patient PHYSICAL THERAPY

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Rx:

Select all txs authorized

☐ **MASSAGE THERAPY**	☐ **WELLNESS CARE** active pain management, posture reversal, well consult
☐ **PHYSICAL THERAPY** >6 wks rehab / recovery from serious injury/surgery	☐ **GRASTON TECHNIQUE™** scar reduction, msk pain, lost range of motion

Patient Name: _____

MD / DO / NP / DC Name: _____

Medical Necessity: Describe the condition to be treated & how it will benefit from the treatment(s) prescribed above

Duration: _____ **Frequency:** _____

Provider signature: _____

Clinic/Hospital/Office Name: _____

Address: _____

Phone Number: _____

Ask your physician, nurse practitioner, or chiropractor to fill out this form to help ensure that your treatments at Patient PT will remain payable via HSA / FSA, or to seek reimbursement for out-of-pocket therapy services via your insurance carrier.

***NOTE**: Patient PT is out-of-network for all insurance coverage and services are not eligible for any form of reimbursement via federal payor, including Medicare & Medicaid.*