PATIENT ATTESTATION FORM

1. Legal Full Name (Please Print or Type)

First	Middle	Last	Suffix or Maiden

Address	City	State	Zip Code

Contact Phone Number ( ) Email address:	Alternate Phone Number ( )

2. Patient Information

Patient's chief complaint (why patient is seeking physical therapy care)

Please Check One Below:

a) I am not under the care of a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant for the symptoms listed on this form and wish to seek physical therapy care at this time.

b) I am under the care of a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant for the symptoms listed on this form and wish to seek physical therapy care at this time. The Practitioner identified on this form will be provided a copy of the initial evaluation and a copy of patient history obtained by the physical therapist within 14 days. (Fill out section 3 below)

3. Practitioner of Record.

If after receiving physical therapy care for 30 business days for the condition for which I sought treatment does not improve, I intend to seek further treatment and evaluation from the practitioner listed below.

Additionally, I consent to the release of my personal health and treatment records to the listed practitioner.

Practitioner's Full Name & Address:	**Practitioner's Contact Phone Number's:** **Office ( )** **Fax ( )** **Email:**
Date	**Signature of Patient**