AD/HD BEGINNER'S GROUP THERAPY PROGRAM
INFORMATION AND REGISTRATION PACKET

Jeff Sosne, Ph.D.

WHAT IS THE GROUP?

This group is designed for elementary age children with problems of self-control and/or effortful attention (AD/HD). Groups have run each year since 1982. The program strives to teach children how to work productively and play appropriately within a group setting that more closely approximates classroom and social situations.

Parents observe the class so that they can help apply the same concepts at home. Classroom teachers of students attending the weekly format have the opportunity to observe the group as well, to help build consistency across settings. Parent classes provide additional information regarding parenting and teacher strategies and give parents the opportunity to discuss what they have observed in class.

The group is led by Dr. Jeff Sosne, a child psychologist who specializes in helping children with attention and self-control problems. Dr. Sosne has conducted over 100 groups, serving over 1000 children. His AD/HD Notebook and Anger Control Notebook are used by parents and schools throughout the Pacific Northwest.

The cost of the program is $500. Student sessions may be covered by health insurance.

Frequently Asked Questions About the Beginner's AD/HD Group

How are the groups set? There are group meetings for the children. Parents observe the sessions through a two-way mirror. There are parent-only sessions the children do not attend. If registration is sufficient to require two groups, students are assigned to a group by Dr. Sosne at the first parents' meeting. Group times depend on the age of the child and number of groups.

What is the cost of the group? Group sessions are billed in 75 minute blocks. Student sessions may be insurance reimbursable. The parent meetings cannot be billed to insurance. A deposit is collected prior to the start of the group.

What if we miss one? The program is considered a "package" service. There is no credit for group sessions or parent meetings that are missed and CANNOT be billed to your health insurance. Handouts for a missed session may be obtained at a later visit.

What if I decide the group is not for my child? For weekly group attendees, if you decide the group program is not right for your child before the third session you will not be charged for any additional sessions. Once a family has begun the third session, they have made a commitment to the program and will be billed for all subsequent sessions/meetings unless we agree that it is not in the student's best interest to continue.

Do you bill insurance? Our office is contracted to bill certain insurance companies. Please refer to the Financial Information sheet for a list of the insurance companies we currently bill or contact the billing office at (503) 452-0307. Remember, billing insurance is not a guarantee of payment. Sessions missed for any reason cannot be billed to insurance and the fee for that session ($50) is owed. The balance owing will be charged to the credit card on file at the end of the group.

My insurance requires pre-authorization. Will you call them or fill out the necessary paperwork? Not without an appointment. If your insurance company requires pre-authorization and they are unwilling to pre-certify with the information already provided to you, you may schedule an appointment to complete the treatment planning. At that time, the authorization will be requested via phone or letter. These appointments are scheduled for 45 minutes at the treatment-planning rate of $150.00.

What about bad weather? In case of inclement weather, please call the office (503) 452-8002 to check if group will be held. We request an email address for each family so we can communicate information in this way as well.

Dear Parents:

We are excited to have gotten things started! Here are some important details that we want you to consider.

S C H E D U L I N G

1. Please arrive promptly so that the group will not be disrupted by children entering late.

2. Please refer to the group calendar for dates/times of parent and student meetings.

3. Depending on the enrollment, Dr. Sosne may assign your child to a group **at the first parent meeting.**

4. For the weekly format group attendees, there will also be a "teacher night," where families can invite their child's teacher to observe the group. Usually, this is scheduled for the 5th week of the group.

5. ALL FAMILIES ARE ASKED TO PROVIDE AN EMAIL ADDRESS for contact purposes.

B I L L I N G

1. You should have already received forms that need to be completed and returned so your child can participate in the group program.

2. Please follow the steps on the Financial Information form. A deposit is required to register prior to the group starting. Families not paying in full for the group program MUST PROVIDE A CREDIT CARD NUMBER in order to register their child. This card will be charged for any remaining balance (after insurance) at the conclusion of the group.

3. Although we bill by session we consider the group a "package" service. Sessions not attended cannot be made-up nor billed to health insurance. When possible, we will make handouts from parent meetings available to families that cannot attend.

