Middleburg
SPORTS & ORTHOPEDIC

PHYSICAL THERAPY

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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 understand that the current course of physical therapy care will last no more than **60 consecutive days**, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from a licensed health care practitioner.*

☐ 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 current course of physical therapy care will last no more than **60 consecutive days**, and that additional physical therapy services for the symptoms listed on this form shall only be upon the referral and direction of a licensed health practitioner. To receive additional physical therapy services beyond this 60-day period, I will be required to obtain a referral from the licensed health care practitioner named above.*

*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**

(Edited 06-14-21)