

**Young Adult Group Summer Group Program**

**REGISTRATION FORM**

*Please be sure to fill out the front and back of this form.*

**Please return completed form to Reading office.**

New Application     Re-enrollment

**Location: Reading**

**Days/Times: TENTATIVELY Tuesdays and Thursdays, at 5:30pm, July 11<sup>th</sup> to August 10<sup>th</sup>  
(Subject to change)**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_ **Grade:** \_\_\_\_

**Parent Name (1):** \_\_\_\_\_ **Parent Name (2):** \_\_\_\_\_

**Guardian's Name(s):** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **W#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **C#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Address:** \_\_\_\_\_ **Town/Zip:** \_\_\_\_\_

**Fees:** Interview fee (if applicable): \$95.00 (\$5.00 convenience fee will be added if paying via credit card)

Group program: \$620.00 for the ten-week session (\$62.00 per session).

\_\_\_\_\_ Enclosed is my prepayment check payable to the **Triumph Center** for \$620.00

\_\_\_\_\_ Please charge my Visa/MasterCard account (**\$15.00 convenience fee for all credit card payments**):

**Acct#:** \_\_\_\_\_ **Name on Card:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**PLEASE SEE BACK OF PAGE**

**Important Insurance Information:** The Triumph Center is a provider for some BCBS, HPHC, and some TUFTS insurance plans. Please contact our office to find out whether your insurance will pre-authorize group services and pay for behavioral health benefits. With the exception for covered plans, you will be responsible to pay for your child's group in advance and will then be reimbursed directly by your insurance company. When applicable, we will work with you to complete the necessary paperwork in order for you to utilize your insurance benefit for the group program.

**IF ATTEMPTING TO PAY BY INSURANCE:**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Name of Person Insured: \_\_\_\_\_

Phone: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_

Employer's name if coverage is provided by employer: \_\_\_\_\_

Insurance Plan or Program Name: \_\_\_\_\_

Do you have a deductible? \_\_\_ YES \_\_\_ NO If yes, how much is it? \_\_\_\_\_

Do you have a Copay? \_\_\_ YES \_\_\_ NO If yes, how much is it? \_\_\_\_\_

If your insurance pays only a percentage, how much do they cover (in percentage)? \_\_\_\_\_

**IF SCHOOL DISTRICT OR OTHER AGENCY HAS AGREED TO PAY:**

WE NEED A SIGNED CONTRACT FROM THE SCHOOL DISTRICT OR AGENCY BEFORE THE CHILD CAN BEGIN TO ATTEND GROUP.

Name of School District or Agency: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Billing Address if Known: \_\_\_\_\_

**Notes:**