

Thank you for requesting an **ADULT** application package. We look forward to getting to know you and providing you with our unique services.

To get started with the NACD program, you must complete these steps:

1. Purchase and listen to the *Parent Education Series – Guide to Child Development and Education* CD series. If you have not already ordered this series, please visit our website (www.nacd.org) or contact the National Office at 801-621-8606 to place your order.
2. **Read** the forms enclosed in this application package. They explain important information about how to participate in the NACD program.
 - NACD Chapters and How They Work
 - How to Schedule an Appointment
 - NACD Service Locations
 - Fee Schedule
3. Fill out and **sign** the following forms enclosed in this application package.
 - Client History
 - Payment Authorization
 - Confidentiality Agreement
4. **Return** your completed application along with the deposit for your first evaluation (see Fee Schedule) to:
NACD National Headquarters
549 25th Street
Ogden, UT 84401-2422
Fax – 801-621-8389
Email – denise@nacd.org

The application takes 3-4 weeks to process. A representative will call you regarding your acceptance.

For more information about NACD (including complete descriptions of services, fees, chapter locations, journal articles, family testimonials, etc.), please visit our website at www.nacd.org.

NACD CHAPTERS AND HOW THEY WORK IMPROVING LIVES AND IMPACTING COMMUNITIES

NACD works with some of the best families in the world. When these families get together to change how their communities view individuals with delays, they can make a resounding difference. How does this work? It works best when NACD families join forces with other NACD families within a geographic area to effect change.

NACD is able to serve the most clients in our main offices in Utah, Pennsylvania, and Texas. However we do have a number of local chapters where we work with parent groups in that location. Our ability to travel to these chapters and conduct evaluations there is dependent upon the local families being able to build and maintain the client base. NACD does not guarantee that we will be able to continue traveling to a particular chapter, although we will make every feasible effort to do so.

Each quarter as NACD evaluators travel to various branches, in addition to holding individual evaluations, they are able to meet with families to discuss new approaches and changes within NACD. They also have the opportunity to discuss ways in which families can have an impact on their communities. Most ideas in this regard actually come from the parents who know their communities the best. The meetings serve as an opportunity to share ideas and build networks among the families. They also serve as an opportunity to allow individuals considering NACD and interested professionals, such as teachers and therapists, learn more about us.

What do families in an NACD chapter do to change their community?

They look for opportunities to educate others within their community about the potential of individuals who have been labeled with delays. They spread the word to other families who are seeking help. They assist in organizing meetings and participate in these meetings. They network with local support groups and organizations in order to educate them regarding new approaches to working with children with delays.

These efforts have a ripple effect that does impact the community, the schools, the professionals, service organizations, and more.

An excellent example of this is our St. Louis chapter parent group. This powerful group of parents has brought in many new families and have located and participated in conferences, association meetings, and parent groups in their community. They have spread the word of new interventions and provided a clearer understanding of what causes delays and how to fix them. They continue to make their voices heard within their community. What have been the results of their efforts? They have expanded their chapter. They have educated many new families, teachers, therapists and physicians in their community. They have made an impact on agencies within their state, such as the Department of Mental Health.

How do parents in NACD chapters help each other?

One of the many benefits of the Parent Meeting is that it allows parents to meet each other face to face and get to know each other. Talking with and getting to know other NACD families brings a welcome sense of community. You are not in this alone! Things parents have shared to help each other include local physicians who have been helpful, sources of less expensive organic foods, babysitters, places to find materials locally, sources of supplements locally, fun activities to do with kids locally, volunteers and more. Some chapters have set up Mom's Nights Out. Some have organized picnics and barbecues. Groups have set up directories to make contacting each other and communicating easier. Many parents find this additional support invaluable in moving forward with their NACD program.

Building and maintaining your Chapter

NACD is a powerful group of families and staff working together to effect change in individuals and in communities. In order for evaluators to help the most individuals, we continue to build our three base offices, which are in Utah, Texas, and Pennsylvania. Our ability to work with individuals in chapters is based entirely on the ability of parents in a geographic area to build a big enough base to make and keep that chapter viable. We salute our marvelous parent groups who are working together to educate their communities, bring together new families in search of help, and support each other in moving forward. We also salute families seen at the base offices who also work to be voices in their communities to educate others.

