Functional Physical Therapy
3441 Tennyson St.
Denver, CO 80212 info@functionalphysialtherapyllc.com
303-941-0664

Patient Authorizations and Guarantees

____CANCELLATION POLICY: I understand that Functional Physical Therapy, LLC, requests that I reschedule or cancel my appointment at least 24 hours in advance. If I fail to keep my appointment, which includes arriving more than 7 minutes late, or not give 24 hours advance notice my account will incur a full price charge which is not subject to insurance billing.

____CONSENTS AND DISCLOSURES: I hereby voluntarily agree to physical therapy and occupational therapy assessment and treatment procedures which may be administered or performed on me by Nancy Hackett Harrison, MSPT, CFMT, FMTF, and/or other practitioners at Functional Physical Therapy, LLC, A Colorado Professional Company. I understand that the practice of physical therapy is not an exact science and that the assessment and treatment may involve risks. No guarantees have been made to me as to the results of my treatment. I understand that I am encourages to ask questions and voice concerns about my treatment and that asking questions or voicing concerns will not compromise my treatment. I agree to inform the practitioners of any medical conditions which may have any effect on my treatment or on my safety. I understand that the therapists are not physicians, and do not prescribe or administer medications, or make medical diagnoses.

____ASSIGNMENTS FOR INSURANCE BENEFITS: I hereby assign payment directly to Functional Physical Therapy, LLC, for any services that are reimbursable by Medicare or any third party sources. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand that all bills are due and payable at the time of service and I will be held responsible for any costs incurred regarding collection of payment for services rendered.

____VALUABLES: I understand that Functional Physical Therapy, LLC, is not responsible for valuables and personal property brought to the facility.

____FINANCIAL AGREEMENT: I understand that I am financially responsible and agree to pay for services rendered by the above practitioners. Charges will be agreed upon in advance, and paid upon completion of each session, unless other arrangements have been agreed upon. Upon request, the practitioners will provide documentation of services if I wish to submit for insurance or other reimbursement.

____MEDICAL RELEASE OF INFORMATION: I authorize the release and exchange of information with my referring/primary physician, and with other professionals as authorized by me who are involved with my treatment. If insurance (third party payor) or MEDICARE is the responsible party for payment of my account, I authorize to such organizations, release of any medical information by phone or in writing, including reports of diagnosis prognosis, recommendation, benefits payable, as well as any other data necessary to process claims for reimbursement of treatment rendered by Functional Physical Therapy.

____PRIVACY POLICY: I acknowledge that I have been informed of the Privacy Policies for Functional Physical Therapy, LLC. FPT follows HIPPA rules and regulations.

By initialing the above and signing below I certify that I have read this agreement and/or it has been fully explained to me and that I understand its contents, and that I am the patient, or a person duly authorized to execute this agreement and accept its terms.

Print Name:(If under 18, print name of guardian or authorized person)_____

Signature:_____Date_____