



Therapeutic Associates PHYSICAL THERAPY

Name: _____

Phone: _____ DOB: _____

Diagnosis: _____

EVALUATE AND TREAT APPROPRIATELY

Physician's Notes:

Treat _____ times per week for _____ weeks
In making this referral, physician certifies that prescribed rehabilitation is medically necessary.

Physician Signature _____

Physician Name _____

Date _____

(REQUIRED BY MEDICARE)

Thank you for this referral

PORT ANGELES

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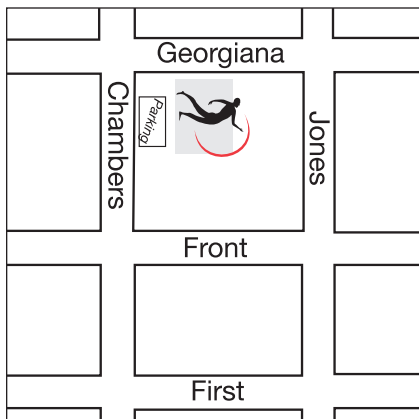
FAX: 360-683-5256

Providers for:

Aetna, Capp Care, Cigna,
Community Health Network of
Washington, Crime
Victims/Washington
Labor & Industries,
Department of
Labor & Industries,
Department of Social & Health
Services, First Choice/First Choice
Health Network, First Health, Great
West Healthcare, Medicare, Molina,
Pacifi care/Secure Horizons, Office
Of Worker's Comp Program - Dept.
of Labor (OWCP), Premera, Private
Healthcare System, Railroad
Medicare, Regence Blue Shield,
Three Rivers Provider Network,
Uniform Medical/ Washington
State Healthcare Authority, United
Healthcare.



*Provider status for other health
plans may vary per office.
Please phone clinic to verify
insurance coverage.*



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Beth Welander PT, DPT, OCS *Director*

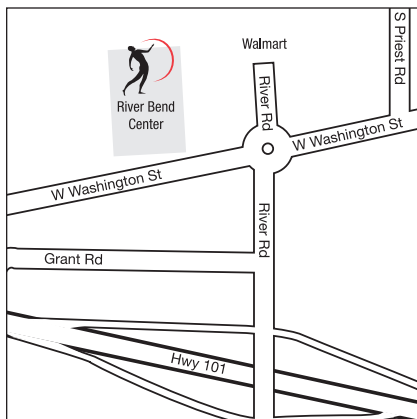
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- Registration Forms

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