If you would like us to contact your Doctor with any updates and reports of your current condition, please provide the name of your Physician.

Doctor:_________________________________

Address:________________________________

City, State:______________________________

Telephone#______________________________

* I have received a copy of the “Notice of Privacy Practices” provided to me by Capitol Rehab of Winchester, PLLC.

Printed Name: ____

Signature: ____

Date: ____

230 Costello Drive – Suite 1, Winchester, VA 22602 T: 540-665-4444

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