DOI: _____

Initials: _____

Start Date: _____

Day/Time: _____

Location: R B L

REGISTRATION FORM 2018-2019

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

Please return completed form to Reading office.

☐ New Application ☐ Re-enrollment

I am interested in enrolling my son/daughter_____ in The Triumph Center's social skills group program.

SCHOOL YEAR SCHEDULE

PLEASE INDICATE ALL POSSIBLE DAYS AND TIMES YOUR CHILD COULD ATTEND

Monday	3:30-4:40	4:50-6:00	Thursday	3:30-4:40	4:50-6:00
Tuesday	3:30-4:40	4:50-6:00	Friday (**Reading site only**)	3:30-4:40	
Wednesday	3:30-4:40	4:50-6:00			

Sites I am interested in (circle all possible): READING BEVERLY* LEXINGTON*

*Additional Days May be Offered **(Tues & Thurs)** **(Tues, & Wed)**

Please note: It is possible that we may not have an appropriate group at your preferred site, day, or time. If you are able to travel to other sites it will increase the likelihood that we will have an appropriate group for your child. Likewise, increased flexibility regarding the day and time of the group increases the chances of a good match for your child.

Child's 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: **NO DEPOSIT DUE! Rates subject to change prior to September 2018.**

Group program: $910 for a fourteen-week session ($60.00 per session plus $70.00 programming fee to cover the cost of regular educational feedback sessions).

_____Enclosed is my prepayment check payable to the **Triumph Center** for $910.00

PLEASE SEE BACK OF PAGE

Important Insurance Information: The Triumph Center is a provider for some BCBS and HPHC insurance plans. Please contact our office to find out whether your insurance will pre-authorize group services and pay for a portion of your 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: