Patient Attestation Form

1. FULL LEGAL NAME (Please print or type)

First Name: **Middle:** **Last Name:** **Suffix/Maiden:**

Address: **City, State:** **Zip Code:**

Primary Phone Number: **Alternate Phone Number:**

2. PATIENT INFORMATION

Patient's Chief Complaint (why patient is seeking physical therapy care):

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.

3. PRACTITIONER OF RECORD

If after receiving physical therapy care for fourteen (14) 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: **Practitioner's Phone Number:**

Patient Signature: _____ **Date:** _____