

# THINKING WELL

## Registration Form

**Personal Information:**

Title: \_\_\_\_\_

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_

E-mail: \_\_\_\_\_

Contact Numbers: (H) \_\_\_\_\_ (M) \_\_\_\_\_

Date of Application: \_\_\_\_\_

Preferred Start Date:  February  May  July  October

If applicable, please circle your individual therapist's name below:

- |         |        |          |            |         |
|---------|--------|----------|------------|---------|
| Heather | Nerida | Rowena   | Anne-Marie | Marissa |
| Louise  | Ester  | Jennifer | Clare      | Nicole  |

Do you have any special dietary requirements? (If so, please specify):

\_\_\_\_\_

**By registering for this Group Program I agree/understand:**

- That to the best of my knowledge, I am not aware of any other persons I know attending the group
- That if I cancel within 24 hours of the commencement date, I will be billed for the full cost of the program
- To give permission for Dr Sarah Cotton to speak with my individual Psychologist (if appropriate) prior to the commencement date

Signature \_\_\_\_\_

Note. Full payment is due on the day of Group commencement; More detailed program information and confirmation of attendance will be sent by the Practice Administration Manager in advance of the first session.