On Point Physical Therapy, LLC

P: (808) 344-8565 F: (808) 575-9109

Treatment Plan and Prescription

Patient Name: _____

Phone: _____ Date of Birth _____

Diagnosis _____ ICD-10_____

Physician _____ Insurance _____

Claim# _____ DOI _____

- **Evaluate and Initiate Treatment as indicated (including Re-evaluation)**

Procedures/ Modalities:

- Manual Therapy: STM, Joint mobilization, MFR, CFM
- Fascial Distortion Method
- MacKenzie Method
- Therapeutic Exercise: joint stabilization; stretching; postural stabilization, body mechanics, spinal stabilization, sports training
- Cardiac Rehabilitation
- Neuromuscular/Coordination Training
- Gait training
- Kinisiotaping
- Post/Pre Surgical Rehabilitation including: Spinal fusion, laminectomy, discectomy; RTC repair; ligament and cartilage reconstruction/repair; Total Joint Replacement, etc

Precautions/Special Instructions:

_____
_____
_____
_____
_____
_____

Frequency (times/week) _____Duration (weeks) _____ Total Visits_____

I certify the services furnished under this plan of treatment are reasonable and necessary.

Physician's signature : _____Date:_____

Adjuster's Name/Signature: _____ Date: _____