TherapeuticAssociates
PHYSICAL THERAPY

PORT ANGELES

Patient Name: ______________________________

Patient Phone: ______________________________

Diagnosis: ______________________________

Date of Birth: ______________ **Follow-Up Visit:** ______________

REQUEST FOR PHYSICAL THERAPY

❒ **EVALUATE AND TREAT AS APPROPRIATE**

Treatment Frequency
(days per week): ______________________________

Treatment Duration
(# of weeks): ______________________________

Precautions/Contraindications:

____

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Comments/Special Orders:

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SPECIALIZED PROGRAMS

- ❒ Advanced TMD Treatment
- ❒ Astym® Treatment
- ❒ Back and Neck Pain Care
- ❒ Motor Vehicle Accident Care
- ❒ Pre and Post-Operative Rehabilitation
- ❒ Sports Therapy
- ❒ Vestibular Therapy
- ❒ Worker's Comp Rehab

Electronic Referrals – Need help connecting your system with ours?
We can help! Please send your inquiry to **interoperability@taipt.com** and a member of our IT Team will assist you.

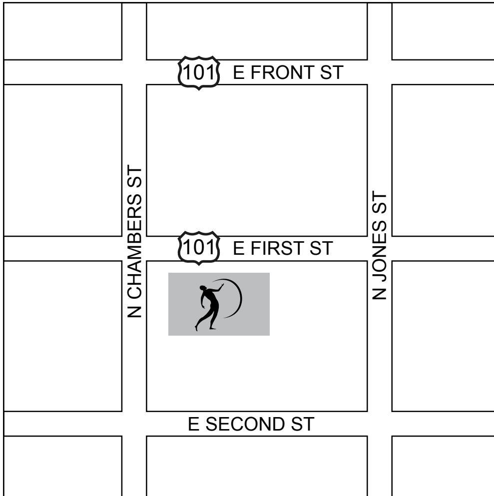
In making this referral, provider certifies that prescribed rehabilitation is medically necessary.

Provider Signature: ______________________________

Provider Name: ______________________________

Provider Phone: ______________ **Date:** ______________
(REQUIRED BY MEDICARE)

CLINIC LOCATIONS & PATIENT INSTRUCTIONS ON BACK



PORT ANGELES

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We also serve the Seattle Metro and Greater Tacoma areas.
For all clinic listings, please visit us online at
www.therapeuticassociates.com/Locations

PATIENT INSTRUCTIONS

Please contact your preferred location to schedule your physical therapy visit. To prepare you for your upcoming visit with us, we encourage you to visit our New Patient webpage, where you can find information on the following:

- What to expect & what to wear
- Insurance & billing
- Shared decision making

www.therapeuticassociates.com/**Welcome**