Physician Authorization to Participate in Exercise

Letter of Medical Necessity (LMN)

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Patient Name: ______________________________ Date: ________________

DOB: ______________ Pt. Phone #: _____________ Alt. Phone #: _____________

Policy #: _________________ Group #: ___________

Date of Most Recent Evaluation: ________________

Patient History and Diagnosis:

___ Cardiovascular disease
___ Pulmonary disease
___ Peripheral vascular disease
___ Sarcopenia
___ Osteoporosis/osteopenia
___ Osteoarthritis: ____________________________
___ Stroke
___ Diabetes
___ Parkinson's
___ Cancer: ______________
___ Other Dx: ____

Comments:____

Recommended Treatment: Exercise Therapy / Balance Training

Objective: Reduce fall risk and improve or alleviate disease/condition by improving mobility, muscle health, gait speed, postural stability, and/or general physical function.

- Baseline and follow-up functional assessments to evaluate functional status, observe movement quality, assess balance confidence, and measure outcomes.
- A customized exercise prescription designed from patient assessment.
- Individualized balance training therapy that includes an effective combination of **joint mobility**, **sensory stimulation**, **muscle strength**, **muscle power**, **static balance**, **dynamic balance**, and **gait enhancement** exercises.
- Program design includes the 9 fundamental human movement patterns for effective functional training with progressions/regressions prescribed as appropriate.

Duration of Treatment: __ 3 months __ 6 months __ 12 months

Summary: Customized exercise therapy / balance training based on research-proven functional assessments and delivered on mobile application. Patient progress is tracked in real time.

Referring Physician: ____________________ ____________________ ___________

Printed Name Physician Signature Date

License #: ______________________

Address: ____ **Phone #:** ______________

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