HOW TO SCHEDULE AN APPOINTMENT

Any family interested in receiving a NACD TDI Targeted Developmental Intervention™ program is required to complete the following steps:

- Purchase the *Guide to Child Development and Education - Miracles of Child Development* audio series. This series provides a basic understanding of the NACD approach to child development and education.
- Listen to the series and complete the note outline enclosed with the CD set.
- Complete the contents of the application package in its entirety.
- Return the completed application package along with your deposit for the Initial Evaluation to the National Office.
- Families are required to have access to high-speed internet to view program videos, along with an active email address. If you don't have high-speed internet access at home, you will need to have an alternate plan, such as going to your local library, using a spouse's computer at work, taking a laptop to an establishment that offers internet access, or asking a neighbor, friend or family member if you can view program video clips at their home.

You will be contacted by our office approximately 3-4 weeks after your application package and deposit have been received and reviewed. At that time, NACD will conduct a preliminary interview prior to your acceptance into the program.

NACD SERVICE LOCATIONS

National Office

549 25th Street Ogden, UT 84401
801-621-8606
info@nacd.org

Regional Centers

Northeastern
West Chester, PA

Southwestern
Dallas, TX

Current Chapter Locations

NACD is able to serve the most children in our main offices in Utah, Pennsylvania, and Texas. However we do have a number of local chapters where we work with parent groups in that location. Our ability to travel to these chapters and conduct evaluations there is dependent upon the local families being able to build and maintain the client base. NACD does not guarantee that we will be able to continue traveling to a particular chapter, although we will make every feasible effort to do so.

Arizona
Phoenix

Georgia
Atlanta

Missouri
St. Louis

California
Greater Los Angeles area

Idaho
Boise

Ohio
Cincinnati

California
Greater Sacramento area

Illinois
Chicago

Virginia
Charlottesville

Florida
Ft. Lauderdale

Minnesota
Minneapolis

Washington
Seattle

Florida
Orlando

Wisconsin
Greater Milwaukee area

International Locations

India
New Delhi

Fee Schedule

October 2009

Family Membership

NACD is a membership organization. The first day of the month after the Initial Neurodevelopmental Evaluation, families will begin paying a monthly membership fee. This fee will cover the basic services provided by NACD in that month. Services include:

1. Unlimited support from our qualified staff through telephone consults, video consults, program reviews, monthly reports and email.
2. Every three months of paid membership, the client will be eligible to receive a re-evaluation. A revised TDI Targeted Developmental Intervention® and program training will be sent via email after each re-evaluation.

Members are encouraged to contact NACD by email or phone to get answers and support any time during their membership.

The monthly membership fee is charged to your credit card or checking account on the first day of each month. Membership continues until such time as the family chooses to stop receiving services and notifies NACD in writing (e-mail is acceptable) of their desire to terminate services. (Letters and reports beyond the scope of the normal NACD evaluation process will require an additional charge.)

Initial Evaluation

The initial evaluation includes a neurodevelopmental evaluation, TDI Targeted Developmental Intervention®, and program training on the internet. A deposit* is required to schedule an initial appointment. Two weeks before the appointment, the balance will be collected via payment authorization. (Deposits will be refunded in full if the appointment is cancelled at least four weeks prior to the schedule appointment day.)

Revisit Evaluation

As stated above, the monthly fee covers re-evaluations, which are scheduled every three months. After a re-evaluation, you will be given a revised TDI Targeted Developmental Intervention® and program training on the internet.

Client Fees

First Family Member

Initial Evaluation

Total Fee: \$950***
Deposit: \$500

Family Membership which includes an evaluation every third month \$210 a month

Additional Family Members**

Initial Evaluation

Total Fee: \$550***
Deposit: \$250

Revisit Evaluation

Total Fee: \$350
Deposit: \$250

*** In these difficult economic times NACD recognizes that many families are having difficulty making ends meet. **We do not want to deny anyone needed services;** therefore we will temporarily provide up to a \$500 scholarship for initial/new families and a scholarship of up to \$200 for any initial second family members. If you are in need of this scholarship, or a part of it, you merely need to make the request when you submit your application. Providing this assistance is very challenging for us as an organization. Therefore we ask that you only request the amount of assistance that you truly need.

Deposits are due when the appointment is scheduled; then, two weeks prior to the appointment, the balance will be collected via payment authorization. A fee of \$25 will be charged to any credit/debit card account not clearing the charges. Deposits will be refunded in full if the appointment is cancelled at least four weeks prior to the scheduled appointment day.

**To receive the Additional Family Members Discount, a family must be a current NACD Family Member.

Rescheduling Fee

A fee of \$100 will be charged for any revisit evaluation that is rescheduled two weeks or less before the appointment.

