PHYSICAL THERAPY + WELLNESS

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PHYSICAL THERAPY ORDER

Patient Name: _____ ***DOB:*** _____

Patient Phone #'s: _____

Primary Insurance: _____

Plan #: _____

Secondary Insurance: _____

Plan #: _____

Diagnosis: _____

Frequency: _____ x/week Duration: _____ weeks

Special instructions/restrictions: _____

_____

Physician Signature: _____ Date: _____

Physician Name: _____

* We accept the following insurance carriers: HMSA PPO/HMO, BCBS, Medicare, UHA, UHC, HMAA, TRICARE, WorkComp, Aetna