4. Some insurance companies will ask for written information regarding the children. Although we will not be writing reports, we will provide the carrier with a description of the group, the dates of the sessions, and your child's diagnosis. Additional treatment planning will require a treatment session with Dr. Sosne.

5. Many families have asked that we consult with the school or meet with them individually. Although we are interested in helping in whatever way we can, these services are beyond the scope of the group. There would, therefore, be an additional charge. If you have any questions regarding billing or charges, please direct them to Dr. Sosne.

6. Although this rarely has happened, it is possible you or we will decide that the group is not appropriate for your child. If this happens before the third child session, there will be no additional charges. Once a family has begun the third session, they have made a commitment to the program and will be billed for all subsequent session unless we agree that is not to the student's benefit to continue.

C O M M U N I C A T I O N

1. *Please leave all messages, notes, paper work, etc., with the front desk.*

2. Schools and therapists are often interested in what we are doing in group. We invite them to call us. They are welcome to visit the group as long as they schedule the visits in advance and obtain your permission to do so.

3. Many families wish to talk with us at the end of group or after a parent meeting. So do our children, so please try and keep things short or arrange some time through reception to talk by phone. Extended phone calls are not part of the group and will be billed to you directly. These are not insurance reimbursable.

L O G I S T I C S

1. Wait for group to begin outside by the back door. Please remember that there are people working nearby and the children are your responsibility until group begins.

2. Please arrive with and pick-up your children downstairs. We will not allow students to leave the clinic without an adult.

3. We ask the families to take turns bringing in snacks. We will sign up for snacks during the review time at the first session. We prefer that the snacks be nutritious and easy to distribute (e.g., popcorn, fruit, juice, crackers, cheese, vegetable sticks, etc.)

C O N F I D E N T I A L I T Y

1. Only parents/legal guardians will be allowed to observe without prior authorization. Everything that goes on in group is strictly confidential. We ask that families not discuss the details of other children in the group.

2. Occasionally, we have students and clinicians observe group. This helps to educate the community regarding the needs of children with attention problems. Visitors would never be given information about your children and we would ask that they tell us if they know any of the youngsters in the group. If there is a problem with observers, please let us know.

3. Observing behind a two-way mirror is a unique experience. It is tempting to chat about the kids and the group; we encourage it. Be careful not to interfere with parents who are trying to hear what is being said in group and please remember that what is being discussed behind the mirror is as confidential as what goes on with the kids.

W R A P – U P

1. At the end of each session we have a wrap-up discussion with parents and students. We will ask that the parents ask 3 questions of the group (not a specific child) about the day's session.

2. Please sit near your son or daughter when you come into the room.

3. As part of the wrap-up, a home project will be assigned for the child and family. We ask the parents to encourage the children to work on the home project, but not to feel responsible for getting the child to complete it. Although you are welcome to call other group members, please do not call the clinic to determine what the home project is.

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___________________________	___________________________
Jeffrey Sosne, Ph.D. Clinical Psychologist	Parent
	___________________________
	Date

Financial Policy for Therapy Groups

We want to clarify billing procedures so you are aware of your financial obligations.

1) Your child is the client. Billing is submitted under the child's name.

2) Our office maintains a direct billing relationship with many, but not all, health insurance companies**.** We bill the companies listed below:

- Aetna (most plans)
- Blue Cross products (unless managed by a third party)
- HMA
- Lifewise
- Managed Healthcare Northwest
- MODA
- PacificSource (Managed Healthcare NW Network only)
- Portland Public Schools Health and Welfare Trust
- Providence Health Plans
- Regence Blue Cross of Oregon
- Teamsters Blue Cross
- United HealthCare/United Behavioral Health
- UMR

3) It is important for families to educate themselves about the mental health benefits of their health insurance policies. Please call your insurance company PRIOR to the beginning of any group to determine your coverage. Inquire if your company provides a managed mental health benefit, whether you must meet a deductible, the amount of your co-payment/coinsurance, and whether pre-authorization is required. In most cases pre-authorization is initiated by the family/patient and NOT the primary care physician/pediatrician. Coverage **may exclude** specific diagnoses e.g., Attention Deficit, Autism Spectrum, or a specific service such as group therapy.