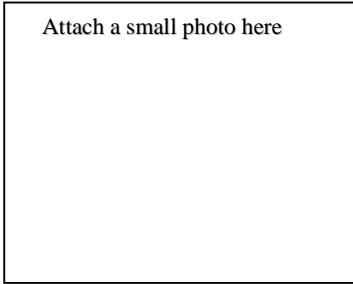
**All fees are for stated services only and are subject to change without notice.



549 25TH STREET
OGDEN, UT 84401-2422

**ADULT
APPLICATION PACKAGE
EFFECTIVE OCTOBER 2009**

CLIENT'S NAME



CLIENT HISTORY – ADULT

Today's Date _____ Form is completed by: Self Parent Guardian (please check one)

Client's Name _____ Date of Birth (mth/day/year) _____

Address _____ Phone (international families please include the country code)

City _____ Home _____

State _____ Zip Code _____ Work _____

Country _____ Cell _____

Occupation _____ Primary Email _____

Mailing Address (if different from above) _____

Client lives with Self Spouse Parent Guardian Other _____

Was the client adopted? yes no If yes, at what age? _____ Gender _____ Male _____ Female

Spouse/Parent/Guardian's Name _____ Date of Birth _____

Address _____ Phone (international families please include the country code)

City _____ Home _____

State _____ Zip Code _____ Work _____

Country _____ Fax _____

Education completed _____ Cell _____

Occupation _____ Email _____

Children Information

<u>Children</u>	<u>On NACD</u>	<u>Children</u>	<u>On NACD</u>
	<u>Program?</u>		<u>Program?</u>
Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ Age _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

At what location would you like your appointment scheduled? _____

Office Use _____

How did you become aware of NACD?

- NACD Family
- Professional Group (Please specify) _____
- Publication (Please specify) _____
- Internet (Please specify) _____
- Other (Please describe) _____

Have you listened to Guide to Child Development and Education "Miracles of Child Development" CD series by Robert J. Doman Jr.?

Client yes no Spouse yes no Parent/Guardian yes no

MEDICAL HISTORY

Family Physician _____ Telephone _____

Address _____

Client's birth weight _____ lbs _____ oz. Length of pregnancy _____

Complications during pregnancy and/or delivery? yes no If yes, please describe _____

Has the client ever had a head/brain injury? yes no If yes, please describe _____

_____ Date(s) _____

Pertinent medical, neurological, visual, hearing, therapeutic, psychological or educational testing:

Date	Examined by	Diagnosis	Recommendations
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries? yes no Please describe _____

Seizures? yes no Frequency of Seizures _____ Length _____

Type(s) _____

Currently taking seizure medication? yes no List medication(s) _____

Seizure medications taken previously? yes no List medication(s) _____

Currently taking other medications? yes no List medication(s) _____

Are there any medical problems which place limitations on physical activity, etc.? yes no List _____

Broken limbs? yes no List specifics _____

HEALTH

Was the client nursed? yes no If yes, until what age? _____

Describe the client's diet _____

	Excessive	Daily	Weekly	Rarely	Never
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Colorings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White Flour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List dietary supplements and vitamins

Food allergies? yes no never tested _____

Food cravings? yes no

Picky eater? yes no

Overeats? yes no

Allergies? yes no If yes, please describe _____

Poor appetite? yes no

Does the client have a history of colds or sinus congestion? yes no

Does the client have a history of ear infections? yes no

If yes, which ears have been affected? left right both

How many? _____ Over what period of time? _____

Does the client have Tinnitus? yes no

If yes, which ears have been affected? left right both

Is the Tinnitus continuous intermittent

Does the client have a hearing loss? yes no

If yes, which ears have been affected left right both

Degree of hearing loss _____

Does the client have hypersensitive hearing? yes no

Has the client had a tympanogram, audiogram, ABR? yes no

If yes, what were the results _____

Has the client had an eye examination? yes no

Does the client wear glasses or contact lenses? yes no

If yes, what is the prescription _____

Has the client been diagnosed with any of the following: (please check)

- near sighted far sighted astigmatism amblyopia
- strabismus macular problems glaucoma cataracts
- nystagmus blind cortical blindness other

Has the client ever received vision therapy? yes no Please comment _____

Sleep times from _____ to _____ Naps from _____ to _____

Physical activity

Types of activities	Duration	Days per week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the client currently seeing a specialist? yes no

- Neurologist Occupational therapist Other
- Psychiatrist Physical therapist _____
- Psychologist Speech therapist _____
- Orthopedist EEG Neurofeedback therapist _____
- Cardiologist Vision therapist _____
- Osteopathic Physician Music therapist _____
- Naturopathic Physician AIT, Tomatis, Sound therapist _____
- Chiropractor Counselor _____
- Tutor _____

