Patient Signature Form

AGENCY: _____ PATIENT NAME: _____

THERAPIST NAME: _____ THERAPIST SIGNATURE: _____
(Print)

I certify that the above named therapist has provided therapy for me on the following date(s) below:

Patient Signature:	Date of Visit(s):	Time		Vital Signs: (Optional) BP: Sys-100-160, Dia-60-90 P: 60-90			
		Time In		Before tx			
		Time Out		After tx			
		Time In		Before tx			
		Time Out		After tx			
		Time In		Before tx			
		Time Out		After tx			
		Time In		Before tx			
		Time Out		After tx			
		Time In		Before tx			
		Time Out		After tx			

Notes/Comments: