# PRO IMPACT

Physical Therapy • Sports Performance

Patient's Name: _____

Contact Number: _____

Referring Diagnosis: _____

Insurance: _____

## Consult Evaluate and Treat

Physician's Signature: _____

Date: _____

- I certify that therapy services for the above named patient are required, medically necessary and authorized by me.

## BRING THIS REFERRAL WITH YOU ON YOUR FIRST VISIT!

- Patients can complete paperwork online at www.proimpactpt.com

| Huntingdon Office | Montgomery Office | Prattville Office |
|---|---|---|
| 1160 Navarro Ave<br>334-833-4076 | 2000 Berry Chase Place<br>334-356-6453 | 635 McQueen Smith Rd N.<br>334-658-4705 |

## Fax Referrals to 334-239-8126