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www.SouthFloridaTherapists.com
(305) 936-1002 (305) 936-1022
South Florida & New York Tri-State Area
Telepsychology Across PSYPACT States

Summer 2025 Programs - Registration Form

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

Child's Name:_____ DOB:_____

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

Parent(s) Phone Contact Information:_____

Parent(s) Email Address(es):_____

Emergency Contact-Name and Phone #:_____

School and Grade Child Attends:_____

Home Address, City, State and Zip:_____

Individuals authorized to pick up your child:_____

_____

Are you a new patient/family to our practice?: ☐ Yes ☐ No

Please *CHECK* the box for the program your child will be attending:

Intensive Social Skills Programs:

☐ **Ages 7 to 10** > **9 am - 12 pm** *Minimum 4 participants to run program.
☐ **Ages 11 to 14** > **1 pm - 4 pm**

Aventura	Boca Raton	Miami Beach	South Miami	Weston
☐ August 4-8	☐ July 21-25	☐ July 28-Aug 1 ***only ages 6-8 10am-1pm**	☐ July 14-18	☐ June 16-20 ☐ July 7-11

High School Life Skills:

Teens Entering Grades 9-12 > 10 am – 12 pm *Minimum 4 participants to run program.

☐ July 28- August 1 **Aventura Location**
☐ July 7- July 11 **South Miami Location**

Summer 2025 Programs - Registration Form (page 2)

Child's Name:_____

Does your child have any dietary restrictions (allergies, kosher, gluten-free)? If so, please list:_____

_____

Please list any goals/expectations you may have for your child's camp experience:_____

_____

What activities does your child enjoy doing?_____

_____

Please tell us anything else that would be important for us to know about your child:_____

_____

Consent for Summer Programs

I voluntarily give consent for treatment by *Pediatric Psychology Associates* for myself and/or my family members. I understand the purpose is to assist in the formation and development of improved social skills and emotional health. I can withdraw my consent at any time without penalty to me or my child.

I understand that summer programs may be taped 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 patient is imminently dangerous to her/himself or others, or in cases of child abuse.

Signature: _____ **Date:** _____

Print Name: _____ **Relation to child**_____

Photograph and Videotape/Media Release Consent Form

The following is a Consent Agreement, which authorizes the videotaping, photographing and social media release of videotapes and photographs taken during Pediatric Psychology Associates' Summer Programs. Pediatric Psychology Associates may photograph and/or videotape participants during their participation at Pediatric Psychology Associates' Summer Programs. These videos and photographs may be posted on social media for the purpose of educating the public with regards to recreational services available to children with social challenges. Please initial an option below and sign at the bottom of this page.

_____ Yes, my child's photographs/video may be released for use in social media. I understand that I am free to withdraw my consent at any time without penalty to me or my child.

_____ No, my child's photographs/video may not be released for use in social media.

Signature: _____ **Date:** _____

Print Name: _____ **Relation to child**_____

Summer 2025 Programs - Registration Form (page 3)

Child's Name:_____

Fees and Payment Options for Summer Programs:

$1000 per program

**If child is not a patient of PPA, all programs include a phone screening and, if needed a no-cost 15-minute video or in-person consultation to determine appropriateness of fit.*

Please note paperwork must be completed in order to secure your child's spot in our programs.

All summer program fees are due fourteen (14) days prior to the start date of the program*

In order to provide adequate staffing and preparations, please note that cancellation less than 7 days prior to program/camp and no show or missed days will not be refunded.

Please initial one:

_____ I will pay $1000 by cash or check (payment must be received on or before 14 days prior to the First day of my child's scheduled program).
_____ I will pay $1000 by credit card (credit card will be charged 14 days prior to the first day of my child's scheduled program).

Below is my credit card information. This option is recommended.

Name on Card _____

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

Type of Card: □ Visa □ MasterCard □ AMEX Expiration Date _____

Credit Card Number _____ - _____ - _____ - _____, CVV Number _____

Card Holder's Billing Address for Credit Card Statements

_____
Street City State Zip

PLEASE SIGN- Signature _____ **Date** ___ /_____ /____

Print Name and Relationship to Camper:_____