

MEDICAL & SPORTS

REHABILITATION CENTER, INC.

Physical Therapy * Occupational/Hand Therapy * Massage Therapy

Functional Capacity Evaluation Authorization

Dear: _____

Date: _____

I am confirming your request that a FCE (Functional Capacity Evaluation) test is be performed on the below mentioned patient. The charge for the FCE is **\$780.00 and must be paid in full regardless of contractual agreements or fee schedules.**

It should be noted that our facility would allow one re-scheduled appointment or no-show. *After the first missed initial appointment a fee of **\$200.00** must be paid immediately to Medical & Sports Rehabilitation Center for each date thereafter that a scheduled initial appointment is missed.*

Please sign below to confirm that the full amount of \$780.00 will be paid for the FCE as well as \$200.00 if applicable for each missed initial appointment.

Patient: _____

Date of Appointment: _____

Printed Name of Authorized Personnel

Signature of Authorized Personnel

Date