Function First Therapy, LLC
Authorization to Submit Insurance Claims
Notification of Privacy

Patient Name: ________________________ Guarantor Name (if applicable):______________________________

Patient or Guarantor Phone: ___________________Patient or Guarantor Email: ____________________________

Patient or Guarantor Mailing Address:
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Insurance Company:
____

Policy No. _____________________________________ Group Number: _________________________________

Name of Policy Holder: ____

Policy Holder's DOB: _____________________________ Payer ID:____

Provider Phone Number on Insurance Card (if applicable): ____

Insurance Address Located on Insurance Card: ____

AUTHORIZATION TO SUBMIT INSURANCE CLAIMS

I, ____________________________, hereby certify and attest that I or my minor child have sought evaluation, treatment, or medical advice from the staff at Function First Therapy, LLC. I authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical claim payment. I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any of my or my minor child's medical bills not covered by my insurance or otherwise paid, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. I further understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-payment may result in denial of service and/or a legal claim against me for non-payment.

NOTIFICATION OF PRIVACY:

Function First Therapy, LLC complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have been offered Function First Therapy, LLC Notice of Privacy Practices.

My signature below indicates that I understand and accept the content of this form.

Signature: ____ Date: __________________________