



Patient Name _____

Date of Birth _____ Phone _____

Insurance _____ Group # _____

Policy # _____

Please fill out or attach demographics sheet

Eval and Treat

PT **OT** (Hand Therapy)

Frequency _____

Duration _____

Dx _____

Surgery _____

I certify by signature that the following treatment is medically necessary

Physician Signature

Date

Physician Name (Print)

Auburn

1530 East Glenn Avenue
Suite C
Auburn, AL 36830

P: (334) 502-7839
F: (334) 502-7879

Opelika

2701 Frederick Road
Suite 306
Opelika, AL 36801

P: (334) 610-0354
F: (334) 610-0355

Columbus

6053 Veterans Parkway
Suite 103
Columbus, GA 31909

P: (706) 786-6530
F: (706) 786-6535

North Auburn

1661 Shug Jordan Parkway
Suite 500
Auburn, AL 36832

P: (334) 203-4570
F: (334) 203-4575

Montgomery (East)

8117 Old Federal Road
Montgomery, AL 36117

P: (334) 380-5920
F: (334) 380-5921

**Montgomery -
Carmichael Road (Midtown)**
(Industrial Rehab Center)

4142 Carmichael Road
Suite B
Montgomery, AL 36106

P: (334) 839-5070
F: (334) 839-5075

SCAN THE QR CODE
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ALL CLINIC LOCATIONS