4) Most groups include two different activities: Parent Meetings that are not billable to health insurance and Group Therapy Sessions that are insurance reimbursable. Therapy groups are a package. There is no credit for missed parent meetings or group therapy sessions. Please note: missed group sessions cannot be billed to your health insurance and the fee for that session is then owed by the family. The agreement with your insurance carrier is a contract between you, your insurance company and, in some cases, your employer. Please remember, billing insurance is not a guarantee of payment.

5) If we are billing your primary health insurance please complete the following:

- ✓ A Registration form
- ✓ An Information form
- ✓ A Consent for Payment and Healthcare Operations form
- ✓ A photocopy of your health insurance card

Registrations must include the required deposit **AND** Credit Card Information. Incomplete registrations will not be accepted. If you must cancel, please notify us within 4 business days prior to the start of the group so we can refund your registration fee. Cancellations received after that time will receive a refund, less a $35 administrative fee. We reserve the right to refund your registration by check. Your refund will be mailed to you within approximately four weeks.

Our policy is to bill a patient's primary insurance carrier and allow 60 days for the claim to be paid. If a payment has not been received from an insurance company within 60 days, we encourage the patient to contact their insurance company. Please review the Explanation of Benefits your insurance company provides. Accounts unpaid after 60 days are your responsibility.

6) If we are NOT contracted to bill your health insurance, **payment in full** is due at the time of registration. Families using an out-of-network benefit should contact their insurance carrier **prior** to beginning a group. Verify your mental health benefits and whether pre-authorization or treatment planning is required. If an insurance company requires completion of paperwork in order for you to receive reimbursement, you must schedule an appointment with the clinician running the group prior to the first group session. This appointment is billed at a rate of $150 for a 50-minute session. Please contact our Accounts Manager at to obtain copies of the materials you will need to send a claim to your insurance company along with a guide for self-billing insurance. This information is available after the group has ended.

7) Financial arrangements between divorced parents must be handled independently of the Children's Program. In cases of divorce, the parent seeking service is responsible for the account and must sign the Consent for Payment and Healthcare Operations form. If the other parent holds the insurance, they, too, must sign the Consent for Payment and Healthcare Operations form. This gives us permission to bill the health insurance.

8) Payment can be made with a check, cash, MasterCard, Visa, Discover, American Express, PayPal, or with an HSA, HRA or Benefits credit card. Please call our Billing Office if you need a printout of your account or to answer any questions.

9) Accounts with unpaid balances after 90 days must be paid to avoid collection action. We will make every attempt to contact you to settle the balance and reserve the right to use the credit card number on file to settle the balance.

10) In the event of non-payment of charges, the Children's Program shall be entitled to recover all costs and expenses incurred in seeking collection of such charges, including, without limitation, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, and/or mediation.

TREATMENT CONSENT

WELCOME TO THE CHILDREN'S PROGRAM! We look forward to assisting you with your goals. Here is some important information you should know BEFORE we begin to work with you/your child(ren)/family.

STAFF AND OUR SERVICES: The Children's Program is a private, multidisciplinary clinic. Our clinical staff consists of a licensed developmental/behavioral pediatrician, consulting psychiatrists, licensed psychologists, licensed professional counselors, and certified educational specialists. We help adults, families and children with social, emotional, developmental, and learning concerns. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information we will schedule appointments for consultation, evaluation and/or treatment with appropriate staff.

During the first appointment, your clinician will introduce him/herself to you and, at your request, share specifics regarding his/her education and training. You can then further clarify goals and agree how they will be reached. If you have difficulty describing clear goals for treatment, it is important to discuss this with your clinician. We will work with you to meet your/your family's specific needs. It is a collaborative process that is provided without a guarantee of satisfaction or results. You retain the right to request changes in treatment or to end treatment at any time. When medication is recommended, your doctor will discuss the risks, benefits, and alternatives. When accepting a prescription for medication, you agree to follow the prescribing physician's recommendations regarding *ALL* ***aspects of treatment. If we recommend referral inside the clinic, information will be shared between clinicians. If we recommend referral outside our clinic, we will attempt to provide you with alternatives.***