Other health problems? yes no List _____

BEHAVIOR

Does the client have a history of emotional or behavioral disorders? yes no

Please describe _____

Is there a family history of emotional or behavioral disorders? yes no

Please describe _____

Client's specific positive behaviors _____

Client's specific negative behaviors _____

Do you have specific behavioral goals for the client? yes no

Please describe _____

distractibility	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	avoidance behavior	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
short attention span	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty following directions	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
hyperactive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with parents	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
hypoactive (low activity level)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with siblings	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
rigid or inflexible	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with teachers	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
impulsive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	difficulty with peers	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
temper tantrums	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive to sound	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
sucks thumb	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive to touch	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
few or no friends	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive to odors	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
socially immature	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	tics	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
perseverating (talking on a topic)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	phobias	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
low frustration level	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	emotional	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
overreacts	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	overly sensitive	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
destructive behavior	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	high tolerance for pain	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
aggressive behavior	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	low tolerance for pain	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
cyclical behavior (good days/bad days)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	compliant	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
academic output (good days/bad days)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	cooperative	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
achievement	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	obedient	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
(high in some cases, but low others)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	organized	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
disorganized	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	flexible	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
likes competitive games	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	social	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

PHYSICAL MOTOR SKILLS (please check problem areas)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> low muscle tone | <input type="checkbox"/> walking | <input type="checkbox"/> balance |
| <input type="checkbox"/> high muscle tone | <input type="checkbox"/> running | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> coordination | <input type="checkbox"/> athetoid movement | _____ |
| <input type="checkbox"/> crawling (on stomach) | <input type="checkbox"/> ataxic | |
| <input type="checkbox"/> creeping (on hands and knees) | <input type="checkbox"/> weak | |

HAND PREFERENCE

	Right	Mixed	Left
writing	_____	_____	_____
eating	_____	_____	_____
throwing	_____	_____	_____
brushing teeth	_____	_____	_____
combing hair	_____	_____	_____
other _____	_____	_____	_____
_____	_____	_____	_____

LANGUAGE AND READING SKILLS

articulation problems	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure		
stammer or stutter	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	letter reversals	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
Aphasia	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	mirror writing	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
poor pencil grasp	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	right, left confusion	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
sloppy writing	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	poor judge of time	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
poor reading ability	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	poorly organized	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
difficulty copying from a blackboard	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure		

MATH RELATED (check areas of concern)

computation	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	word problems	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
concepts	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	poor logic	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure

COGNITIVE (check areas of concern)

Visualization	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	Short-term Memory	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
Long-Term Memory	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure	Forgetful	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure
Conceptualization	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure		

DEVELOPMENTAL HISTORY

Age.....

crawled (on stomach)	_____years	_____months
crept (on hands and knees)	_____years	_____months
walked	_____years	_____months
toilet trained	_____years	_____months
first word	_____years	_____months
use of couplets (two words together)	_____years	_____months
3-4 word phrases	_____years	_____months
sentences	_____years	_____months
conversational language	_____years	_____months
read	_____years	_____months

Does the client enjoy watching television? yes no

Speech and language problems? yes no

Does the client enjoy being read to? yes no

Fine motor problems? yes no

Does the client enjoy reading books? yes no

Gross motor problems? yes no

Does the client bed wet? yes no

List client's preferred free time activities

EDUCATIONAL HISTORY

Present educational placement

Days per week _____

Hours of attendance _____

Home School Private Charter Behavioral Public college/university Special _____

List all schools/programs attended, years attended and grade(s) completed.

List any educational problems (past or current)

List any labels, classifications, or educational diagnoses (past or current)

List any exceptional abilities, academic, physical, artistic, musical, etc.

List any classes/lessons the client is enrolled in (musical, physical/sports, art, languages, etc.)

Are there any events which may be currently affecting the client adversely? yes no

Please describe _____

GOALS AND PLANS

What are your goals and expectations?

Professionally: _____

Academically: _____

Personally: _____

Who will implement the program? _____

Daily length of time parents can work with client _____

Daily length of time others can work with client _____

The National Association for Child Development is an organization of parents and professionals dedicated to assisting individuals in the achievement of their innate potentials. Program recommendations are not medical, therapeutic, or psychological prescriptions. Program recommendations are offered for the client and families' review, investigation and education. Application of said procedures is the responsibility of the client and family. Robert J. Doman, Jr., (founder), is an educator. He does not, nor is he licensed to, practice medicine. If medical or other licensed professional advice is needed, the family is urged to consult a licensed physician or other licensed professional.

