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## GROUP THERAPY ENROLLMENT FORM

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ EMAIL: \_\_\_\_\_

COMING WITH SPOUSE/FRIEND: YES NO DOB: \_\_\_\_\_

I would like to join the Therapy Group that meets alternating days: (circle one)

Wednesdays 8:00-8:55 pm (adults)

1. I understand that I must commit to a minimum of ten (10) consecutive sessions.
2. I understand that these 10 sessions must be prepaid & the monies paid are non-refundable.
3. I understand if I am using my insurance for payment I am responsible for the copay if I attend or the full amount if I am absent from one of these sessions.
4. I may pay with check(s), cash or credit card.
5. I understand the commitment is to the group.
6. The sessions will run 55 minutes and will cost \$75 per session. Insurance is accepted.
7. After the required 10-session requirement is met group members who continue will be expected to attend regularly.
8. Each group member will be financially responsible for absences greater than 2 in a 52 week period starting from the time the 10 pre-paid session requirement is met.
9. I understand that I am responsible for payment of the group session WHETHER I ATTEND OR NOT until the 10-session requirement is met.
10. If the group does not meet due to Dr Allender's cancellation it will not count towards the allowed 2 absences.
11. Formal termination means informing Dr Allender of the desire to terminate, attending one last session & announcing to the group that it will be the last session.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME \_\_\_\_\_