Expressive Therapy Center, LLC
10810 Darnestown Road, Suite 103, N. Potomac, MD 20878
1320 Vincent Place, McLean, VA 22101
P: 301.869.1017, ext. 1 or 703.349.5225 ext. 1/ F: 301.755.9493

Today's Date: _____

Xpress Yourself Camp Application (2019)

**Please send completed application to camp@expressivetherapycenter.com or via fax at 301-755-9493*

Location [Please select location]

☐ **N. Potomac, MD** *10810 Darnestown Rd, Ste 103, N. Potomac, MD 20878*	☐ **McLean, VA** *1320 Vincent Place, McLean, VA 22101*

Session Preference [Please select session(s)]

☐ **Social Skills Session I** *July 15th – July 19th: 10am – 1:30pm*	☐ **Social Skills Session II (N. Potomac Only)** *July 22th – July 26th: 10am – 1:30pm*

Client & Contact Information

Client Name_____ DOB_____/_____/_____ Gender_____
School_____ Grade in Fall 2018_____

Home Address_____
Home Phone (_____) _____ - _____

Marital Status of Parent(s)/Guardian(s): Single / Married / Domestic Partners / Separated / Divorced / Widowed

Parent/Legal Guardian1:_____
Contact Info: Cell (_____) _____ - _____ Work (_____) _____ - _____

Parent/Legal Guardian 2:_____
Contact Info: Cell (_____) _____ - _____ Work (_____) _____ - _____

Emergency Contact:_____
Contact Info: Cell (_____) _____ - _____ Work (_____) _____ - _____

Medical Information

Medications _____
Allergies _____
MD _____ Phone (_____) _____ - _____
Will you be submitting for insurance reimbursement? ☐ Yes ☐ No

Cancellation Policy

100% Refund: Cancellation 2 weeks or more before session start. 50% Refund: Cancellation 1 week before session start.
No refunds within 6 days before session start. No charge to change sessions if openings are available.

Payment Information

Cost: **$385** (+ $20 material fee to be paid in CASH on the 1st day of camp - Please DO NOT include $20 material fee with application.)

Payment Method: ☐Cash ☐ Check#_____ ☐Visa/MC/Discover (Enter credit card info below.)

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ VISA/MC/AMEX/Discover Account #

☐☐ / ☐☐ Expiration Date

☐☐☐ Security Code

_____

Name as it appears on Credit Card Cardholder's Signature Date

*All credit card fields required. With my signature, I authorize Expressive Therapy Center to charge my credit card as noted above. I realize it is my responsibility to inform ETC of any changes to my credit card information.

Client Name: _____

What would you like us to know about your child?

_____
_____
_____
_____
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Before & After Care Sign Up

To be eligible for Before or After Care, you must sign up in advance.
Cost is $10/hour, to be paid in cash that day.

Earliest Drop-Off Time: 8:30am
Latest Pick-Up Time: 3:30pm

Day	*Early Drop-Off Time*	*Late Pick-Up Time*
Monday	_____am	_____pm
Tuesday	_____am	_____pm
Wednesday	_____am	_____pm
Thursday	_____am	_____pm
Friday	_____am	_____pm

How did you hear about our camp? (Please specify)

☐ Website_____ ☐ Doctor_____ ☐ Friend
☐ Magazine_____ ☐ Other_____

* Please expect a call from your child's therapist/counselor approximately 4 days in advance of your start date to discuss your particular goals. At the end of the camp, you will receive a statement in the mail that details charges and payments that will allow you to submit to your insurance carrier for potential reimbursement. *Please contact the administrative office at 301-869-1017 ext. 2 with any questions.*

Reminder: Please do not include $20 materials fee payment with camp application. This should be brought to your child's therapist on the first day of camp, in CASH ONLY. The camp fee of $385 should be included with the camp application, payable by cash, check or credit card.

ETC is not responsible for the children prior to or after the scheduled camp program, unless they are enrolled in Before or After Care. In the event of a medical emergency where the emergency contact cannot be reached, I authorize ETC to transport my child to the nearest emergency room.

Parent/Guardian Signature **Date**

For ETC Use Only

Copy for: ☐ Billing ☐ Director ☐ Therapist
Payment Rec'd? ☐ Billing Conf. Call: _____
Client Entered: ☐ Invoice Created: ☐
Pmt Entered: ☐ Inv & Stmt Printed: ☐

For ETC Use Only

Session: ☐ I ☐ II
Therapist: _____ Therapist Call: _____
End Mtg: _____ am/pm
Dx Needed? ☐ Yes ☐ No Dx Code: _____