Lighthouse Infusions & Seattle Ketamine

Phone: 425-835-2363
info@lhinfusions.com
Fax: 425-368-7634

5701 NE Bothell Way STE 4
Kenmore, WA 98028

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

