Deep Relief // Peak Performance
810 Kokomo Road, Suite 159
Haiku, HI 96708
P: 808.214.8224
F: 808.442.1140

MASSAGE THERAPY PRESCRIPTION AND TREATMENT PLAN

Patient Name _____ Date of Birth _____ Phone _____

Diagnosis _____ ICD 10 _____

Date of Injury _____ Date of Surgery _____

☐ Work Comp ☐ MVA ☐ Private Insurance ☐ Other

Insurance: _____ ID# or Claim #: _____

☑ Massage Therapy 97124

Frequency: _____ times per week Duration: _____weeks Total: _____visits

Precautions/Comments _____

I certify that the services rendered under this prescription and plan of treatment are reasonable and necessary.

Physician's Name _____ Date _____

Physician's Signature _____