PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

Patient: **DOB:** **DATE:**

Address	
Phone Number	
Email	

Physician's info:

Name			
Address			
Contact Info	**Phone:**	**Fax:**	**Email:**

Services rendered by: Mellow Bliss Spa

REFERRED TO	**Name: Dana I Serrano**	**Licence Number: 81655**	**NPI: 1265191514**
Company	**Name: Mellow Bliss Spa**	**Address: 242 E Airport Drive Suite 112, San Bernardino CA 92408**	
Contact Info	**Phone: (909) 698 - 8177**	**Email: contact@mellowblissspa.com**	

Any of the following Physician's Current Procedural Terminology, CPT™ Procedures and / or Modalities, that are within this Therapist's Scope of Practice, Training and State License or Certification & Patient's Insurance Policy Regulations may be used as therapist deems necessary during any treatment session. Normally up to maximum 4 procedure units and 2 modality units allowed per visit. A Unit = 15 - minutes. Or as conditions per prescription may require.

PROCEDURES and MODALITIES

97010 ☐ HOT/COLD PACKS (as necessary)
97014 ☐ ELECTRICAL STIMULATION, un-attended
97018 ☐ PARAFFIN BATH
97022 ☐ WHIRLPOOL
97026 ☐ INFRARED
97032 ☐ ELECTRICAL STIMULATION, attended
97034 ☐ CONTRAST BATHS
97035 ☐ ULTRASOUND

97036 ☐ HYDROTHERAPY (full immersion)
97124 X MASSAGE THERAPY
97139 ☐ UNLISTED PROCEDURE, by report
97140 X MANUAL THERAPY TECHNIQUES
97799 ☐ Unlisted Physical Medicine Rehab Services or Procedure (By Report) (EX: Initial Visit Assessment)
☐ OTHER ____________________________
☐OTHER_____________________________

PHYSICIAN'S DIAGNOSIS OF PATIENT

_______☐ MIGRAINES
_______☐ HEADACHES
_______☐ CERVICAL, Inc. Whiplash Injury Sprain / Strain
_______☐ JAW (TMJ & Ligament) Sprain /Strain R ___ L_____
_______ ☐ CERVICALGIA (pain in neck)
_______☐ INFRASPINATUS Sprain / Strain R_____ L ____
_______☐ SUBSCAPULARIS Sprain /Strain (muscle) R____ L _____
_______☐ SUPRASPINATUS Sprain/ Strain (muscle) R____ L _____
_______☐ SHOULDER & ARM (unspecified site) R ____ L_____
_______☐ ELBOW & FOREARM (unspecified site) R ____ L _____
_______ ☐ WRIST Sprain / Strain (unspecified site) R ____ L _____
_______ ☐ CARPAL TUNNEL SYNDROME R ____ L _____
_______ ☐ HAND Sprain / Strain (unspecified site) R ____ L _____
_______ ☐ PAIN IN THORACIC SPINE
_______☐ THORACIC (DORSAL) Sprain / Strain

_______ ☐ LUMBAR Sprain / Strain
_______ ☐ PELVIS (unspecified site) Sprain / Strain
_______ ☐ HIP & THIGH (unspecified site)
_______ ☐ SACROILIAC REGION (unspecified site) Sprain /Strain
_______ ☐ SACRUM Sprain / Strain
_______ ☐ LUMBOSACRAL RADICULITIS R _ L_
_______ ☐ SCIATICA (neuralgia, neuritis) R _ L _
_______ ☐ KNEE OR LEG Sprain/Strain R _ L _
_______ ☐ ANKLE (unspecified site) Sprain/Strain R _ L _
_______ ☐ FOOT (unspecified site) Sprain/Strain R _ L _
_______ ☐ MYOFIBROSIS; muscles, ligament, fascia
_______ ☐ SPASM OF MUSCLE___________________
_______ ☐ MYALGIA & MYOSITIS (Fibro myositis)
_______ ☐ Unspecified Disorder of Muscle, Ligament, Fascia
_______ ☐ OTHER ______________________________

Physician's Office ONLY:

PHYSICIAN'S COMMENTS: ____

Times Per Week:_______ for ______ Weeks, OR Times Per Month: _______ for _______Months or Total Visits This Script _____

PHYSICIAN'S SIGNATURE:______________________________NPI#:__________________LIC#:________________

NOTES: 1. Only treating physicians may enter or check Diagnoses Codes. 2. Any claim to insurance company or attorney that indicates a diagnosis or DX Code(s) MUST have a signed, written prescription by treating physician or therapist is practicing medicine without a license and would be subject to state massage license being revoked and/or other possible legal ramifications. 3. Only physician may modify this prescription form with exception of Patient, Physician, Therapist & Procedures & Modality Sections. 4. LMTs may NEVER use physician's NPI or other identifying information when filing claims. Therapists must sign daily notes. Patient to return or call, prior to renewal of prescription.