BERRYVILLE PHYSICAL THERAPY AND WELLNESS

322-A North Buckmarsh St. Berryville, VA 22611
540-955-1837 phone 540-955-1838 fax

PATIENT ATTESTATION FORM For Direct Access PT

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)

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 calendar days for the condition for which I sought treatment does not improve, I understand I can seek further treatment and evaluation from the practitioner listed below or another provider.

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

Practitioner's Full Name	**Practitioner's Contact Phone Number** ( )

I understand I can be seen for a new course of direct access therapy for this issue 60 days from the date of this initial evaluation if needed. I can be seen direct access for another issue without a wait.

Date	Signature of Patient