



**LAKE OCONEE
REHABILITATION
PHYSICAL THERAPY™**

Name: _____ Date: _____

Patient Phone # _____ DOB: _____

Diagnosis: _____

Area To Be Treated: _____

PHYSICAL THERAPY - Evaluate and Treat

Special Instructions / Precautions: _____

Patient Provider's Name: _____

Office Phone # _____

Referring Provider Signature:

I hereby certify that the services indicated
above are medically necessary

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