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

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

1. Read the forms enclosed in this application package. They explain important information about how to participate in the NACD program.
    - How to Schedule an Appointment
    - NACD Service Locations
    - Membership Schedule
    - NACD Chapters and How They Work
2. Fill out and sign the following forms enclosed in this application package.
    - Client History
    - Payment Authorization
    - Confidentiality Agreement
3. Return your completed application and letter of endorsement (optional), along with the deposit for your first evaluation (see Membership Schedule) to:

    NACD National Headquarters
    5492 S 500 E
    Washington Terrace, UT 84405
    Email: pam@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, current chapter locations, journal articles, family testimonials, etc.), please visit our website at:

www.nacd.org

International Headquarters 5492 S 500 E - Washington Terrace, UT 84405 ph: 801.621.8606 email: info@nacd.org www.nacd.org

Thank you for your interest in the National Association for Child Development.

NACD is an organization of dedicated parents and professionals founded in 1979 by internationally recognized educator and lecturer Robert J. Doman, Jr. NACD has developed a unique and effective approach to enhancing the development and function of children and adults. NACD believes in the innate potential of every child and works with families to help every child reach their full potential.

Over the years we have seen educational and health-related fields become more and more compartmentalized. Treatment approaches have come to be driven more by symptom and label, rather than by cause and an appreciation of the uniqueness and totality of the individual.

In contrast, NACD has created an approach to human development, the achievement of human potential, and the remediation of developmental, educational, and neurological problems that is based upon the gestalt of the individual. NACD's Neurodevelopmental Approach utilizes a neurologically based, targeted, eclectic treatment methodology.

The efficacy of NACD's Neurodevelopmental Approach has been demonstrated with clients with functions ranging from comatose to gifted and from infant to geriatric. NACD has worked with children with labels including, but not limited to, ADD, ADHD, LD, Dyslexia, Developmentally Delayed, Brain Injured, Cerebral Palsy, Down Syndrome, PDD, and Autism.

NACD has centers located around the country and internationally, where families bring their child once every four months. At that time our staff evaluates the child, and an individualized program is designed to meet the child's developmental and educational needs. The parents are then trained in the implementation of the program. NACD's program is carried out within the child's home or school, under the guidance and support of the NACD team of professionals.

If we can help you schedule an appointment with NACD, please feel free to contact us.

Sincerely,

NACD Staff
info@nacd.org

International Headquarters 5492 S 500 E - Washington Terrace, UT 84405 ph: 801.621.8606 email: info@nacd.org www.nacd.org

HOW TO SCHEDULE AN APPOINTMENT

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

- Complete the contents of the application package in its entirety.
- Obtain letters of endorsement from current or past NACD families, if possible.
- Return the completed application package along with your deposit for the Initial Evaluation to the National Office (email or US mail accepted).
- 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.
  *__NOTE:__ ***If you have any religious or cultural reasons that limit or restrict your access to or ability to use the internet, NACD can make provisions so that internet access is not required.***

Our office will contact you 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

5492 South 500 East • Washington Terrace, UT 84405
801-621-8606
info@nacd.org

CURRENT CHAPTER LOCATIONS

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

Arkansas
Little Rock

California
Greater Los Angeles area

California
Greater Bay area

Colorado
Denver

Florida
Orlando

Georgia
Atlanta

Illinois
Chicago

Missouri
St. Louis

New York/New Jersey
Parsipanny

Ohio
Cincinnati

Pennsylvania
Greater Philadelphia area

Texas
Greater Dallas area

Texas
Greater Houston area

Utah
Ogden/SLC/Provo & St. George

Virginia
Charlottesville

Washington
Seattle

INTERNATIONAL CHAPTER LOCATIONS

London, England
New Delhi, India
Sydney, Australia
Bucharest, Romania

NACD FAMILY MEMBERSHIP SCHEDULE - USA/INTERNATIONAL
JANUARY 2018

Family Membership Program

01/26/18: NACD has received a donation earmarked specifically to aid new families who wish to join NACD. If you need the assistance the initial fee is reduced from $950 to $450. This will only be available for a limited time and must be requested.