IF YOU ARE RECEIVING SERVICES UNDER A MANAGED CARE HEALTH INSURANCE CONTRACT, your policy may limit behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. It is the responsibility of the patient/ family to ensure all necessary preauthorization is current. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your record or request a copy of your record be sent to their office for review. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. If you do not want us to send or receive information in this manner on your behalf please inform your clinician and specify this request in writing. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

The Children's Program will not be a party to any legal proceedings/lawsuits. Our goal is to support clients to achieve therapy goals, not to address legal issues. Clients entering treatment agree not to involve the Children's Program and their treating clinician in legal/court proceedings or attempts to obtain records of treatment/evaluation for use in legal/court proceedings.

CONFIDENTIALITY: The privacy of your evaluation/treatment is important to us. Information shared with clinicians is confidential. The Children's Program maintains a single chart to record the services that are provided. We will maintain your chart for 7 years from the last date of treatment. Information from that record can be shared with other professionals/agencies/individuals **ONLY** with your **WRITTEN** consent by signing a release to disclose confidential information. Please be conservative and circumspect when requesting release of information. This is to protect your child/family's privacy now and into the future as your child ages. Please be aware that the record we release may be released by other providers/agencies. The Release to Disclose Confidential Information form requires specifying **WHAT** information is to be shared, **WHO** shall receive it, for **WHAT** purpose and the **DATES** of the confidential information. In Oregon, the age of consent for treatment and release of mental health records is 14 years of age. The signature of patients 14 years or older is required to release the information in the treatment record. With written permission, we can communicate with other professionals on your behalf via phone or email and provide evaluation reports and/or a summary of treatment. We do not generally release patient chart notes or test protocols. If under a special circumstance, release of additional information is requested, this will be reviewed after conferring with the patient/family members and the requesting clinician/physician. There may be charges for photocopying and mailing records. In the case of divorce, both parents have equal access to the information in the chart of a child under the age of 14. If consultation with other professionals on your behalf is necessary, your anonymity will be preserved.

We may, but do not guarantee calls to remind you of upcoming appointments. Please let us know **EACH** time you schedule an appointment if you **DO NOT** want a reminder call.

We respect the rights of a child/parent/adult to have particular information remain private between themselves and the therapist. If you have concerns about this, let your therapist know and a comfortable arrangement can be reached which allows therapy to progress, yet respects the rights of individuals. Please advise us in writing if you wish to be contacted only in a particular way or only at particular phone numbers. There are several situations in which the law requires clinicians to make exceptions to the confidentiality of communications between client and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

(please see reverse side)

information may be required by your insurance company to process a claim. Typically, this involves disclosure of a diagnosis and the dates of services, though at times, more may be required. Your file may be reviewed for quality assurance by the Children's Program or your insurance company. We will maintain your confidentiality during this process.

ELECTRONIC COMMUNICATION, I.E., E-MAIL/FAX, PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits. While families and patients may find this a convenient way to communicate they must be aware of the risks and discuss them with their clinician. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. Clinically relevant information exchanged by fax/email may become a part of the clinical record.

FEES/PAYMENT: Fees are billed on an hourly basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. We request payment of the fee(s) at each appointment. In some cases, we will bill your primary insurance directly. HOWEVER, THIS DOES NOT GUARANTEE COVERAGE. Health insurance plans vary widely in their mental health coverage. A copy of our **FINANCIAL POLICY** is available on our website. **Please read our Financial Policy**. We require that you read/sign **INFORMATION** and **CONSENT FOR PAYMENT** forms prior to initiating evaluation/treatment**.** We require you provide a valid credit card number. Charges remaining after 90 days may be charged if you have not called us regarding arrangements for payment of a past due balance. **If you must cancel/change an appointment please do so with a minimum of ONE FULL BUSINESS day's advance notice to avoid a charge.**

There are circumstances that impose additional fees. You will be charged for telephone/email consultation outside a session or a cancellation without sufficient notice. This is billed at the clinician's hourly rate and is not reimbursable by a health insurance company. Same day requests for refills of prescriptions incur a $10 charge. If a clinician is required to testify on a client's behalf court preparation/travel/testimony will be billed at $200 per hour. In the unlikely event that your account is referred to a collection agency or small claims court, we will release your name, address, phone number, social security number, and amount owed. You will be notified in writing if this is to occur.

