ACCELERATION PHYSICAL THERAPY

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❑ Physical Therapy

Patient Name: _____

Diagnosis: _____

Insurance _____ Follow-up Apt. Date: _____

Frequency of Rx: ❑ 1 ❑ 2 ❑ 3 x/week for _____ weeks

Precautions: _____

_____

❑ Evaluate and Treat

❑ Work Conditioning

❑ Functional Capacity Evaluation

❑ Balance Training

❑ Special Instructions _____

_____

Provider's Signature_____ **Date**_____

Printed Name_____

"I certify/recertify the need for these services furnished under this plan of treatment and while under my care."