

**RESILIENCE BUILDER PROGRAM® VIA TELEHEATH
FALL GROUP 2020 REGISTRATION FORM
(Please Print)**

3200 Tower Oaks Blvd.
Suite 200
Rockville, MD 20852
p. 301-593-6554 f. 301-255-0461

8401 Connecticut Ave.
Suite 1120
Chevy Chase, MD 20015
p. 301-593-6554 f. 301-754-1034

GROUP MEMBER INFORMATION

Child's Last Name:		Child's First Name	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Self-Identity _____	Birth Date:	School as of Fall 2020	Grade as of Fall 2020

GROUP CHOICES (SELECT 2)

Leader	Grades	Day	Time	Location
1.				via Telehealth
2.				via Telehealth

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 agree and understand that, as part of group, our child must be in a private space and use headsets, as needed, to maximize confidentiality for all group members. We understand that I/we must also sign a telehealth via video conferencing agreement, if I/we have not already done so.
		I/we agree and understand that there is a required parent meeting to discuss my/our child's progress in group for which there is a \$210.00 charge. I/we also agree and 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 agree and understand that 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.
		I/we agree and understand that 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 the 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:

In order for your registration to be complete, it must be signed and accompanied by the non-refundable deposit in the amount of \$130.00, of which \$105.00 will be applied to the last group session:

\$105.00 Group deposit applied to last session
\$ 25.00 Materials fee
\$130.00 Total Due (non-refundable)

Office Use Only				
	Method of Payment	Amount	Forms	Rec'd
TH			Telehealth	
XL			CC Permission	