Patient Signature Form

AGENCY: ______________________ PATIENT NAME: ______________________

THERAPIST NAME: ______________________ THERAPIST SIGN: ______________________
(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 In	Time Out	Vitals within parameters? Y or N

Notes/Comments: ______________________

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Report all out-of-parameter vitals to HHAgency * Sign-in Hhagency's folder in patient's home * Note completion >48 hours from visit date

Submit Signature Form to: Fax: (888) 403-8326 or Email: staffing@sterlingtherapy.com