BERRYVILLE PHYSICAL THERAPY AND WELLNESS

322-A North Buckmarsh St. Berryville, VA 22611

540-955-1837 phone 540-955-1838 fax info@berryvillept.com

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 **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 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