

CHKD Registration Form
Healthy You Weight Management Program

REGISTRATION INSTRUCTIONS

Return this completed registration form along with your non-refundable check or money order for \$350 plus your mental health co-pay, payable to CHKD. The mental health portion minus your co-pay will be billed to your insurance, if applicable. You are responsible for the total mental health cost (\$130) if your insurance does not cover this visit. Please also send a copy of the front and back of your insurance card. We need your pre-authorization number and a copy of the authorization letter if mailed to you for the mental health portion.

Limited tuition assistance is available depending on financial ability. If your child is on Medicaid or disability, please check here and send a copy of front and back of the child's insurance card.

CHILD AND ADULT INFORMATION

Child's Name: _____

Parent or Guardian's Name: _____

Relationship to Child _____

Home Phone: _____

Work Phone _____

Address: _____

Parent's Email _____

Child's Email _____

Age of Child _____ Date of Birth _____ Gender: Male Female

When was the child's last doctor appointment? _____

Child's Doctor, Address, and Phone (this must be completed) _____

Starting Date of the Class You are Interested In _____

MAILING INSTRUCTIONS

Mail this completed registration form and payment to:

Children's Hospital of The King's Daughters
601 Children's Lane
Norfolk, VA 23507
Attention: Babs Benson, Community Outreach

CREDIT CARD INSTRUCTIONS

If paying by credit card, please complete the information below.

Credit Card: Master Card VISA American Express

Credit Card # _____

Expiration Date: _____ Amount of payment: _____

Name as it appears on card (please print) _____

Signature: _____

If you have questions about the Healthy You program, please contact Babs Benson at 668-7035.