

ALVORD, BAKER & ASSOCIATES, LLC
RESILIENCE BUILDER PROGRAM®
FALL GROUP 2018 REGISTRATION FORM
 (Please Print)

GROUP MEMBER INFORMATION

Child' Last Name:		Child's First Name	
Birth date:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Self-Identity _____	School as of Fall 2018	Grade as of Fall 2018

GROUP CHOICES (SELECT 2)

Leader	Grades	Day	Time	Location
1.				
2.				

PARENT CONSENT

*** Signature of both parents is required if parents are divorced or separated. ***

I/We consent to allow our child to participate in group therapy at Alvord, Baker & Associates, LLC. My/our initials, to the left of each of the following statements, indicates that we agree to

Parent (1)	Parent (2)	
_____	_____	I/we authorize the taking digital photos and/or videotaping for the purpose of group discussion. I/we understand these photos and/or videotapes will be erased following the termination of the group.
_____	_____	I/we understand that there is a required parent meeting to discuss my/our child's progress in group for which there is a \$205.00 charge. I/we also understand that a maximum of two (2) absences with 24-hour notice will be forgiven (not charged). All other absences will be charged (i.e. no shows, with no calls, will be charged the full fee for the missed session).
_____	_____	I/we understand the registration fees are non-refundable. Registration is for the entire semester and if, for some reason, my/our child withdraws from group, I/we will be obligated to make payment for all sessions, attended or not through the end of the semester.
_____	_____	Group sessions are to be paid monthly when using a credit card and payable at the beginning of each month for all sessions scheduled that month. When paying by check or cash, payments can be made per session.

My/our signature(s) below confirms that I/we understand the policies associated with Alvord, Baker & Associates, LLC Resilience Builder Program®. I/we also agree that the following information is provided in order to contact me/us concerning our child's participation in group.

Parent signature (1):	Date
Parent signature (2):	Date

PARENT INFORMATION

Parent (1) First and Last Name:			
Address:			
City:		State:	Zip:
Home Phone:	Cell:	Work Phone:	Email:
Parent (2) First and Last Name:			
Address:			
City:		State:	Zip:
Home Phone:	Cell:	Work Phone:	Email:

Please check if you are interested in being considered for participation in a research study at the National Human Genome Research Institute and would like to be contacted for more information.

In order for your registration to be complete, it must be signed and accompanied by the non-refundable deposit in the amount of \$135.00, of which \$100.00 will be applied to the last group session:

\$100.00 Group deposit applied to last session
 \$ 35.00 Materials fee
 \$135.00 Total Due (non-refundable)

Office Use Only		
	Method of Payment	Amount
TH		
XL		