



Lucas Therapies, PC

Providers of Physical & Occupational Therapy Phone 540.772.8022 Fax 540.772.0294

Direct Access Attestation Form

1. Legal Full Name

<first>	<middle>	<last>	Suffix or Maiden
<addr>	<city>	<state>	<zip>
<phone>		<email>	

2. Patient Information

Patient's chief complaint (why patient is seeking physical therapy care)
<p>Please Check One Below:</p> <p>a) I am not under the care of a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant for the symptoms listed on this form and wish to seek physical therapy care at this time.</p> <p>b) I am under the care of a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physician assistant for the symptoms listed on this form and wish to seek physical therapy care at this time. The Practitioner identified on this form will be provided a copy of the initial evaluation and a copy of patient history obtained by the physical therapist within 14 days. (Fill out section 3 below)</p>

3. Practitioner of Record

<p><i>If after receiving physical therapy care for 30 consecutive days for the condition for which I sought treatment does not improve, I intend to seek further treatment and evaluation from the practitioner listed below.</i></p> <p><i>Additionally, I consent to the release of my personal health and treatment records to the listed practitioner.</i></p>	
Practitioner's Full Name & Address:	Practitioner's Contact Info Office Fax

Patient Signature _____

Date _____