

Patient Name _____
Date of Birth _____ Phone _____
Email _____
Insurance _____ Group _____
Policy # _____

Is this a work-related injury? ☐ Yes ☐ No

Employer _____

Case Manager Info

Evaluate and Treat

I certify by signature that the following treatment is medically necessary.

Dx _____

Surgery _____ Treatment _____

Frequency _____ Duration _____

Physician Signature

Date

Physician Name (Print)

☐ **Andalusia** ♀

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Clinic Director

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☐ **Fairhope** ♀

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☐ **Foley**

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☐ **Saraland** ♀

Kristen Rather, PT, DPT
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♀ Pelvic Health Therapy Available

SCAN THE QR CODE
FOR INFORMATION ON
ALL CLINIC LOCATIONS

