



Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Phone # \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis \_\_\_\_\_

Area To Be Treated \_\_\_\_\_

**PHYSICAL THERAPY** - Evaluate and Treat

Special Instructions / Precautions \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

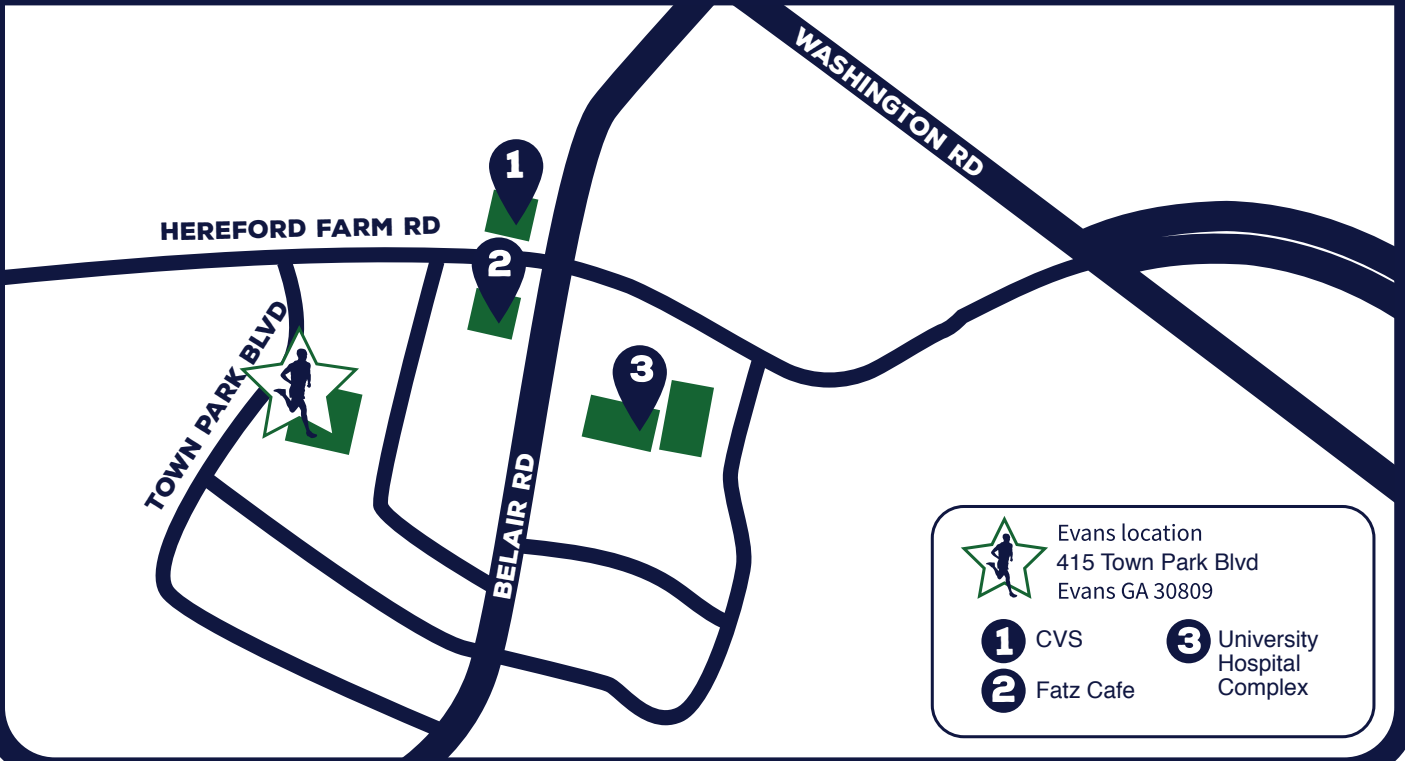
Print Provider's Name \_\_\_\_\_


Office Phone# \_\_\_\_\_

Referring Provider Signature:

