Parker
Physical Therapy
Because Experience Matters

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PLAN OF TREATMENT

Date: _____ Appointment Time: _____

Name: _____

Diagnosis Codes: _____

Specific Instructions/Precautions: _____

_____

_____

☐ Evaluate and Treat ☐ Attached Protocol

Frequency 2 • 3x Week x _____ weeks Next Dr. Appt. _____

I certify that the above prescribed is medically necessary for this patient.

Doctor's Signature _____

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