Functional Integrated Therapeutic Services
5945 Pacific Center Blvd. Ste 510
San Diego, CA 92121
(858)695-9444

Please read and initial each line.

_____ **Privacy Practice Acknowledgement.** I acknowledge I have read and understood the Notice of Privacy Practices given to me. I understand the Notice of Privacy Practices is subject to change. Should any changes be made, I will be provide an updated copy of the Privacy Practices.

_____ **Acknowledgment of Risk.** I acknowledge that there is some risk inherent in the use of the therapy equipment utilized at the above organizations and incorporations and I agree to indemnify and hold the above organizations and incorporations harmless from any and all losses and claims for any injuries occurring to myself or my child from the use of therapeutic equipment.

_____ **No Show and Late Cancellations.** I understand that in an effort to continue making progress, consistent attendance is necessary. Due to this, the above organizations and incorporations reserve the right to adjust appointment schedules as needed due to many cancellations or no shows. In certain situations, evaluated on a case by case basis, a fee will be assessed.

_____ **Insurance Assignment and Release.** I hereby authorize and assign payment of insurance benefits to the above organizations and incorporations for services provided to members of my family or myself. I authorize the above organizations and incorporations providing service to release all information necessary to secure the payment of these benefits and process my insurance claims. I understand the above organizations and incorporations will file claims on my behalf for those whom they are in network with. If my plan is Out of Network I understand I may be subject to pay a higher fee. If for any reason my insurance denies my claim, I understand it will be my responsibility to pay the fee in full. I understand the office collect copays, deductibles, and coinsurance.

_____ **Responsibility of Payment.** I understand that I am responsible for the remainder or full payment if I am an insurance patient. If I am not an insurance patient I understand that I will be responsible for paying the cash pay rate for service. For IEEs I understand I am responsible for payment if the district chooses to not pay.

_____ **Questions.** Open communication is an important part of ongoing treatment and is essential. If you have any questions regarding your care, please ask.

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.

Signature: ____________________________________ Date: ____________________________