EMERGENCIES: Office phones are answered between 8:00 a.m. and Noon and 1:00-5:15 p.m. Monday through Thursdays and between 8:00 a.m. – Noon and 1:00-3:30 p.m. on Fridays. The office is closed on Fridays during July and August. Messages may be left on the voicemail at any time. Our clinicians will attempt to return your call within 24 hours. If you feel you have an **emergency** situation that cannot wait until the office re-opens, please call the Answering Service at (503) 294-1309. They will make every effort to contact your clinician; however, it is possible that your clinician may be unavailable or unreachable. Families needing immediate attention are advised to contact the Emergency Room of the nearest hospital.

GRIEVANCE PROCEDURE: If you have concerns regarding these policies, please discuss them with your clinician during your initial session. Should you feel dissatisfied with your treatment for any reason, please talk to your clinician. If you and your clinician are unable to resolve the problems, you may submit a written letter of concern to our Clinic Administrator. You will receive notice of action taken within 10 working days.

****

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND I CONSENT TO TREATMENT.

BY FURNISHING MY EMAIL ADDRESS, I CONSENT TO THE USE OF EMAIL TO COMMUNICATE.

Email Address: ____

____ _______________________
(Name of Patient) (Date of Birth)

____ _______________________
Signature (clients age 14 years and above) (Date)

____ _______________________
Signature (Parent/Guardian/Legal Rep.) (Relationship to Client) (Date)

(If Guardian/Legal representative, please provide documentation of guardianship status.)

____ _______________________
Clinician's Signature (Date)

Please sign and return this form.

Children's Program 7707 S.W. Capitol Hwy. Portland, OR 97219
(503) 452-8002 www.childrensprogram.com

CONSENT FOR HEALTHCARE OPERATIONS

CLIENT____**DOB:**______________________

I understand I am financially responsible for all charges. Payment is due in full on the day of service. If the Children's Program agrees to bill insurance, I will pay co-payments, co-insurance or deductibles as required at each visit. I understand billing insurance is not a guarantee of payment. If my insurance denies coverage for services or procedures, I am responsible for the charges. Accounts must be paid in full within 90 days. Balances remaining after 60 days will accrue billing charges. Charges remaining after 90 days will be charged to the credit card on file to avoid further billing or collection fees.

- I request health insurance payments be made directly to Children's Program. If the insurance carrier sends payment to the patient/family member, I will forward payment to the Children's Program for credit to my account. **The Children's Program may disclose the information necessary to process my insurance claims to any person, corporation, or agency responsible for payment including: ______insurance carrier ______school ______other (specify)**

- I acknowledge that the patient does not hold Oregon Health Plan Insurance (OHP). If the patient unknowingly has OHP insurance, as either primary or secondary insurance, I waive the right to have OHP billed.

- In cases of divorce, the parent/guardian initiating service is responsible for the account and must sign this form. If that parent does not carry the client's health insurance, this form must also be signed by the individual who carries the insurance in order to submit a claim and have the benefits assigned to our office.

- I understand that I must call **DURING OFFICE HOURS** and give at least **24 business hours advance notice** when canceling an appointment. If I fail to do so, I understand I will be charged up to the full appointment fee.

- If I am receiving services under a managed care mental health insurance contract, I understand I may be required to obtain preauthorization before scheduling appointments. The health insurance carrier may limit the number of appointments I can schedule, or the time period in which appointments may occur. My health insurance may limit the types of procedures or diagnoses for which treatment is provided. I agree to be financially responsible for appointments that are not covered by health insurance because of breech of any of these conditions.

- If I choose to submit claims for services outside Children's Program insurance billing policies, I am aware that Children's Program will not accept assignment/provider discounts.

- I understand I must notify the Children's Program of any changes in my health insurance coverage prior to the next appointment. I understand the Children's Program will not retroactively bill for changes if insurance carrier.

- In the event of nonpayment of charges, the Children's Program shall be entitled to disclose information and recover all costs and expenses incurred in seeking collection of such charges including, without limitations, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, or mediation.

