



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

PEERS® South Florida - Boot Camp Registration

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

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

Caregiver/Social Coach Name: _____

Best Contact Number(s): _____

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: _____

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

If you are new patient, has the no-cost consultation been scheduled (check one)? Yes No

**Please note this must be completed prior to starting the program*

Select Program* to Attend (check one): **Please note that 18-year-olds will be assessed for the program they are appropriate for*

PEERS® Adolescents (ages 14-18)		PEERS® Young Adults (Ages 18+)	
<input type="checkbox"/> Aventura	<input type="checkbox"/> South Miami	<input type="checkbox"/> Weston	<input type="checkbox"/> South Miami
June 17 & 24 July 1 & 8	June 18 & 25 July 2 & 9	July 21 & 28 Aug 4 & 11	June 18 & 25 July 2 & 9
2:30 – 4:00pm 6:30 – 7:00pm	12:20 – 2:00 pm 7:00 – 7:30pm	12:20 – 2:00 pm 6:30 – 7:00pm	10:30am – 12:00 pm 6:30 – 7:00pm

Participant in-person workshop Caregiver/Social Coach virtual meeting

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: _____





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PEERS® South Florida - 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:

_____ **\$1,000 for 4 sessions of PEERS® Boot Camp Group Program** (*Program for the Education and Enrichment of Social Skills*). Fee includes *both* Adolescent/Young Adult group and Caregiver/Social Coach group.

_____ A non-refundable deposit of \$100 is made at confirmation of appropriateness of PEERS® program to hold the space for the participant.

_____ The remaining cost of \$900 is collected 5 business days prior to the start of the PEERS® Boot Camp.

_____ Cancellations 4 business days prior to the start of PEERS® will receive a 50% refund (less deposit).

Cancellations less than 2 days will not incur a refund.

No charge 30-minute initial consultation.

Must have 6 participants to start PEERS® Boot Camp Program (deposit will be refunded if group does not commence).

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:

_____ \$100 non-refundable deposit

_____ **\$900 remaining balance 5 business days prior to start of program**

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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PEERS® 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)

Signature of Parent/Guardian (if minor)