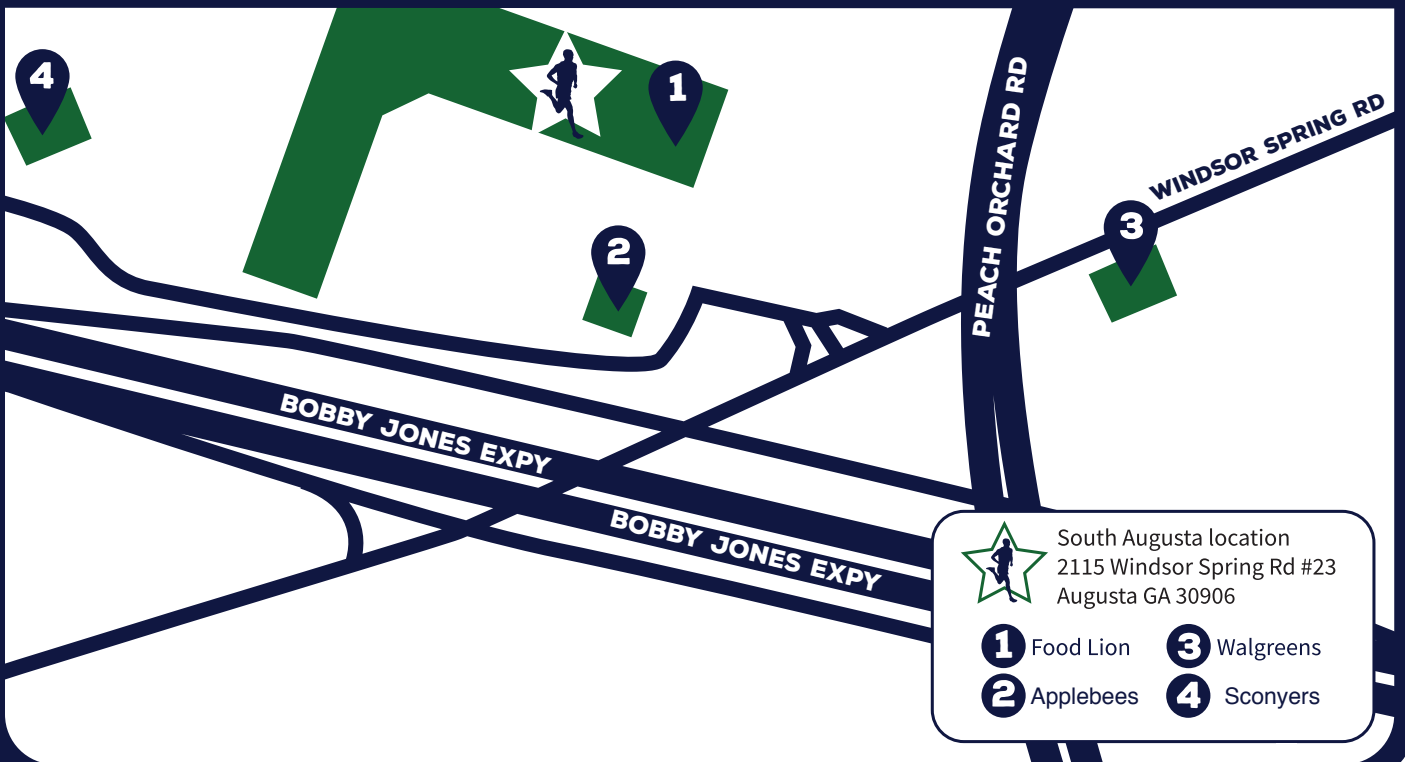
\_\_\_\_\_


I hereby certify that the services indicated  
above are medically necessary



 Evans location  
415 Town Park Blvd  
Evans GA 30809

<b>1</b> CVS	<b>3</b> University Hospital Complex
<b>2</b> Fatz Cafe	



 South Augusta location  
2115 Windsor Spring Rd #23  
Augusta GA 30906

<b>1</b> Food Lion	<b>3</b> Walgreens
<b>2</b> Applebees	<b>4</b> Sconyers