



# FUNCTIONAL THERAPEUTICS

## OCCUPATIONAL THERAPY

### PATIENT RESPONSIBILITIES

Please read and initial each of the following and sign and date below.

- It is the patient's responsibility to know your insurance benefits and policy requirements for office visits and procedures (therapy). Initial \_\_\_\_\_
- It is the patient's responsibility to bring your current insurance card(s) and method of payment (when a co-payment or full payment is needed) for each therapy visit. Initial \_\_\_\_\_
- It is the patient's responsibility to update your insurance information, current address and contact information for our records. Failure to do so will cause the patient to become responsible for all charges. Initial \_\_\_\_\_
- It is the patient's responsibility to provide a current therapy prescription and/or referral prior to treatment. Initial \_\_\_\_\_
- It is the patient's responsibility to inform the therapist if you have been seen at another clinic for physical therapy, hand therapy, or speech therapy. Initial \_\_\_\_\_
- It is the patient's responsibility to notify our office 24-hours prior to your scheduled appointment if you are unable to keep your appointment. Failure to do so will result in a \$25.00 no show/cancellation fee. Initial \_\_\_\_\_
- It is the client's responsibility to participate as fully as possible in the therapeutic process and activities. Initial \_\_\_\_\_

Functional Therapeutics will be responsible for answering any of your related questions about your therapy services and plan of care. Your plan of care can and will be adjusted to meet your needs as they change.

I have read and understand my responsibilities as a patient. All of my questions have been answered.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Patient Signature (parent or legal guardian)