The Bethesda Group

7990 Old Georgetown Road, 10A
Bethesda, MD 20814
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p: 301.718.4544 / f: 301.478.9899 / info@thebethesdagroup.com

Today's Date: ________________

2020 DBT Skills Summer Boot Camp

**Please send completed application to info@thebethesdagroup.com, fax 301-478-9899, or mail to The Bethesda Group, 7990 Old Georgetown Road, Suite 10A, Bethesda, MD 20814*

Session Preference [Please select session(s) Check ALL if you are doing the entire program]

☐ **Session I: 9 am to 10:30 am:** ***Distress Tolerance*** *June 22nd-June 26th*	☐ **Session II: 9 am to 10:30 am:** ***Emotion Regulation*** *June 29th – July 3rd*
☐ **Session III: 9 am to 10:30 am:** ***Interpersonal Effectiveness*** *July 6th – July 10th*	☐ **Session IV 9 am to 10:30 am** ***Walking the Middle Path*** *July 13th – July 17th*

Client & Contact Information

Client Name________________________________DOB_____/_____/_____ Gender________
School______________________________________Grade in Fall 2020____________

Home Address____
Phone (__________)________- __________

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

Parent/Legal Guardian1:____
Contact Info: Cell (_____)________-__________Work (_____)________- __________

Parent/Legal Guardian 2:____
Contact Info: Cell (_____)________-__________Work (_____)________- __________

Emergency Contact:____
Contact Info: Cell (_____)________-__________Work (_____)________- __________

Payment Information

Cost: Intake $250, DBT Boot Camp $2700 for the 4 week 30 hour program, $725 for a 7.5 hour week (choose which week). There are no refunds.

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

VISA/MC/AMEX/Discover Account # | Expiration Date __ / __ | Security Code

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

*All credit card fields required. With my signature, I authorize The Bethesda Group Psychological Services, LLC to charge my credit card as noted above. I realize it is my responsibility to inform TBG of any changes to my credit card information. I understand that all payments are final and non-refundable.

Client Name: ______________________________

Please tell us about what you hope to get out of participating in this program. For parents, what would you like your teenager or young adult to get out of this program?

How did you hear about our program?

* Upon completion of the program, 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.

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Participant Signature **Date**

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Parent/Guardian Signature **Date**