

NEURO REHABILITATION INSTITUTE • THERAPEUTIC RECREATION CHARGE SHEET

Patient: _____ Insurance: _____
 Account #: _____ Insurance Expiration Date: _____
 Therapist: _____



Bill Code	Description	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
46400029	INITIAL EVALUATION	96150																	
46400031	INITIAL EVALUATION WITH PATIENT AND FAMILY	96154																	
46400030	RE-ASSESSMENT	96151																	
46400064	SENSORY INTEGRATION	97533																	
46400062	COGNITIVE SKILLS RETRAINING	97532																	
46400069	COMMUNITY INTEGRATION	97537																	
46400098	NO CHARGE VISIT - ADULT																		

Patient Name: _____
 Treatment Days/Time: _____
 Therapist: _____

Modalities:

Moist Heat		
Ultrasound		
Cold Pack		
Paraffin		
Cervical Traction		
Lumbar Traction		
Other:		

CONTACT THERAPIST / ASSISTANT:

Patient to exercise in gym after modalities Yes No
 Patient to be stretched in modality room Yes No

