DIRECT ACCESS PATIENT ATTESTATION AND MEDICAL RELEASE FORM

PATIENT INFORMATION

Date

Name (Full Legal Name) | **Primary Phone Number** ( )

Street address, City, ST, ZIP Code | **Alternate Phone Number** ( )

Email address | **Alternate Phone Number** ( )

Reason why you are seeking physical therapy care:

CURRENT CARE AND ATTESTATION

Please check one below:

☐ I **AM NOT** under the care of a licensed health practitioner for the symptoms listed on this form and I wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

I understand that the current course of physical therapy care will last no more than 60 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from a licensed health care practitioner.

☐ I **AM** under the care of a licensed health practitioner for the symptoms listed on this form and wish to seek physical therapy care at this time. (Licensed health practitioner includes a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant.)

PRACTITIONER INFORMATION:

Practitioner Name | **Office Number**

Street address, City, ST, ZIP Code | **Fax Number**

I understand that the current course of physical therapy care will last no more than 60 consecutive days, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from the licensed health care practitioner named above.

I understand that the practitioner named above will be provided a copy of my initial evaluation and patient history within 14 days. ***I hereby consent to the release of my personal health and treatment records to the practitioner named above.***

Patient Signature **Date**

For Administrative Use Only - Expiration Date: