

NewAgeTouch PRESCRIPTION / LETTER OF REFERRAL

“THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY”

DATE: ____ / ____ / ____

PATIENT: _____

PHYSICIAN: _____ ADDRESS: _____

PHONE: _____ FAX: _____

REFERRED TO: NewAgeTouch, Gregory Neely, LMT MA#54198 MM#22105 PAC: 000832900 Phone: 386-492-2958

Fax prescription/letter of referral to: 1-800-481-0685

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 units are allowed per visit. A Unit = 15 minute segments of time. 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 checked="" type="checkbox"/> MANUAL THERAPY TECHNIQUES |
| 97034 <input type="checkbox"/> CONTRAST BATHS | 97799 <input type="checkbox"/> Unlisted Physical Medicine Rehab |
| 97032 <input type="checkbox"/> ELECTRIC STIMULATION, attended | 97112 <input type="checkbox"/> Neuromuscular Re-education |
| 97035 <input type="checkbox"/> ULTRASOUND | _____ <input type="checkbox"/> OTHER _____ |

PHYSICIAN'S DIAGNOSIS OF PATIENT

- | | |
|--|---|
| 346.00 <input type="checkbox"/> MIGRAINES | 847.1 <input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain |
| 357.6 <input type="checkbox"/> PERIPHERAL NEUROPATHY (PAC) | 847.2 <input type="checkbox"/> LUMBAR Sprain / Strain |
| 457.1 <input type="checkbox"/> LYMPHEDEMA (PAC) | 848.9 <input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain |
| 784.0 <input type="checkbox"/> HEADACHES | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) |
| 847.0 <input type="checkbox"/> CERVICAL, Inc. Whiplash Injury Sprain / Strain | 846.9 <input type="checkbox"/> SACROILIAC REGION (unspecified site) Spr/Str |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) Sprain / Strain R__ L__ | 847.3 <input type="checkbox"/> SACRUM Sprain / Strain |
| 723.1 <input type="checkbox"/> CERVICALGIA (pain in neck) | 724.4 <input type="checkbox"/> LUMBOSACRAL RADICULITIS R__ L__ |
| 840.3 <input type="checkbox"/> INFRASPINATUS Sprain / Strain R__ L__ | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R__ L__ |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Sprain / Strain (muscle) R__ L__ | 844.9 <input type="checkbox"/> KNEE OR LEG Sprain/Strain R__ L__ |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle) R__ L__ | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain R__ L__ |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) R__ L__ | 845.10 <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain R__ L__ |
| 841.9 <input type="checkbox"/> ELBOW & FOREARM (unspecified site) R__ L__ | 728.2 <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia |
| 842.00 <input type="checkbox"/> WRIST Sprain / Strain (unspecified site) R__ L__ | 728.85 <input type="checkbox"/> SPASM OF MUSCLE _____ |
| 354.0 <input type="checkbox"/> CARPAL TUNNEL SYNDROME R__ L__ | 729.1 <input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis) |
| 842.10 <input type="checkbox"/> HAND Sprain / Strain (unspecified site) R__ L__ | 728.9 <input type="checkbox"/> Unspecified Disorder Of Muscle, Ligament, Fascia |
| 724.1 <input type="checkbox"/> PAIN IN THORACIC SPINE | Other <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: _____