PEDIATRIC PSYCHOLOGY ASSOCIATES

Aventura • Weston • Coral Gables
Miami-Dade (305) 936-1002
Broward (954) 753-1112
Fax (305) 936-1022

PEERS Teens 14-18 & PEERS Young Adults 18-30
Group Initial Paperwork

Please fax the forms to (305) 936-1022 or email the forms to: info@mailppa.com

PEERS Participant's Name: _____ DOB:_____

Parent(s)/Caregiver(s) Name:_____

Best Contact Phone #:_____

Email address(es):_____
(email and text will be used to provide courtesy reminders of the group-please write legibly)

Emergency Contact-Name and Phone #:_____

School and Grade Attending (if Applicable):_____

Home Address, City, State and Zip:_____

_____

Circle which PEERS Program*: PEERS Teen 14-18 PEERS Young Adult 18-30

**Please note that 18-year-olds will be assessed at the consultation for which program they are appropriate*

Which location you prefer for groups (circle): **Aventura Coral Gables Weston**

Are you a new patient/family to our practice (circle)? Yes No

If you are new patient, has the no-cost consultation been scheduled (circle)? Yes No
**Please note this must be completed prior to starting group*

Are there any dietary restrictions (allergies, kosher, gluten-free)? If so, please list:_____

_____

Please list any goals/expectations you may have for this group experience:_____

_____

What activities does the participant enjoy doing?_____

_____

Please tell us anything else that would be important for us to know about the group participant:_____

_____

Signature: _____ **Date:** _____

Print Name: _____ **Relation to Participant**:_____

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PEERS Financial and Group Commitment Form

Must be completed by all Families

Patient Name_____

Parent/Caregiver Name:_____

Email address_____ **Best Contact Number**_____

I. Please Read and Initial:

Our office policy for our groups is that a commitment to attendance is mandatory. Attendance of the group sessions is important not only for the participant's growth, but also for the integrity of the entire group, and any absences take away from the group process. Please note there is no refund for groups missed and payment for the entire program is required to attend.

_____ **I have reviewed and agree to the group commitment and cancellation policy**.

II. Payment Policy and Fees

PEERS Program (*Program for the Education and Enrichment of Social Skills)*
$1500 for 16 weeks. Fee includes *both* Adolescent/Young Adult group and Parent/Caregiver group, which run simultaneously. First payment of $750 is due 3 business days prior to the first group and remaining $750 will be charged on the 8th group session.

No charge 30-minute initial consultation.
Must have 6 participants to start group.

Please check type of payment: ☐Check/Cash ☐Credit Card (my credit card information is below)
From our experience, a credit card on file has made the group billing most convenient for our families.

Name on Card _____

I authorize *Pediatric Psychology Associates* to charge my credit card as follows:

_____ Total Fee: $1500 for PEERS Program-this includes both Adolescent/Young Adult and Parent/Caregiver groups which run simultaneously - $750 will be charged 3 business days before the first group session and remaining $750 will be charged on the 8th group session (16 weeks total)
Initials

Type of Card: ☐ Visa ☐ MasterCard ☐ AMEX **CVV Number:** _____ (Security Code)

Credit Card Number: _____ - _____ - _____ - _____ **Expiration Date (Month/Year)**_____

Billing Address for Credit Card: _____
Street City State Zip

Signature _____ **Date** ____/____/_____

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Group Consent Form

Patient's Name:_____ DOB:_____

Please Read and Initial each section:

1. _____I voluntarily give consent for treatment by *Pediatric Psychology Associates* for me and/or my family members. I understand the purpose of the groups is to assist in the formation and development of improved social skills and emotional health. However, I also understand that *Pediatric Psychology Associates* cannot guarantee that the process will always result in positive outcomes.

2. _____I understand that group sessions may be videotaped for the purpose of ongoing assessment and training of group participants. *Pediatric Psychology Associates* will not release confidential material to other outside parties without written permission. As provided by law, confidentiality may only be breached for protection purposes when the client is imminently dangerous to her/himself or others, or in cases of child abuse.

3. _____I understand that the results and data from this group may be used for research and thus benefit others in the future. I have been assured that the information that I give will be held in confidence and that my and my child's data and responses will not be used in any way that makes us individually identifiable.

4. _____I am free to withdraw my consent at any time without penalty to me or my child.

I hereby give my consent for my child's participation in the group activities described in the informed consent agreement under the conditions stated above.

_____ _____
Signature of Participant (if adult) Date

_____ _____
Signature of Parent/Guardian (if minor) Date