Kids In Sync Summer Day Camp Registration – 4 and/or 8 week

Child's Name: _____Date of Birth_____

Address: _____City/State/ Zip:_____

Language Spoken at home: _____

Insurance Carrier:_____

Group #_____ Member ID_____

**Please provide us with a copy of your insurance card prior to the start of camp*

Pediatrician Name and Address:_____

Parent/Guardian_____

Home Phone: _____ Work Phone:_____

Cellular: _____ e-mail:_____

Parent/Guardian_____

Home Phone: _____ Work Phone:_____

Cellular: _____ e-mail:_____

Please indicate if both parents live with child: _____

Alternative Emergency Contacts

Name and Telephone Number (s):_____

Name and Telephone Number (s):_____

Name and Telephone Number (s):_____

Summer Camp Acknowledgements

I acknowledge that I am registering my child for the 2019 Summer Camp (Initial all that apply):

- 4 weeks from Monday, June 17th through Thursday, July 11th at a cost of $200 per day, Monday through Thursday. _____ (initial here)

  ***There will be no camp and no fees collected on Thursday July 4th**

- 4 weeks from Monday, July 15th through Thursday, August 8th at a cost of $200 per day, Monday through Thursday. _____ (initial here)

Medical History

Allergies, (Please list and indicate if your child carries an Epipen) _____

_____

_____

Dietary restriction

_____

_____

History of broken bones or fractures including dates

_____

_____

Please discuss any additional health issues, which have played a significant part in your child's development (frequent ear infections, surgery, health problems, etc.)_____

_____

_____

_____

Getting to know your child: Please provide answers that will help us better understand your child.

Temperament: _____

_____

Describe your child's play and favorite activities (i.e. prefer to play alone or with others, routine vs. exploratory play):_____

_____

How would you describe your child's social skills with both adults and children_____

_____

_____

Does he/she behave worse/better in a group setting?_____

Please describe your child's communication_____

Is your child toilet trained? Bowel and bladder_____

Does your child fall, crash, or bump into things?_____

Does your child demonstrate difficulty with transitions or changes in his/her schedule?_____

_____

Does it take a long time for your child to calm after being upset? If yes, what will usually calm him/her Down?_____

_____

Acknowledgment of Receipt of Kids in Sync Financial Policy Summary

Client Name:_____ **Date of Birth:**_____

The parent or legal guardian is responsible for payment. In consideration of services to be rendered, you, as the undersigned parent or guardian, agree to pay Kids in Sync for all services and supplies provided to you at the established rate, including any deductibles, co-payments or other charges, as permitted by third-party prayers. By signing the Financial Summary Policy, you accept responsibility for any costs, including attorney's fees incurred by Kids in Sync in the collection of these charges for examination, diagnosis and treatment received. Furthermore, you certify that the information given by you for purposes of payment is, to the best of your knowledge, complete and accurate.

- The full cost of the four-week camp is $3200.00. Some of the cost is billable to your insurance and is due at the time of receipt of your statement _____(*initial here)*
- You are ultimately responsible for payment of all services._____ (*initial here)*
- Should your account be delinquent for 30 days, Kids in Sync will automatically bill your credit card for the total payment as well as a $25.00 late fee. You will be responsible for any costs of collecting any past due balances, including collection and litigation costs.
  (*initial here)*
- There will be a $50.00 fee for any returned check (s). _____(*initial here)*

We require a valid credit card on file for all accounts with our clinic.

I understand and agree that I am responsible for the entire balance on my account, for all professional services provided to the child (or myself). I have read all the information contained in the financial policy and have completed the above answers. I certify that, to the best of my knowledge, this information is correct and true. I will notify the office in case of any changes to my dependents insurance coverage (or my coverage).

Signed:_____ Date:_____
(Signature of person financially responsible of the bill, Parent or Guardian)

VISA/MC/DISCOVER Credit Card #: _____Exp. Date:_____

Card Billing Address:_____

Credit Card Billing Zip Code:_____ CVV2 Code:_____

Signature of cardholder: _____

The following are our policies that govern insurance claims (PLEASE KEEP FOR YOUR RECORDS):

To expedite your child's care, we will submit claims to BCBS, but cannot guarantee the coverage of your services.

You (the parent) of the financially responsible party, will pay all past due portions of your charges not covered by insurance, specified by the insurance. This portion is due in full at the time of receiving your monthly statement. If payment is not received in a timely manner this may affect future appointments with your therapist. Your co-pay is due at the time of your visit. Please arrive 5 minutes early before your schedule time to sign in and make your co-payment.

All insurance information in required claim forms must be complete. If incomplete, we will be unable to appropriately bill the insurance company and the responsibility for payment then becomes that of the insured.

Our office does NOT guarantee that your insurance company will pay on claims. However, if for some reason, your insurance company pays differently than determined at the time of your visit, or your insurance claim is denied, you (the parent/ guardian) are then considered to be responsible for the full amount of the bill.

Insurance payments ordinarily are received within 30 to 60 days from time of submission. If your insurance company has not made payment to our office within 60 days, we request that you (the insured) pay the balance due, and then seek reimbursement from the insurance company when and if it is paid.

Our office will not enter into a "dispute' with BCBS over a claim, although we will work with the insurance company to sort any confusions or questions that may arise. If necessary we will request that you contact your insurance company to assist with the resolution of any problems.

Please contact your insurance company in advance to see if they cover the services we provide at out clinic.