Patient care coordination standards strongly recommend the practice of sharing information with the patient's PEDIATRICIAN. I consent to the Children's Program exchanging information as appropriate.

____

Name of Pediatrician **Group Affiliation if Applicable**

____

Office Address

I have read and authorized the above.

____

Financially Responsible Party/Legal Guardian Date Relationship to client

Photo and Video Release Form for Minor Children

I hereby authorize Children's Program to publish the photographs and videos taken of me and/or the undersigned minor children, and our names, for use in Children's Program's printed publications, website and training purposes.

I release Children's Program from any expectation of confidentiality for the undersigned minor children and myself and attest that I am the parent or legal guardian of the children listed below and that I have the authority to authorize Children's Program to use their photographs, videos and names.

I acknowledge that since participation in publications and the websites produced by Children's Program is voluntary, neither the minor children nor I will receive financial compensation.

I further agree that participation in a publication and website produced by Children's Program confers no rights of ownership whatsoever. I release Children's Program, its contractors and its employees from liability for any claims by me or any third party in connection with my participation or the participation of the undersigned minor children.

Signature: ________________________________ Date: ____________________________

Street Address____

City, State, Zip: ____

Names and Ages of Minor Children:

Name:____________________________________ Age: _____________________________

Name:____________________________________ Age: _____________________________

Name:____________________________________ Age: _____________________________

EVALUATION OPPORTUNITY

FOR THE PARENTS OF STUDENTS IN THE AD/HD BEGINNER'S GROUP THERAPY PROGRAM

The literature suggests that AD/HD children are at risk for learning problems or underachievement. Despite this fact, many students are never tested to assess their learning styles. We believe that an evaluation helps us understand a student's learning strengths and weaknesses and to address their educational needs.

While schools are sometimes able to do testing, you must go through a screening process to decide whether your child is eligible for an evaluation. Often, schools must wait until a child falls far enough behind to warrant the testing. Students who are underachieving, but still performing near grade level, are rarely tested.

We are pleased to offer families in the AD/HD Beginner's Group an opportunity for a psychoeducational evaluation at a reduced cost. Participants will schedule a 3-hour visit with Children's Program Educational Specialist, Susan Hutchison, M.Ed. This will include 2½ hours of testing and a 30-minute feedback session. A test score summary sheet will be provided.

The cost for the evaluation, feedback session, and data sheet is $225. Call Mindy at (503) 548-4844 to schedule this.

Group Registration Form

☐ **Spring** ☐ **Fall** ☐ **Winter**

Child's Name: ____ DOB:________________

Address: ____

____

Parent / Guardian Name: ____

Phone Numbers: Day ________________ Cell _________________ Evening: ____________

E-mail ______________________________________

Has your child been seen at this clinic before? ☐ Yes ☐ No

If yes, for: ☐ evaluation ☐ therapy

Desired Group Name ____

Dates/Times ____

Please read the Financial Policy for Groups and call the office to determine if we bill your health insurance. Send this registration form with a photocopy of your insurance card, the Information and Consent for Payment and Healthcare Operations forms, and your deposit. A CREDIT CARD NUMBER MUST ACCOMPANY ALL REGISTRATIONS NOT PAID IN FULL. Balances owed 90 days after insurance has paid will be charged to this credit card. If you must cancel, please notify us within 4 business days prior to the start of the group so we can refund your registration fee. Cancellations received after that time will receive a refund, less a $35 administrative fee. We reserve the right to refund your registration by check. Your refund will be mailed to you within approximately four weeks.

Insurance Company: ____

Address: ____

Policy #: ___________________________ Group #: _____________________________

Policy Holder Name: ______________________________________ DOB: ________________

Employer: _____________________________________ Phone: _______________________

☐ **Check (please mail)** ☐ **Mastercard** ☐ **Visa** ☐ **Discover** ☐ **AMX** ☐ **PayPal**

(Provide credit card information below)

Cardholder's Name: ____

Card Number: ____ **Exp. Date:** ______________

Security Code: ________

Return this form by mail, fax or email to the Children's Program.

7707 SW Capitol Hwy, Portland, OR 97212

(503) 452-0084 (fax) info@childrensprogram.com