



16815 S. Desert Foothills Pkwy. Suite 126, Phoenix, AZ 85048 | Phone 480.704.5954 | Fax 480.704.5807

**JUNIOR JABBEREE SUMMER DAY CAMP REGISTRATION FORM**

Child's Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Father/Guardian \_\_\_\_\_ Phone # \_\_\_\_\_ (cell / home / work)

Mother/Guardian \_\_\_\_\_ Phone # \_\_\_\_\_ (cell / home / work)

Primary email address \_\_\_\_\_

T-Shirt Size: (youth) \_\_\_\_\_ XS \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ L

**EMERGENCY CONTACTS**

Please list two emergency contacts we may use in the event you cannot be reached.

1. Name \_\_\_\_\_ Phone # \_\_\_\_\_ (cell / home / work)

2. Name \_\_\_\_\_ Phone # \_\_\_\_\_ (cell / home / work)

**TRANSPORATION**

Please list all people who will be providing transportation to and from Junior Jabberree Summer Day Camp.

\_\_\_\_\_

**MEDICAL**

Pediatrician/Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Child's Medical Condition(s)/Diagnosis \_\_\_\_\_

Does your child currently work with a behavioral therapist? \_\_\_\_\_ Y \_\_\_\_\_ N

Please list all medications currently taken by the child \_\_\_\_\_

Please list all known allergies \_\_\_\_\_

Special dietary restrictions and other considerations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Junior Jabberree

Summer Day Camp  
"We're the Talk of the Town!"

Junior Jabberree is a summer day camp whose program focuses on social skills to help your child learn to interact and communicate with their family and peers through a curriculum developed by speech pathologists and occupational therapists. The camp has a 4-week June session and a 3-week July session. The June session runs from June 4<sup>th</sup> through June 29<sup>th</sup>. The July session runs from July 9<sup>th</sup> through July 27<sup>th</sup>. You may register for one or both sessions. Each session has a 3 to 5 year old group and a 6 to 9 year old group that meet every Monday, Wednesday, and Friday from 8:30 until 11:30am. Each class is facilitated by a licensed speech/language pathologist and an occupational therapist or preschool teacher who will be assisted by 2 to 3 classroom aids. Each group will consist of no more than 15 children with approximately 5 of those being typical peer role models. Placement will depend on age, ability, group size, and group dynamics. DVPT reserves the right to place a child in a different group and/or to dismiss a child from the camp at any time for any reason. If your child is dismissed, DVPT will refund the tuition paid for the remaining sessions. There are no refunds if your child misses camp for illness.

I would like to register for:

\_\_\_\_\_ June Session **\$850.00**  
4 weeks  
June 4<sup>th</sup> – June 29<sup>th</sup>  
M/W/F 8:30am to 11:30am

\_\_\_\_\_ July Session **\$650.00**  
3 weeks  
July 9<sup>th</sup> – July 27<sup>th</sup>  
M/W/F 8:30am – 11:30am

**TOTAL AMOUNT DUE:** \_\_\_\_\_

Payment is due in full by May 31st for the June session and by June 30th for the July session. We require a \$100.00 deposit upon registration in order to hold your spot in the Junior Jabberree Camp. You will receive a \$50.00 discount if paid in full by April 30<sup>th</sup> for the June session AND another \$50.00 discount if paid in full by May 30<sup>th</sup> for the July session. We accept cash, checks and credit cards via PayPal. If you provide your insurance information we will gladly bill your insurance for therapy services rendered. Any payments made by your insurance will be refunded to you up to the amount paid. For questions regarding your insurance coverage, please contact Nancy at (480) 704-5954 or [nancy@dvpediatrictherapy.com](mailto:nancy@dvpediatrictherapy.com).



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Date payment received: \_\_\_\_\_ Type of payment: \_\_\_\_\_

### GOALS / EXPECTATIONS

What are your goals and/or expectations for your child while attending Junior Jabberee Summer Camp?

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Please indicate and describe which skills your child has difficulties with:

- \_\_\_\_\_ Make friends/Play with others \_\_\_\_\_
- \_\_\_\_\_ Use joint attention \_\_\_\_\_
- \_\_\_\_\_ Initiate interactions with a peer \_\_\_\_\_
- \_\_\_\_\_ Respond to interaction with a peer \_\_\_\_\_
- \_\_\_\_\_ Use greetings \_\_\_\_\_
- \_\_\_\_\_ Share appropriately with a peer \_\_\_\_\_
- \_\_\_\_\_ Defend self in a conflict \_\_\_\_\_
- \_\_\_\_\_ Stay on topic \_\_\_\_\_
- \_\_\_\_\_ Use turn taking appropriately \_\_\_\_\_
- \_\_\_\_\_ Use eye contact \_\_\_\_\_
- \_\_\_\_\_ Identify and express their own feelings appropriately \_\_\_\_\_
- \_\_\_\_\_ Identify and recognize other peers feelings \_\_\_\_\_
- \_\_\_\_\_ Use appropriate tone of voice and volume \_\_\_\_\_
- \_\_\_\_\_ Identify and respond to humor \_\_\_\_\_
- \_\_\_\_\_ Read body language and facial expressions of others appropriately \_\_\_\_\_
- \_\_\_\_\_ Use appropriate body language and face expressions \_\_\_\_\_
- \_\_\_\_\_ Follow directions \_\_\_\_\_
- \_\_\_\_\_ Flexibility \_\_\_\_\_
- \_\_\_\_\_ Accepts change in routine/schedule \_\_\_\_\_

Please list any other concerns you have regarding your child's social / communication skills: \_\_\_\_\_

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I, \_\_\_\_\_, have read the information from DVPT regarding the summer camp and understand my obligation to provide transportation for my child to and from Junior Jabberee in a timely manner. I understand the cost of the camp is to be paid in full on the last day of the month prior to the summer camp session. I understand the rights of Desert Valley Pediatric Therapy to dismiss my child from Junior Jabberee Summer Day Camp at any time and for any reason. I authorize the named physician to render such treatment as deemed necessary in an emergency, for the health of the child. In the event that physicians, parents, or other persons named cannot be contacted, Desert Valley Pediatric Therapy is hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of the child. Desert Valley Pediatric Therapy is not liable for accidents or injuries that may occur. Information on this form has been completed to the best of my knowledge.



# Desert Valley Pediatric Therapy

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Parent/Caregiver Signature \_\_\_\_\_

Date \_\_\_\_\_

## INSURANCE INFORMATION

<b>Patient Name</b>	Birthdate	Age	Sex	SS#
Address	City	State		Zip Code
Home Phone	Diagnosis			
Father				Mobile/Work Phone
Mother				Mobile/Work Phone

<b>Primary Insurance Plan</b>	Employer			
Policy Holder	SS#	Birth date		
Group #	ID or Policy #			
Effective date: _____/_____/_____	Termination date: _____/_____/_____	Phone		
Send claims to: Address	City	State	Zip	

<b>Secondary Insurance Plan</b>	Employer			
Policy Holder	SS#	Birth date		
Group #	ID or Policy #			
Send Claims to:	Phone			
Address	City	State	Zip	

### MEDICAL INFORMATION RELEASE

I hereby authorize the release of medical records, or copies of the records, to be transferred to Desert Valley Pediatric Therapy, Inc. 16815 S. Desert Foothills Pkwy. #126, Phoenix, Arizona 85048 with a fax number of (480) 704-5807. I also authorize Desert Valley Pediatric Therapy, Inc. to release information, records, or copies of records, pertaining to the diagnosis, as well as, treatments and examinations, which have been provided, to my insurance providers and my other health care agencies.

### FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services provided by Desert Valley Pediatric Therapy, Inc. and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance. Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment charges.

### CANCELLATION POLICY

Please notify your therapist as soon as you know you will be unable to maintain your scheduled appointment. Desert Valley Pediatric Therapy, Inc. receives no compensation for canceled appointments or 'no shows.' If you have 2 or more cancellations within in 4-week period, or 2 or more no shows, we reserve the right to discontinue services.

### ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to Desert Valley Pediatric Therapy.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## **BILLING INSURANCE WAIVER**

I understand that this notice is not a guarantee of payment. Benefits are subject to all contract limits and the member's status on the date of service. Accumulated amounts such as deductible may change as additional claims are processed. I understand that I am ultimately responsible for all charges assessed by Desert Valley Pediatric Therapy for the therapy services provided during Junior Jabberoo Summer Day Camp.

I will provide Desert Valley Pediatric Therapy with a doctor's prescription containing the following information before the summer camp begins:

- Type of therapy
- Dates therapy provided (i.e. 6/4/12 to 7/27/12)
- Frequency of therapy (i.e. 3x weekly for 7 weeks)

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Parent/Guardian Signature

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Date



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## PERMISSION TO TAKE PHOTOS/VIDEO

I \_\_\_\_\_, parent/guardian of \_\_\_\_\_,

(please circle one) DO / DO NOT give permission to Desert Valley Pediatric Therapy, Inc. to photograph and/or video my child during Junior Jabberee Summer Day Camp for the purpose of using said photographs or videos for instruction, demonstration and/or utilization in brochures and/or website for marketing by Desert Valley Pediatric Therapy, Inc. No other uses of these photographs/videos will be granted unless further agreed by me at a further date.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



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