

Client Information	Therapy Information
<hr/> Client Name	AGES: 3 – 18 yrs. old TUITION FEE: FIT Jr.: \$395 flat rate ELEMENTARY: \$450 flat rate ADVANCED FIT: \$550 flat rate
<hr/> Date of Birth	STUDENTS NEW TO FIT: Each student who is not currently in the FIT Program is required to participate in a FIT Consultation in order for the speech-language pathologists to determine eligibility. Call (216) 929-0195 (ext. 108) to schedule the consultation. A \$60 FIT Consultation fee (additional to the tuition fee) is due on the date of the consultation. Ineligible students will be refunded any part of the tuition fee already paid.
<hr/> Home Address	REGISTRATION: Weekly Therapy registration is on a first-come, first-served basis. Space is limited and families are encouraged to register early. To reserve a space for your child, send this form and the tuition fee to our NEW address;
<hr/> City/State/Zip Code	FIT (Friendship In Teams) Attn: Hilary Anderson 19910 Malvern Road Shaker Heights, OH 44122
Parent/Guardian Information	
<hr/> Name of Parent/Guardian	Relationship to Client
<hr/> Home Phone	Work Phone
<hr/> Cell Phone	Email
<hr/> Name of Other Parent/Guardian	Relationship to Client
<hr/> Home Phone	Work Phone
<hr/> Cell Phone	Email
Emergency/Medical Information	
<hr/> Name of Emergency Contact	Relationship to Client
<hr/> Home Phone	Work Phone
<hr/> Cell Phone	Email
<hr/> Medical needs/Allergies	<input type="checkbox"/> FIT Jr. <i>Winter 2010</i> (ages 3-7) @ 3:00–4:00 or 4:10-5:10 (Saturdays, Jan 9, 23,30, Feb. 6, & Feb. 27, March 6,13, & 20) <input type="checkbox"/> FIT Elementary <i>Winter 2010</i> (ages 7-12) @ 6:00pm – 7:00pm (Thursdays, January 14 to March 18) <input type="checkbox"/> FIT Advanced <i>Winter 2010</i> (ages 12-18) @ 7:10pm – 8:10pm (Thursdays, January 14 to March 18) Amount enclosed: \$ _____ Payment Method (check one): <input type="checkbox"/> Check # _____ Make payable to FIT. <input type="checkbox"/> Third Party Payor (Please fill out other side) <input type="checkbox"/> Credit card: Visa or MasterCard ←CIRCLE ONE: # _____ Expiration date: _____ 3-digit security code (see back of card): _____ Billing address: _____ _____ Name on card (print): _____ Signature: _____ Families paying by credit card may fax this form to FIT: (216) 991-5472.
<p>PLEASE REMEMBER TO READ, SIGN AND SUBMIT THE WAIVER AND CONSENT FORM WITH THIS REGISTRATION. (OVER)</p>	
<p>Therapy sessions will NOT be filed with insurance companies.</p> <p>PAYMENT POLICY: Full tuition fees are due at the time of registration. They are non-refundable regardless of number of sessions attended. We will help families that choose to submit for reimbursement from their insurance provider by providing Health Insurance Reimbursement Forms. (Please fill out other side)</p> <p>CANCELATIONS: Please let us know if you need to cancel by email, handerson@wrslp.com or calling (216) 929-0195 (ext. 108). The sooner we know the better so that we can plan our staff accordingly.</p>	

PAYMENTS AND THIRD PARTY PAYOR INFORMATION AND POLICIES

This section should be completed by the person responsible for payment ("Responsible Party") for services the individual ("Child") receives from FIT (Friendship In Teams). The Responsible Party must be the Child's legal parent or guardian. "Third Party Payors" are other public and private agencies that fund services for children with special needs.

Please initial one:

_____ I will self-pay for FIT tuition. Please do not file a claim with any Third Party Payors.

_____ I will self-pay for FIT tuition but would like to submit for reimbursement from my insurance provider by using a Health Insurance Reimbursement Forms.

_____ I would like FIT to file claims with one or more Third Party Payors. I authorize FIT or a representative of FIT to do the following: file claims with Third Party Payors for tuition for my Child; contact Third Party Payors to collect oral and written information about the terms of my Child's policy or arrangements and/or the status of claims filed by FIT; and provide Third Party Payors with oral and written information about the tuition for FIT and what FIT provides to my Child and about the status of my Child's progress.

Check all Third Party Payors with whom you authorize FIT to file claims to and your Child has been approved.

Post Adoption Special Services Subsidy (PASSS) Autism Scholarships Program (ASP)

Other _____

Contact Person & Phone Number _____

Please note the following:

- FIT will file Third Party Payor claims in a timely manner. Claim information received by this office will be credited to the Child's account and will appear on statements sent to the Responsible Party.
- FIT does not guarantee full or partial Third Party Payor reimbursement for any services provided. The Responsible Party is responsible in full for all fees charged to the Child's account.
- FIT recommends that the Responsible Party call the Child's Third Party Payor(s) to inquire about reimbursement policies for the FIT Program for the Child.
- If the Child's Third Party Payor(s) will reimburse the Responsible Party directly, full payment is due on the final date of the programs semester.

Payments: Full tuition fees are due at the time of registration. They are non-refundable regardless of number of sessions attended. We will help families that choose to submit for reimbursement from their insurance provider by providing Health Insurance Reimbursement Forms. Payment arrangements can possibly be made by contacting the FIT Billing Manager.

All information I provided on this form is complete and accurate to the best of my knowledge. I read, understand, and agree to the (1) Attendance Policies and (2) Payments and Third Party Payor Information and Policies.

Signature of Responsible Party _____
Date

Print name of Responsible Party: _____

(OVER)