Initial Evaluation: $950†
Deposit: $450*

NACD is a membership organization. Following the initial evaluation monthly membership dues of $260 will be processed on the first of every month.**

Monthly Family Membership includes:

- Interview with the family and review of client's history
- Evaluation of the primary family member
- Design of an individualized **TDI Targeted Developmental Program™**
- Training videos and materials in the implementation of the program for parents and caregivers
- Access to the Family Portal, which contains a record of all evaluations, programs, program instructions, video library of the client and other critical information
- Ongoing coach support and access to your TDI specialist who can answer questions, review videos, and make ongoing program enhancements as needed, through email, phone and Skype
- Live or Skype re-evaluations and program enhancements every 4 months
- Availability to have assessments and TDI programs designed for additional family members at a greatly reduced fee

Additional Family Members

Initial Evaluation: $250
Deposit: $150*

NACD encourages families to work together so that everyone is working toward achieving their potentials, parents and sibling alike. Additional family members may receive an evaluation and TDI Program for an initial fee of $250, then for an additional monthly membership fee of **$50 receive ongoing four-month evaluations**. We also provide the opportunity for any additional family member to come when and as needed for a fee of $250 per evaluation. Deposit of $150 is required to hold the evaluation slot.

Returning Families: $650
Deposit: $350*

This fee reactivates the family membership and funds their new evaluation. The monthly membership becomes reactivated. This is only available for families who are returning after 12 months or more.

Additional Services: $250

Additional services will be charged at the rate of $250 per hour for phone or Skype meetings with schools or therapists, as well as for letters or reports. Membership does not cover specific materials that may be recommended on program activities.

Rescheduling Fee: $75

A fee of $75 will be charged for any evaluation this is rescheduled two weeks or less before the appointment.

† Partial scholarships may be available. Please contact the Main Office for an application.

*Deposits are due when the appointment is scheduled. 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 four weeks prior to the scheduled appointment day.

**The monthly membership is charged to the member's credit card or checking account on the first day of each month. Monthly membership continues until the family chooses to stop NACD services and notifies NACD in writing or email of their desire to terminate services. Monthly membership fees are not refundable.

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

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 children with delays, they can make a resounding difference. How does this work? It works best when NACD parents join forces with other NACD parents within a geographic area to effect change.

NACD is able to serve the most children at our international headquarters in Utah. 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.

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 parents considering NACD and interested professionals, such as teachers and therapists, learn more about us.

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

Parents look for opportunities to educate others within their community about the potential of children who have been labeled with delays. They spread the word to other families who are seeking help with their children. 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 individual children and in communities. In order for evaluators to help the most children, we continue to build our base office in Utah. Our ability to work with children 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 with their children. We also salute parents whose children are seen at the base offices who also work to be voices in their communities to educate others.

5492 South 500 East
Washington Terrace, UT 84405

CHILD
APPLICATION PACKAGE
EFFECTIVE MARCH 2014

____

CHILD'S NAME

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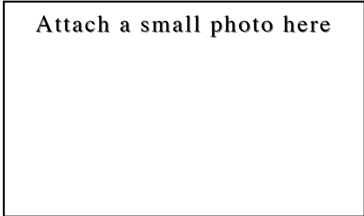

Attach a small photo here

APPLICATION – CHILD

Today's Date ________________ Form is completed by: ☐ Parent ☐ Guardian ☐ Other ________

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

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

City ________________ ________________

State ________ Zip Code ________ Primary E-mail ________________

Country ________________ Skype Name ________________

Mailing Address (if different from above) ________________

Client lives with ☐Both Parents ☐Mother Only ☐Father Only ☐Guardian ☐Other ________

Was the client adopted? ☐yes ☐no If yes, at what age? ________ Gender ____ Male ____ Female

