THINK IT, MOVE IT!

Children will learn and practice the core social concepts while on the move. Concepts will be introduced in a fun and motivating way, encouraging the children to improve their social thinking skills and enhance their motor development.

Ages: Preschool to Kindergarten

Duration: 6 weeks, Starting January 26 – March 2

Day and Time: Friday | 2:00 - 2:45 PM

These sessions will be coordinated by Fitness for Health staff with collaboration from Sue Abrams, M.A. CCC-SLP. Ms. Abrams has completed the Social Thinking® Clinical Training Program with Michelle Garcia Winner.

I am registering my child for:

□ Fridays Total fee: $585.00

Child's Name_______________________________________ Date__________________________

Grade (2016-2017)________School_____________________ Date of Birth____________________

Parents Names____

Home Phone___________________________ Cell Phone____________________________________

Street Address____

City__________________________________ State_______ Zip____________________________

Email Address____

Policies

PLACEMENT
We group students with peers that function similarly in cognitive, social, language and /or motor skills. If your child is new to the Center a "Meet and Greet" will allow us to learn about him/her and determine which group is appropriate.

While we invest much time in forming our groups there are times where the group dynamics may necessitate that a child not continue their participation in that group. If that occurs we will discuss the options available for your child. A pro-rated refund will be provided. We want the experience to be a positive one for all children.

If you apply to the program and we are unable to find a match for your child, we will be happy to consider your child for future groups. Your deposit will be refunded in full. Center for Communication and Learning and FFH reserve the right to cancel a group if there is insufficient registration.

INSURANCE
The social cognitive thinking groups may be covered by your insurance plan. You can check with your carrier regarding coverage. While we will give you an invoice with the CPT code 92508 (Group Speech Therapy) we **do not** accept insurance reimbursement directly from your carrier. At times your insurance company may ask us to complete forms and/or provide therapy notes. Depending upon the time involved, there may be an additional fee to fulfill their requests. You will be given notice of this at that time.

FEES
A non-refundable deposit of $100.00 is required with this application. The deposit will be refunded if it is decided after the meeting that the group will not benefit your child at this time. Payment in full is expected two weeks prior to the group's start date. Payments can be made by check, credit card and/or PayPal.

8 weeks: $585.00

PARENT PARTICIPATION
Parents are expected to be involved in their child's therapy program. We will try to provide weekly feedback via emails regarding the concepts/activities introduced. Individual parent coaching sessions are available with your child's therapists for a fee. These sessions allow you to discuss your specific concerns and/or develop strategies that are individualized for your child. We welcome your input so we can learn about your child. and his/ her social or motor challenges.

Please sign below to indicate your agreement with all of the policies as described above.

Signature____ Date: ____________________

Participant Agreement and Waiver & Release of Liability

Participant's Name: ____

Parent / Legal Guardian Information (if Participant is not at least 18 years of age):

Name ____

Email ____

Cell ________________________ Home _________________________

Work ______________________________

Medical Information (please share any medical conditions): ____

Waiver & Release of Liability

Fitness for Health, Inc. ("FFH") and Center for Communication and Learning ("CCL") are not responsible for any illness, harm, bodily injuries, including death and loss or damage to property suffered while participating in FFH and CCL activities, using equipment, whether on or off FFH premises, or for any reason.

In consideration of being allowed to participate in FFH and CCL activities and use FFH facilities and equipment, I hereby release and covenant not to sue FFH and CCL, owners, employees, instructors, or agents, from any and all present and future claims for loss, damage, or theft of personal property, personal injury, or death, arising as a result of using the facilities and equipment of FFH and engaging in any FFH and CCL activities, wherever, whenever, or however the same may occur. I hereby voluntarily waive any and all claims, both present and future, that may be made by me, my family, estate, heirs, or assigns.

I understand that all physical activities of FFH and CCL involve certain risks, including but not limited to, death, serious neck and spinal injuries resulting in complete or partial paralysis, heart attacks, and injury to bones, joints, or muscles. I am voluntarily participating in FFH and CCL activities with knowledge of dangers involved and hereby agree to accept any and all inherent risks of property damage, minor or serious personal injury, or death.

I agree to indemnify and hold harmless FFH and CCL, owners, employees, instructors or agents for any and all liabilities, losses, costs, damages, claims, expenses (including attorney's fees) of any kind and nature arising from participant's engaging in FFH and CCL activities.

By signing this, the undersigned declares that:

1. The undersigned is aware of the activities that the participant is participating in and the locations.
2. The participant is medically capable of participating in the contemplated events or activities and, to the extent necessary, the undersigned has consulted a personal physician to confirm this.
3. The undersigned acknowledges that the participant has the ability to find out more about the program and that all the undersigned's questions have been adequately addressed.
4. The undersigned understands that FFH and CCL have the right to change activities and/or activity locations for safety or other reasons.
5. The undersigned understands that this Participant Agreement and Waiver & Release of Liability is intended to be as broad and inclusive as permitted by the laws of Maryland and agrees that if any portion is held invalid, the remainder of the waiver will continue in full legal force and effect.
6. The undersigned grants permission for first aid and/or CPR to be given to the participant in an emergency, as determined by the sole discretion of any of the employees, personnel, or agents of FFH and CCL .
7. If the participant is less than 18 years of age, the undersigned is the parent or legal guardian of the participant and is executing this Participant Agreement and Waiver & Release of Liability on behalf of the participant. The undersigned has read this form and understands that by signing this form, the undersigned is giving up legal rights and remedies that the undersigned and the participant has now or in the future.

Participant's Name: ____

Participant's Signature: ____

Parent / Legal Guardian Name (if Participant is not at least 18 years of age): ____

Parent / Legal Guardian Signature: ____

Date: ________________

HIPAA Authorization for Use or Disclosure of Patient Photographic and/or Video Images and Testimonials

Authorization:
I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Fitness for Health and Center for Communication and Learning. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:
The photographic/video images, and/or testimonials will be used for: Marketing such as Social Media and/or Advertising.

Revocability:
I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:
I understand that Fitness for Health and Center for Communication and Learning cannot condition treatment on whether or not I sign this authorization.
If desired, copy provided:

- "Yes, I would like a copy of this form."
  (Initialed by team member, copy provided by ___________________________)

Name:
Name: ____

Date: ____

Signature: ____

If Personal Representative:
Name: ____

Date: ____

Signature: ____

Relationship to Patient: ____

If Patient is a Minor:
Parent / Legal Guardian: ____

Date: ____

Signature: ____

Payment Authorization Form

Client Name ____

Parent/Guardian Email Address ____

Payment Method (Please check one) Credit Card _____ Check _____

Credit Card Number: Visa _______ Mastercard _______

CCV: [ ] **Exp date:** [ ][ ] / [ ][ ]

Cardholder's name as it appears on the credit card:

Cardholder's billing address:

Street:		
City:	State:	Zip:

I, _____________________________________, authorize Fitness for Health to charge my credit card for services rendered for each session.

____________________________________ ______________________

Cardholder's Signature Date