NEW ATHLETE

Patient Name: ______________________________

Patient Phone: ______________________________

Diagnosis: ______________________________

Date of Birth: ______________ Next MD Visit: ______________

REQUEST FOR PHYSICAL THERAPY

☐ EVALUATE AND TREAT AS APPROPRIATE

Treatment Frequency *(days per week):* ______________

Treatment Duration *(# of weeks):* ______________

Precautions/Contraindications:

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Comments/Special Orders:

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PROGRAMS & SERVICES

- ☐ ARPWAVE THERAPY
- ☐ HYPERBARIC CHAMBER
- ☐ INFRARED SUANA
- ☐ MANUAL THERAPY
- ☐ FUNCTIONAL MOBILITY & ASSESSMENT/INTERVENTIONS
- ☐ JOINT MOBILIZATION
- ☐ INJURY MITIGATION
- ☐ PATIENT EDUCATION
- ☐ CHRONIC PAIN EDUCATION
- ☐ THERAPEUTIC EXERCISE
- ☐ STRENGTH AND CONDITIONING
- ☐ SPORTS PERFORMANCE
- ☐ HEALTH AND WELLNESS EDUCATION

In making this referral, physician certifies that prescribed rehabilitation is medically necessary.

Physician Signature: ______________________________

Physician Name: ______________________________

Physician Phone: ______________ **Date:** ______________
(REQUIRED BY MEDICARE)

CLINIC LOCATIONS & PATIENT INSTRUCTIONS ON BACK

NEW ATHLETE

300 GRAND BLVD, SUITE B200
VANCOUVER WA 98661

DR. STEVEN CABRALES PT, DPT, ATC, CSCS
REHAB DIRECTOR

Phone: 360-567-0553

Fax: 360-573-9075

newathletephysicaltherapy@gmail.com

PATIENT INSTRUCTIONS

CALL TO SCHEDULE APPOINTMENT

Date: ____________________

Time: ____________________

***Please arrive 15 minutes early** to complete all new patient paperwork.*

INSURANCE/BILLING

Preferred providers for most insurance plans, however plan eligibility varies. We are happy to verify therapy benefits and insurance coverage prior to your first visit. Please contact us for further questions.

CASH PAY & ALTERNATIVE PAYMENT STRUCTURES

We offer flexibility in our services and provide a number of payment and membership options depending on your unique situation. For billing or payments questions please contact: 360-567-0553