PTcares Physical Therapy

Refund Request Form

Full Name: _____

DOB: _____

Medical insurance 1: _____

Medical insurance 2: _____

Date of PT Eval: _____

How many visits you had been to our clinic for the latest episode? _____visits

Statement:

☐ All the treatments I received in the last 3 weeks did 100% nothing beneficial to my condition.

Signature: _____

Date: _____

**********For clinic use only**********

Dates: _____

Total amount: $_____

Check number: _____

Officer name:

_____

Date: _____