Lighthouse Infusions & Seattle Ketamine

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Provider Statement of Diagnosis

PROVIDER Information:

First Name: Last Name: Credentials:

Phone: Email: Fax:

Facility name (if applicable):

PATIENT Information:

First Name: Last Name: Date of Birth:

ICD-10 Codes	Diagnoses

By signing below, I hereby attest that the patient listed above is, or has been, under the care of me or a member of my healthcare team, and has received the above listed diagnoses.

Signature: _____ Date: _____

Name of person signing: Credentials or position:

Thank you for completing and signing this form. You can give the completed form to the patient, fax it to 425-368-7634, or email it as an attachment to our HIPAA-compliant email address: info@lhinfusions.com

