

# 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 ( )	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 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.*

<b>Practitioner's Full Name</b>	<b>Practitioner's Contact Phone Number</b> ( )
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Date

Signature of Patient