FUNCTION PHYSICAL THERAPY
12450 Tamiami Trail East
Naples, FL 34113

Insurance Assignment/Authorization to Release Confidential Consent for Treatment

1. _____ (Initials) I give my consent for a physical therapy evaluation and treatment to be administered by Function Physical Therapy.

2. _____ (Initials) I authorize my medical information to be released from my chart to my physician and in addition to any third-party billing company working with or on behalf of Function Physical Therapy in efforts to bill my insurance company.

3. _____ (Initials) If this is a workman's compensation claim or a motor vehicle claim, I authorize the release of information to claim adjusters, case managers and employers as needed. This is to includes any attorneys involved.

4. _____ (Initials) I understand that I am responsible for payment of services rendered. Billing will be done from this office to my insurance carrier and I am responsible for my deductible. I am aware that I am responsible for co-payment amounts dictated by my insurance carrier. I will be charged "usual and customary amounts" based on the fee schedule for rehabilitation that my insurance carrier has developed or allowed.

5. _____ (Initials) I understand that Function Physical Therapy, will verify my insurance benefits as a ***courtesy*** to me and collect Copayments, Coinsurance and Deductibles based on *estimates* only provided by my insurance carrier. Should my insurance carrier deny or make only a partial payment, I understand that I am responsible for any remaining balances.

6. _____ (Initials) I authorize my insurance carrier to directly pay Function Physical Therapy, for services appropriately rendered and billed for.

7. _____ (Initials) I recognized that it is my responsibility to remit checks issued directly to me from my insurance carrier to Function Physical Therapy, If my insurance carrier issues payment to me for services rendered and I have a remaining balance with Function Physical Therapy, I understand that it is my responsibility to not only turn over the payment but that I am responsible for any remaining balances not covered by my insurance carrier.

8. _____ (Initials) **I understand that should I not provide 24 hours notice to Function Physical Therapy, to cancel my appointment, I will be charged a No Show/Cancellation fee of $25.00, which cannot be waived.**

This Insurance Assignment/Authorization to Release Confidential Information/Consent for Treatment is applicable to all Function Physical Therapy, LLC. office locations.