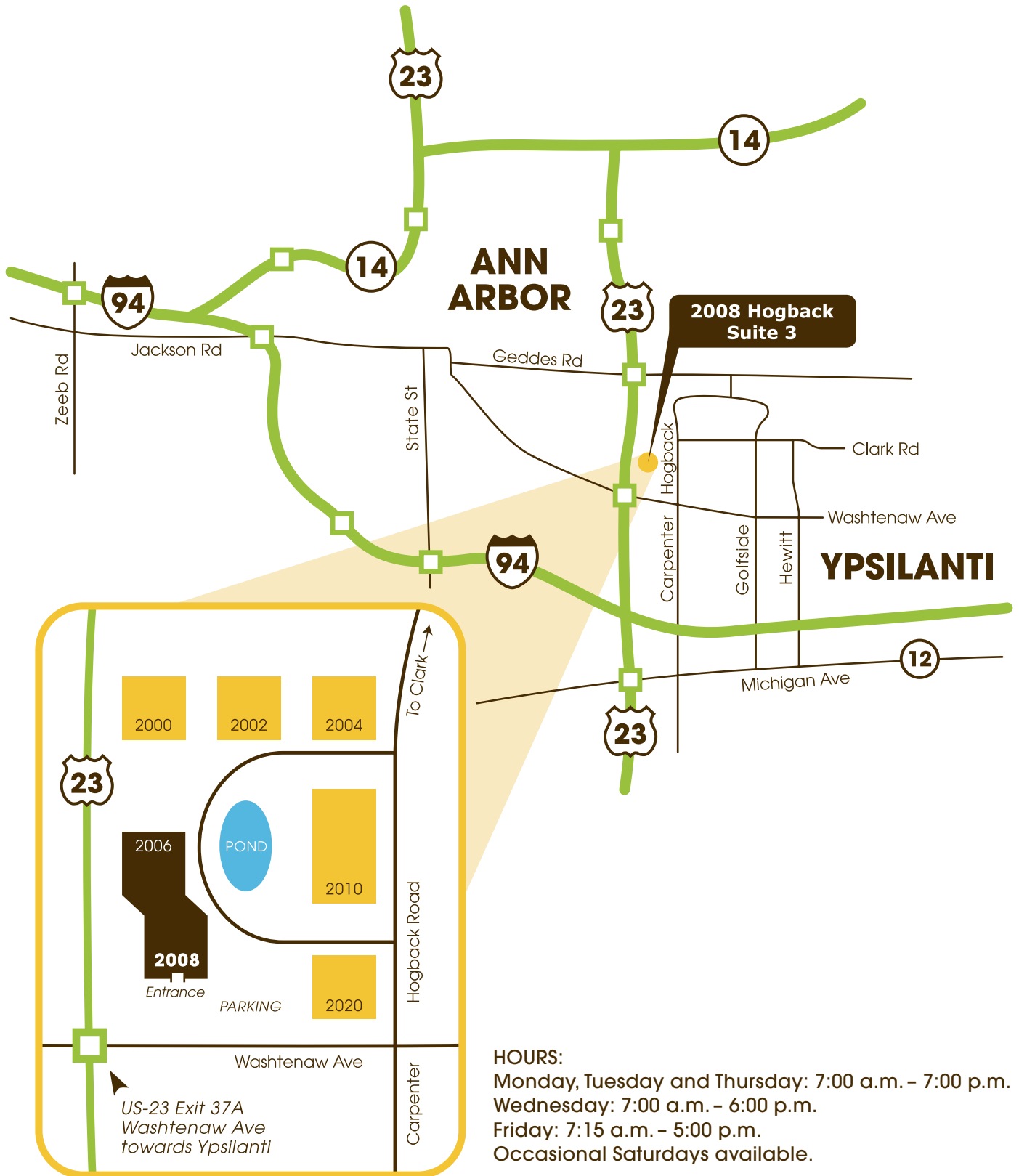




PHYSICAL THERAPY
& WELLNESS CENTER

PHYSICIAN AUTHORIZATION

PATIENT NAME:	
DIAGNOSIS / ICD-9 CODE:	
RELEVANT MEDICAL FINDINGS:	
TREATMENT:	<p>FREQUENCY / DURATION</p> <p>_____ x/WEEK FOR _____ WEEKS</p> <p>TOTAL # OF VISITS _____</p>
CONTRAINDICATIONS:	
<p>SERVICES REQUESTED (CHECK BELOW):</p> <p>PHYSICAL THERAPY</p> <p><input type="checkbox"/> Evaluation & Treatment</p> <p>MANUAL THERAPY</p> <p><input type="checkbox"/> Joint Mobilization</p> <p><input type="checkbox"/> Spinal Manipulation</p> <p><input type="checkbox"/> Myofascial Release</p> <p><input type="checkbox"/> Manual Traction</p> <p><input type="checkbox"/> Massage</p> <p><input type="checkbox"/> Taping</p> <p>MODALITIES</p> <p><input type="checkbox"/> Iontophoresis</p> <p><input type="checkbox"/> Phonophoresis</p> <p><input type="checkbox"/> Ultrasound</p> <p><input type="checkbox"/> Electrical Stimulation</p> <p><input type="checkbox"/> Mechanical Traction</p> <p><input type="checkbox"/> Hot/Cold Packs</p>	<p>INSURANCES ACCEPTED</p> <p>Aetna</p> <p>Blue Cross Blue Shield</p> <p>CIGNA HAP</p> <p>Cofinity</p> <p>Commercial Insurance</p> <p>Health Alliance Plan*</p> <p>Medicare</p> <p>Medicare Plus Blue</p> <p>Medicare Advantage</p> <p>No-Fault Auto</p> <p>Priority Health</p> <p>Theramatrix Network</p> <p>United Healthcare</p> <p>Workers Compensation</p> <p><i>*Specific Referral Form Required</i></p>
<p>EXERCISE</p> <p><input type="checkbox"/> Therapeutic Exercises</p> <p><input type="checkbox"/> Strengthening</p> <p><input type="checkbox"/> Stretching</p> <p><input type="checkbox"/> ROM</p> <p><input type="checkbox"/> Stabilization</p> <p><input type="checkbox"/> Posture</p> <p><input type="checkbox"/> Neuromuscular Re-Education</p> <p><input type="checkbox"/> Home Exercise Program</p> <p>OTHER</p> <p><input type="checkbox"/> Gait Training/Evaluation</p> <p><input type="checkbox"/> TENS Unit</p>	<p>SELF-PAY SERVICES</p> <p>We offer an affordable self-pay rate for uninsured Physical Therapy patients.</p> <p>We also offer:</p> <p><input type="checkbox"/> Massage Therapy</p> <p><input type="checkbox"/> Personal Training</p> <p><input type="checkbox"/> Rolfing</p> <p>Contact us for details.</p>
DATE:	PHYSICIAN SIGNATURE:
PHYSICIAN NAME / ADDRESS:	



REHABILITATION HEALTH CENTER, INC.

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