Elite
THERAPY SOLUTIONS

PHYSICAL & OCCUPATIONAL THERAPY IN YOUR NEIGHBORHOOD

Patient Name:_____
Primary Phone:_____DOB:_____
Diagnosis:_____ICD 10:_____

☐ EVALUATE AND TREAT

_____

_____

_____

Frequency:_____times per week | Duration:_____weeks

I hereby agree that the services rendered are medically necessary.

Physician Signature:_____
Physician Name:_____
Office Phone:_____
NPI#_____ Date:_____