DIRECT ACCESS PATIENT ATTESTATION FORM

1. Full Legal Name (Please Print or Type)

First	Middle	Last	Suffix or Maiden
Address	City	State	Zip Code
Contact Phone Number ( )		Alternate Phone Number ( )	

2. Chief Complaint

Patient's chief complaint (why patient is seeking physical therapy care)

3. Primary Care Practitioner Attestation (MD, DO, DC, DPM, DDS, PA, LPN)

Please check which box applies to you

☐ 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. Therefore, no practitioner will be identified below.

☐ I ***am*** under the care of the primary care practitioner identified below, for the symptoms about which I am currently seeking physical therapy evaluation and I consent to the release of my personal health and treatment records to the identified primary care practitioner. The practitioner identified below will be provided a copy of the initial evaluation and a copy of the patient history obtained by the physical therapist within 14 days.

Primary Care Physician's Name	Primary Care Physician's Phone Number ( )

4. Direct Access to Physical Therapy Attestation

If I was previously evaluated in physical therapy under direct access law for the same condition, it has been at least **60 days** from the last evaluation.

I understand that treatment beyond **30 consecutive days** shall only be upon referral of a primary care practitioner. The physical therapist may assist me by contacting the identified practitioner to determine if additional services will be authorized until the practitioner can schedule and conduct a consultation.

5. Patient Signature

Date	Patient Signature