPINE | ____ <input type="checkbox"/> Unspecified Disorder of Muscle, Ligament, Fascia |
| ____ <input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain | ____ <input type="checkbox"/> _____ |

Times Per Week: ____ for ____ Weeks, OR Times Per Month: ____ for ____ Months, or Total Visits This Script _____

Patient to return or call, prior to renewal of prescription PLAN OF CARE / COMMENTS:

PHYSICIAN'S SIGNATURE: _____ NPI #: _____