PATIENT ATTESTATION FORM

As a Direct Access Provider in the State of Virginia, it is mandated by the Virginia Physical Therapy Board that this form be read and signed by all patients. By signing this form you are consenting to communication between **Innovative Physical Therapy, LLC** and your primary care physician to ensure there is continuity in your care.

1. Patient Name (Please Print or Type)

First	Middle	Last	Suffix or Maiden

Address	City	State	Zip Code

Contact Phone Number ( )	Alternate Phone Number ( )

2. Patient Information

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

3. Practitioner of Record.

If after receiving physical therapy care for 14 business 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.

Additionally, I consent to the release of my personal health and treatment records to the listed practitioner.

Practitioner's Full Name	Practitioner's Contact Phone Number

Date	Signature of Patient