PEDIATRIC PSYCHOLOGY ASSOCIATES

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

2019-2020 PEERS Group Paperwork

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

PEERS Participant's Name: _____ **D.O.B.:** _____

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

Best Contact Phone #: _____

Email Address(es): _____

Please print legibly. Email will be used for courtesy reminders for group sessions.

Emergency Contact-Name and Phone #: _____

School and Grade Attending (if Applicable): _____

Home Address, City, State and Zip: _____

_____

Select Program* to Attend: ☐ PEERS Teen (14-18) ☐ PEERS Young Adult (18-30) ☐ PEERS Weekend Workshop

**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 ☐ South Miami ☐ 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: _____

_____

Parent Signature: _____ **Date:** _____

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

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PEERS Financial and Group Commitment Form

Participant Name: _____

Parent/Caregiver Name:_____

Email Address:_____ **Best Contact Number:**_____

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/days missed and payment for the entire program is required to attend.

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

Payment Policy and Fees:

_____ **PEERS Group Program** (*Program for the Education and Enrichment of Social Skills)*
$1,500 for 16 weeks. Fee includes *both* Adolescent/Young Adult group and Parent/Caregiver group, which run simultaneously. First payment of $750 is due one week prior to the first group and remaining $750 will be charged on the 7th group session.

_____ **PEERS Weekend Workshop**
$500 for two-day weekend workshop on select topics. Fee includes *both* Adolescent/Young Adult group and Parent/Caregiver group. Fee will be paid at least one week before workshop start date.

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

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 billing most convenient for our families.

Name on Credit Card: _____

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

_____ $1,500 for PEERS Program – $750 will be charged one week prior to the 1st group session and remaining $750 will be charged on the 7th session.
Initials

_____ $500 for Weekend Workshop – Full amount will be collected one week prior to workshop start date.
Initials

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

Credit Card Number: _____ - _____ - _____ - _____ **Expiration Date: (MM/YY)**_____

Billing Address for Credit Card: _____
Street *City* *State* *Zip*

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

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Group Consent Form

Participant's Name:_____ **D.O.B.:**_____

Please Read and Initial Each Section:

_____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.

_____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.

_____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.

_____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***