FYZICAL®
Therapy & Balance Centers
at Decatur ENT

ORDER FOR PHYSICAL THERAPY

Patient Name: _____ DOB: _____

Address: _____ City/State: _____

Phone: _____ Email: _____

Insurance Company: _____ Policy # _____

2nd Insurance: _____ Policy # _____

☐ Evaluate and Treat

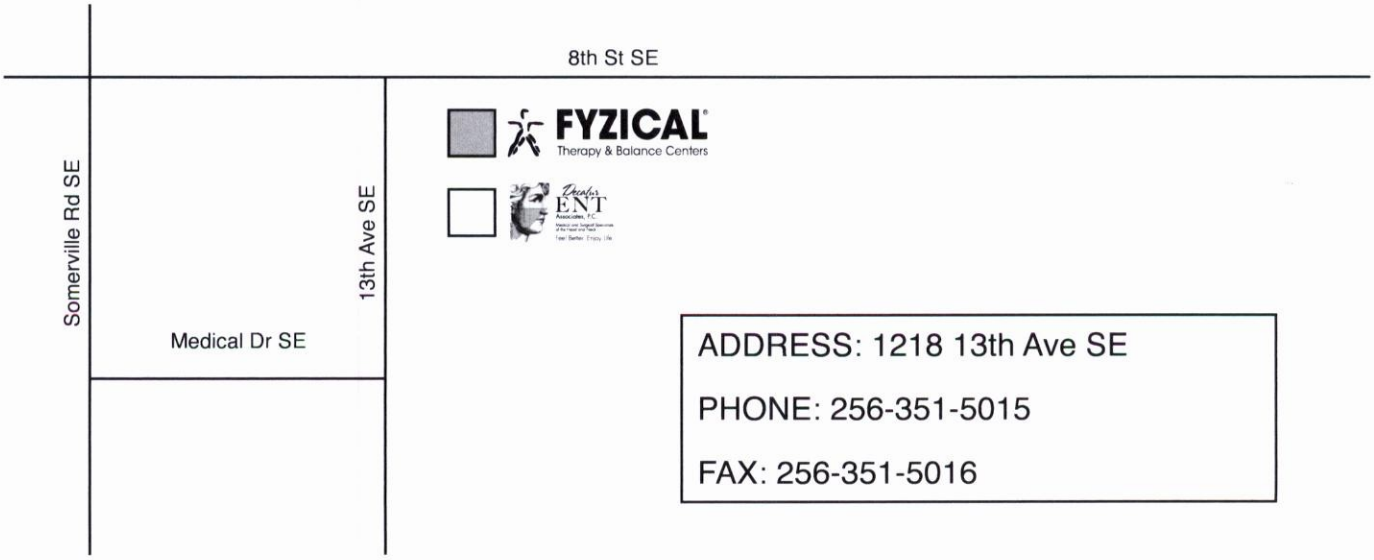
Diagnosis ICD-10 Code: _____

_____

_____

Precautions: _____

Return Fax # (For POC) _____



ADDRESS: 1218 13th Ave SE

PHONE: 256-351-5015

FAX: 256-351-5016

MD Signature: _____ **DATE:** _____

Form # FCP-0716-24