I acknowledge that I have read and completed this information to the best of my knowledge and ability, and that I understand that neither NACD nor those trained by or employed by NACD are assuming responsibility or liability for the client, and that I, as parent, guardian or client, assume full responsibility.

Signature _____ Date _____

Signature _____ Date _____

Client Name _____

Commitment and Confidentiality Agreement

This Agreement is between the National Association of Child Development (“NACD”) and the client identified below.

The National Association for Child Development (NACD) is an international organization that exists to gather, evaluate, and disseminate information and procedures relative to human development.

We empower individuals with the specific expertise to assume primary responsibility for their maximum growth and development.

NACD dedicates its time to individuals who are committed to helping themselves. As such, we are limited in the number of families we can serve.

Development and neurological organization is an ongoing process. It takes hard work, a great deal of time and energy. All of our families have committed their time and energy to ongoing education through the evaluation process.

Your commitment is important to your progress.

- *We the undersigned understand the commitment NACD has made to assist individuals in helping themselves realize their fullest potential.*
- *We commit to working with other chapter members to raise awareness of NACD in our community and to help maintain a large enough base to make and keep our chapter viable.*
- *We commit to doing our best in using the knowledge gained to help work toward his/her fullest potential through the use of the NACD program designed.*
- *We understand that we are required to have an active email account.*
- *We understand that we will need high-speed internet to access program videos. If we don't have high-speed internet access at home, we will have an alternate plan, such as going to our local library, using a spouse's computer at work, taking a laptop to an establishment that offers internet access, or asking a neighbor, friend or family member if we can view my program video clips at their home.*
- *To meet these specific needs, we agree to meet the evaluation requirements by traveling quarterly to our assigned NACD location.*
- *If we should break this commitment, please give our appointment slot to another family. We understand this will drop us from NACD's caseload. Should we wish to return, we understand we will be put on the National waiting list to return as a new client.*

NACD will create an individualized TDI Targeted Developmental Intervention® program that will be made available via the internet. The information contained on these videos is highly confidential and valuable proprietary information of NACD.

In consideration of the services provided by NACD, we agree as follows:

- *We understand that the information provided to us by NACD is highly confidential and valuable proprietary information of NACD.*
- *We agree that we will not copy or share any of the information provided to us by NACD with any third party unless they are directly involved with treatment and care of client.*
- *We understand that the information provided to us is specific to the needs of the client and agree that it will only be used for our personal, noncommercial use. We agree that we will not use the information, or allow it to be used for or by any other person.*
- *We understand that if we share this information with others, or allow it to be used by others, we will cause irreparable harm to NACD and will be liable to NACD for any resulting damages.*

Name of Client: _____

Name of Parent(s)/spouse: _____

Address: _____

Signature: _____

Date: _____ Email Address: _____

Client Name _____

NACD MEMBERSHIP PAYMENT AUTHORIZATION

We understand that the first day of the month, after our Initial Evaluation, our credit/debit card or checking account will be charged the monthly membership fee the first of each month, until such time as we choose to officially stop receiving services and notify NACD in writing. We understand that if our credit/debit card does not clear that our secondary account will be charged. If neither clears there may be a \$25.00 fee.

If fees are to be paid by a second party, we understand that if services are provided and fees are not paid by second party, we are personally responsible for payment of those fees.

I authorize the National Association for Child Development, Inc. ("NACD") to charge my account listed below for all fees and charges incurred as a result of the goods and services provided to me by NACD. My signature below will be considered to have been made on the applicable account voucher, and I authorize NACD to fill out and sign the voucher on my behalf. If NACD is unable to collect the assessed fees and charges from my account, I agree to pay NACD such amounts upon demand. If I fail to do so, I will pay interest to NACD on the unpaid amounts from the date due until the date paid at the rate of one and one-half percent (1.5%) per month and all of the costs of collection, including reasonable administrative fees, attorneys' fees, and costs.

Responsible Party: _____

Street address: _____ Zip Code _____

Primary Account

Credit Card Debit Card Name as it appears on card _____

Credit/Debit Card Number _____

CVC# _____ Exp Date _____

Secondary Account

Credit Card Debit Card Name as it appears on card _____

Credit/Debit Card Number _____

CVC# _____ Exp Date _____

SIGNATURE - required

Signature

Signature

Date

Email Address