FYZICAL®

Therapy & Balance Centers

Patient Name: _____ **DOB:** _____ **Phone:** _____

Insurance: ❑ **Medicare** ❑ **Medicaid** ❑ **PPO/HMO** ❑ **Tricare** ❑ **Work Comp** ❑ **Other:** _____

Member/Subscriber ID _____ **Group #** _____

Physician: _____ **Follow Up Date:** _____

Diagnosis: _____ **Side:** _____ **ICD-10:** _____

❑ **Evaluate and Treat** ❑ **Pre-Operative Rehabilitation** ❑ **Post-Operative Rehabilitation**

- ❑ Hip
- ❑ Injury Prevention
- ❑ Knee
- ❑ Lumbar
- ❑ Lymphedema Massage
- ❑ Neck
- ❑ Pediatric Orthopedic (4+)
- ❑ Post-Mastectomy Rehab
- ❑ Return to Sport/Work
- ❑ Sacro-Iliac Joint
- ❑ Scapulo-Thoracic
- ❑ Shoulder
- ❑ TMJ
- ❑ Vestibular & Concussion Rehab

Interventions & Procedures

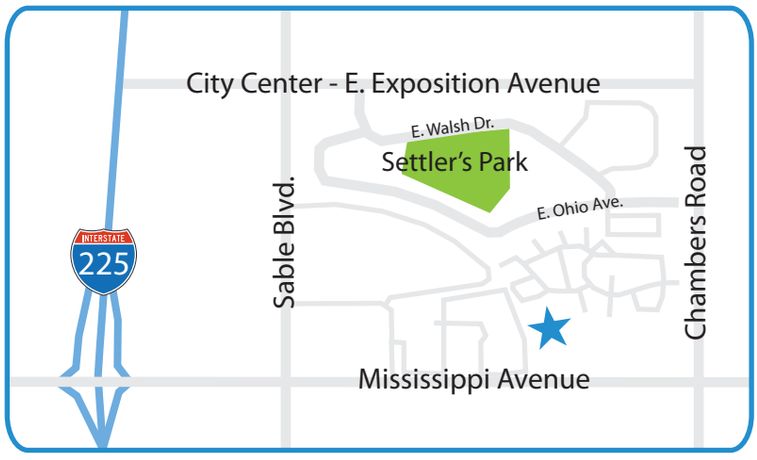
- ❑ Balance Training
- ❑ Core Training
- ❑ Cupping
- ❑ Fall Recovery Education
- ❑ Flexibility & Mobility
- ❑ Home Program
- ❑ Kinesio Taping
- ❑ Manual Joint Mobilization
- ❑ Manual Cervical Traction
- ❑ Manual Lumbar Traction
- ❑ Myofascial Release
- ❑ Sensory Reorganization
- ❑ Soft Tissue Mobilization
- ❑ Spinal Manipulation
- ❑ Strength & Stability

Precautions / Special Instructions / Contraindications

Frequency / Duration_____times per week for_____weeks.

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

Physician Signature:_____ Date:_____



To make an appointment, please call: 720-659-3100

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❑ Check here if you need more referral pads.