

**Check the summer block you wish to be enrolled in:**

1. **June 8<sup>th</sup> – July 1<sup>st</sup> – IEP Support**

2. **July 6<sup>th</sup> -August 1<sup>st</sup> - CAMP**

**Our summer camp fee is: \$475.00 per block.**

Services offered in our summer camp program may be eligible for insurance billing, and our team may submit a claim in advance to see if child can be covered. Families may also use HSA, FSA, and ESA for the program registration fees.

**Child Information**

First Name: \_\_\_\_\_ M.I.\_\_\_\_ Last Name:

Name child prefers to be called: \_\_\_\_\_ Grade/Class: \_\_\_\_\_

Child’s Address: \_\_\_\_\_

Gender: [  ] Male [  ] Female Date of Birth: \_\_\_\_\_ Child’s S.S. #: \_\_\_\_\_

**List any existing medical conditions, medication and/or special attention your child may require?**

\_\_\_\_\_

Allergies: \_\_\_\_\_

Pediatrician’s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Photographs: May we take and maintain a photo of your child for security purposes? [  ] Yes [  ] No

**Parent/Guardian Information**

**Mother/Guardian** First Name: \_\_\_\_\_ M.I.\_\_\_\_ Last Name: \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employed By: \_\_\_\_\_ Office Phone: (    ) \_\_\_\_\_

Work Address: \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

[X] Custodial Parent (If married, mark both parents) Email: \_\_\_\_\_

Marital Status:[  ] Married [  ] Single [  ] Divorced [  ] Separated [  ] Widowed [  ]

Other \_\_\_\_\_

**Father/Guardian** First Name: \_ M.I.\_\_\_\_ Last Name: \_\_\_\_\_

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

Occupation: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employed By: \_\_\_\_\_ Office Phone: (    ) \_\_\_\_\_

Work Address: \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

[ X ] Custodial Parent (If married, mark both parents) Email: \_\_\_\_\_

Marital Status: [  ] Married [  ] Single [  ] Divorced [  ] Separated [  ] Widowed [  ]

Other \_\_\_\_\_

**Payment Information:**

Amount: \_\_\_\_\_ [ ] **Block 1** June 8<sup>th</sup>    **Block 2** [ ] July 6<sup>th</sup>\_\_\_\_\_

Person responsible for bill: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Occupation: \_\_\_\_\_ Home Phone: (    ) \_\_\_\_\_

Employed By: \_\_\_\_\_ Employer address: \_\_\_\_\_

Employer phone no.: (    ) \_\_\_\_\_ Is this child covered by insurance? [ ] Yes [ ] No

Please indicate primary authorization method [ ] Visa [ ] Check [ ] cash [ ] Other

**Subscriber's name** First Name: Erin M.I. \_\_\_ Last Name: Schorr \_\_\_\_\_

Subscriber's S.S. no. \_\_\_\_\_ Birth date: \_\_\_\_\_

Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Child's relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

**Name of secondary insurance (if applicable):**

**Subscriber's name** First Name: \_\_\_ M.I. \_\_\_ Last Name: \_\_\_\_\_ Group no.: \_\_\_\_\_

\_\_\_\_\_ Policy no.: \_\_\_\_\_

Child's relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other

**Emergency Contacts & Authorized Pickup Persons:**

**1<sup>st</sup> Contact/Pick Up** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to the Child: grandparent \_\_\_\_\_

[ ] Able to pick up

[ ] Not able to pick up, use just as an emergency contact

**2<sup>nd</sup> Contact/Pick Up** Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to the Child: grandparent \_\_\_\_\_

[ ] Able to pick up

[ ] Not able to pick up, use just as an emergency contact

**Additional Comments & Information:**

Is there is any other information that that would be helpful to our management and clinical team?

\_\_\_\_\_

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize The Barry Group or insurance company to release any information required for reimbursement eligibility.

**Signature:**

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank You!**