The Total Joint
PHYSICAL THERAPY

Patient Name:_____

DOB:_____Phone:_____

Email:_____

Insurance:_____

☐ **Evaluate and Treat** ☐ **Prehab** ☐ **Other**

Diagnosis:_____

Surgery:_____

Duration/Frequency:_____

I hereby certify these services as medically necessary for this patient's plan of care.

Physician Signature: _____Date:_____

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5518 Crestwood Blvd
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Fax: (205) 201-4481

☐ **Homewood**
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