

Registration Form
By Michele O'Mara, LCSW
6450 West 10th Street, Indianapolis, IN 46214

Please print, complete, sign, and mail (if using check) or fax to 317.244.8425

- Option A** – Pay by Check
- Option B** – Pay by Visa or MasterCard

CREDIT CARD INFORMATION

Full Name on Credit Card _____

Credit Card Billing Address _____ **City** _____

State / Province _____ **Postal Code** _____

Billing Phone # _____ **Email** _____

Card Type **VISA** **MasterCard** **Card#** _____

Exp. Date _____

REFUND POLICY: Make all requests for a refund by email, in writing, or by fax. If you have not received a response by Michele O'Mara, LCSW to your request for a refund within 24 hours, resubmit or assume it has not been received. All refunds requested 31 days or more in advance of the scheduled activity (workshop, class, etc.) will be provided in full, by check. Refunds requested on or within 30 days prior to the event will be given minus a 30% cancellation fee.

I hereby confirm that I have read and understand the Refund Policy (above) and agree to the Financial Arrangement chosen above. If I have chosen Option B or C, I authorize the Michele O'Mara, LCSW to charge a total of \$_____ to my credit card.

Signature: _____ **Date:** _____