MaxWell Therapy, LLC

Physical • Occupational • Speech • Massage

1289 S Linden Rd., Ste A • Flint, MI 48532
P: 810.230.9750 • F: 810.230.8799

8263 S. Saginaw Rd., Ste 5 • Grand Blanc, MI 48439
P: 810.579.7184 • F: 810.579.7185

www.maxwelltherapy.com

Hours
Monday- Friday
8:00 A.M. - 7:00 P.M.
Saturday by appt.

Specialty Programs

Back Pain and Sciatica
Neuropathy
Vestibular Rehab
Parkinson's (LSVT)
Neck/Headaches
Pediatric Therapy
Laser Therapy
Wellness Memberships

Insurances Accepted
Aetna
Auto Insurance
BCBS (All Plans)
BCN (All Plans)
Health Net
McLaren (All Plans)
Medicare
Medicare + Blue
Meridian
Molina
Priority Health
TheraMatrix
Total Health Care
Tri-Care
United Healthcare/Optum
Veteran's Choice
Workers Compensation
Other Insurances

☐ PRESCRIPTION

Bring this prescription along with any HMO referral, Auto or Worker's Comp authorization on your first day.

Date: _____ **Physician:**_____

Patient: _____

Date of Birth: _____ Phone: _____

Diagnosis _____**DX Code:** _____ _____ _____

Precautions/Restrictions: _____

☐ **Evaluate and Per Care Plan**

☐ **Physical Therapy**	☐ 3X	☐ 2X	☐ 1X	For _____weeks _____visits

☐ **Functional Capacity Evaluation** ☐ **Home Tens Unit**

Specific Tx: _____

☐ **Occupational Therapy**	☐ 3X	☐ 2X	☐ 1X	For _____weeks _____visits

Specific Tx: _____

☐ **Speech Therapy**	☐ 3X	☐ 2X	☐ 1X	For _____weeks _____visits

Specific Tx: _____

Please attach medical records, imaging reports, & demographics.

℞ I _____ certify/_____ recertify that I have examined the patient and physical/occupational/and or speech therapy is necessary, and that services will be furnished while the patient is under my care, and that the plan is established and will be reviewed every thirty (30) days or more often, if the patient required.

_____ _____
Physicians Signature Date