Patient Testimonial

Print your first and last name: _____

Name of nursing facility where you received rehab: _____

Your Story:

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Thank you for taking the time to share a testimony about your rehab experience. We value and appreciate your expression. If you need more space, feel free to use the back of this sheet. Please return this form to the therapy department or mail to the following address:

Healthcare Therapy Services, Inc.
Attn: Marketing Department
1411 W County Line Road, Suite A
Greenwood, Indiana 46142

With your signature, you are granting permission for Healthcare Therapy Services, Inc. to use your testimonial either in its entirety, or in a shortened, edited form for social and print media.

Your Signature: _____ **Date:** _____