Functional Integrated Therapeutic Services
9565 Waples St. Suite 100 San Diego, CA 92121
P/F: 858-695-9444

☐FitsOT ☐FitsPT ☐ABA360 ☐Communication Spectrums

Office Policy & Procedures

Please read and initial each line.

_____ **HIPAA Acknowledgement.** I acknowledge I have read and understood the Notice of Privacy Practices provided to me. Should any changes be made, I will be provided an updated copy of the Privacy Practices.

_____ Assignment of Benefits. I authorize my insurance to release direct payments to the above entities *i.e., FITS OT, FITSPT, ABA360 or Communication Spectrums-Speech for In & Out of Network services.*

_____ **Responsibility of Payment.** As a courtesy, we will bill your insurance and request that any denied services is patient's responsibility. Copay, deductibles and coinsurance will always be "Patient's Responsibility" and is expected at time service or within 15 days of receiving the first invoice. FITS verifies insurance but the data exchanged may not always be accurate; therefore, we highly encourage that the subscriber contact the insurance company for full benefit explanation.

____ **Out of Network** This means that FITS does not have a contract with your insurance plan. All claims will be subject to the billed amount which is a higher fee than In Network benefits.

____ **Cash Pay Rate.** I acknowledge to pay the Cash Pay Discounted Rate of $125.00 (2021) and not bill insurance. In January 2022 the Cash Pay Rate will be subject to change.

_____ IEE Clients. I understand that I am responsible for all fees if my district declines to pay for services or pays only a portion of the contracted services.

_____ Acknowledgment of Risk. I agree to indemnify and hold harmless the above entities from any and all losses and claims for any injuries occurring to myself or my child from the use of therapeutic equipment during their therapies.

_____ No Show & Late Appointments. In order to make progress in therapy, attendance is very important. It is my responsibility to call the office 24hrs prior to my child's appointment time to cancel. Failure to do so may be subject to a fee of $125.00 which will be determined on a case by case basis. I will call the office if running late by more than 10 minutes. FITS has the right to make scheduling adjustments for ALL LATE appointments. *Office number: 858.695.9444*

By signing this, you acknowledge that you understand our office policies and if you have any further questions, you are aware that you may ask for clarification prior to signing.

Guardian Signature: ____________________________________ Date: _____________________

Client's Name: _______________________________________