The Wake • Kendall Group PLLC
Psychotherapy & Assessment

5247 Wisconsin Avenue NW Suite 4
Washington, DC 20015
Attention: Admissions Testing

Please print the completed form and MAIL it to the address above accompanied by a check for the designated amount or with your credit card information.

ADMISSIONS TESTING REGISTRATION FORM

Child's Name _____

Child's Date of Birth _____ Sex ☐ Male ☐ Female

Gender: ☐ Male ☐ Female ☐ Genderqueer ☐ Other _____

☐ Transgender male/Trans man/Female to male ☐ Transgender female/Trans female/Male to female

Preferred Pronoun: ☐ He/Him ☐ She/Her ☐ Ze/Zey ☐ They/Them ☐ Other _____

Parent(s) Information:

Full Name _____

Address _____

City_____ State_____ Zip_____

Parent Email address _____

Telephone Numbers _____

Full Name _____

Address _____

City_____ State_____ Zip_____

Parent Email address_____

Telephone Numbers _____

Has child had previous Admissions Test? _____Yes _____No

If Yes, Date of Test (Month and Year) _____

* My signature below indicated that I understand that a refund will be issued if I cancel at least **3 business days** in advance.

Signature _____ **Date**_____

__ (Initial) I elect to pay for the assessment by **credit card**.

__ (Initial) I am **enclosing a check** for assessment.

CREDIT CARD INFORMATION

Cardholder's Name: _____ Amount:_____

Address: _____ City: _____ State: _____ Zip:_____

Cardholder's Signature: _____ Date: _____

Type of Credit Card: _____ Credit Card #: _____

Expiration Date: ____/_____ 3 or 4 Digit Security Code: _____