Functional Therapeutics
Occupational Therapy & Elder Care

Medical Assignment of Benefits and Financial Policy

Please read and initial each the following and sign and date at the bottom.

Functional Therapeutics is pleased to be part of your rehabilitation experience, and we thank you for choosing us. We believe that communication with our patients regarding our financial policy assists in providing the best service to you.

Please note: *The American Medical Association recommends positive identification of all patients in an effort to prevent insurance fraud and identity theft. You will be asked to provide your Social Security number and photo ID for insurance purposes. These will be copied for your therapy file and billing.*

We will gladly call your insurance company to obtain your current benefit coverage.
However, insurance companies will not guarantee medical benefits or payment over the phone.
We can only use this information as a guideline.

- I understand that I have medical insurance which, when billed on my behalf, will (should) pay for my office visits (therapy). Initial _____
- I understand this process may take 4-8 weeks. At that time my insurance company will determine and pay for services according to my insurance plan benefits. Initial_____
- I understand it is my responsibility, and agree, to pay all co-pays, co-insurance, deductibles, or "cash pay" estimated amounts at the time of service. Initial_____
- I understand that a copy of my explanation of benefits (EOB's) will be sent to me by my insurance company when the claims are processed. Initial_____
- I understand that it is my responsibility to pay all uncovered services within 30 (thirty) days after my insurance has paid their portion. Initial _____
- I understand that if for any reason my insurance company does not pay for the covered services within 90 (ninety) days of the services provided, I shall assume responsibility for the total amount owed. Initial _____
- I thereby assign all medical benefits to Functional Therapeutics (aka Lynda Letourneau). Initial _____
- I authorize Functional Therapeutics to release my medical information to insurance companies, physicians, attorneys, and to all other pertinent parties that may be involved in my claim or care. Initial _____

I have read and understand this document and all of my questions have been answered.

Patient Name (please print): _____

Patient Signature (parent or legal guardian): _____

Date: _____

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