# Functional Therapeutics

## Occupational Therapy & Elder Care

### WELCOME TO FUNCTIONAL THERAPEUTICS

Thank you for choosing Functional Therapeutics to be a part of your rehabilitation experience. Please carefully read each section below, sign, date, and please bring to your first appointment.

AUTHORIZATION FOR TREATMENT

All procedures will be thoroughly explained to you before they are performed. We want you to be an active and informed participant in your therapy services. There are limited risks with Occupational Therapy treatment. You will be asked to exert varying degrees of effort and perform activities with increasing degrees of difficulty. There is a minute possibility that this could increase your discomfort or contribute towards a new injury. All therapy is stopped at any time you experience any pain or discomfort and you are re-assessed and consulted with. Your safety and improvement is our goal and you are always encouraged to communicate any concerns you have about your progress and treatment. It is encouraged for you to actively participate on all levels that you can. Based on the above information I agree to cooperate fully and to participate in all Occupational Therapy procedures and to comply with the plan of care as it is established with the therapist. The Plan of care is a document made with patient directed goals. Initial___

NOTICE OF INFORMATION PRACTICES/HIPPA

I have been informed of where I can read and I understand Functional Therapeutics' "Notice of Information Practices." It is a document available for me to read both on-line at the business website and in a clearly labeled notebook in the therapy office. I have been access to a personal copy. This is for my information, my patient rights and to clarify the responsibilities of this therapy practice. It is HIPPA guidelines.

I authorize the use and disclosure of my personal health information for purposes as noted in Functional Therapeutics Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. Initial___

DESIGNATED INDIVIDUALS AUTHORIZATION

I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name_____ Relationship _____

Name_____ Relationship _____

I have read and understand the above information.

Patient Name (Printed) _____

Patient Signature _____ Date _____

Legal Guardian Signature _____ Date _____

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