Father's Name ________________ Date of Birth (mth/day/year) ________

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

City ________________ Home ________________

State ________ Zip Code ________ Work ________________

Country ________________ Fax ________________

Education completed ________________ Cell ________________

Occupation ________________ Email ________________

Mother's Name ________________ Date of Birth (mth/day/year) ________

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

City ________________ Home ________________

State ________ Zip Code ________ Work ________________

Country ________________ Fax ________________

Education completed ________________ Cell ________________

Occupation ________________ Email ________________

Guardian/Other Name ________________ Date of Birth (mth/day/year) ________

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

City ________________ Home ________________

State ________ Zip Code ________ Work ________________

Country ________________ Fax ________________

Education completed ________________ Cell ________________

Occupation ________________ Email ________________

At what location would you like your appointment scheduled ________________

Office Use ________________

____

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Client Name ____

Siblings		On NACD Program?	Siblings		On NACD Program?
Name________________________	Age____	☐Yes ☐No	Name________________________	Age____	☐Yes ☐No
Name________________________	Age____	☐Yes ☐No	Name________________________	Age____	☐Yes ☐No
Name________________________	Age____	☐Yes ☐No	Name________________________	Age____	☐Yes ☐No
Name________________________	Age____	☐Yes ☐No	Name________________________	Age____	☐Yes ☐No

How did you become aware of NACD?

- ☐ NACD Family (Please specify) ______________________________
- ☐ 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.?

Mother ☐yes ☐no Father ☐yes ☐no Other ☐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 child 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

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Client Name ______________________________

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	☐	☐	☐	☐	☐
Fruit	☐	☐	☐	☐	☐
Meat	☐	☐	☐	☐	☐
Sugar	☐	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐	☐
Artificial Colorings	☐	☐	☐	☐	☐
Dairy Products	☐	☐	☐	☐	☐
White Flour	☐	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐

List dietary supplements and vitamins

____

____

____

____

____

____

____

____

____

Food allergies? ☐yes ☐no ☐never tested

______________________ ______________________

______________________ ______________________

______________________ ______________________

Food cravings? ☐yes ☐no

Picky eater? ☐yes ☐no

Overeats? ☐yes ☐no

Poor appetite? ☐yes ☐no

Allergies? ☐yes ☐no If yes, please describe______________________________

____

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Client Name ______________________________

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	________________	

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

PHYSICAL MOTOR SKILLS (please check problem areas)

☐low muscle tone

☐high muscle tone

☐coordination

☐crawling (on stomach)

☐creeping (on hands and knees)

☐walking

☐running

☐athetoid movement

☐ataxic

☐weak

☐balance

☐other______________________

____

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Client Name ______________________________

HAND PREFERENCE

	Right	Mixed	Left
writing	________	________	________
eating	________	________	________
throwing	________	________	________
brushing teeth	________	________	________
combing hair	________	________	________
other ________________________	________	________	________
____________________________	________	________	________

LANGUAGE AND READING SKILLS

articulation problems ☐yes ☐no ☐not sure

stuttering ☐yes ☐no ☐not sure

poor pencil grasp ☐yes ☐no ☐not sure

sloppy writing ☐yes ☐no ☐not sure

poor reading ability ☐yes ☐no ☐not sure

difficulty copying from a blackboard ☐yes ☐no ☐not sure

letter reversals ☐yes ☐no ☐not sure

mirror writing ☐yes ☐no ☐not sure

right, left confusion ☐yes ☐no ☐not sure

poor judge of time ☐yes ☐no ☐not sure

poorly organized ☐yes ☐no ☐not sure

MATH RELATED (check areas of concern)

computation ☐yes ☐no ☐not sure

concepts ☐yes ☐no ☐not sure

word problems ☐yes ☐no ☐not sure

poor logic ☐yes ☐no ☐not sure

COGNITIVE (check areas of concern)

visualization ☐yes ☐no ☐not sure

long-term memory ☐yes ☐no ☐not sure

conceptualization ☐yes ☐no ☐not sure

short-term memory ☐yes ☐no ☐not sure

forgetful ☐yes ☐no ☐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

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Client Name ____

Does the client enjoy watching television? ☐yes ☐no
Does the client enjoy being read to? ☐yes ☐no
Does the client enjoy reading books? ☐yes ☐no

Speech and language problems? ☐yes ☐no
Fine motor problems? ☐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 ☐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 child 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____

____
____

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Client Name ____

GOALS AND PLANS

What are your goals and expectations?____

____

____

____

____

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 ________________________

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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 parents with the specific expertise to assume primary responsibility for their children's maximum growth and development.

NACD dedicates its time to parents who are committed to helping their children. 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 child's progress.

- *We the undersigned understand the commitment NACD has made to assist parents in helping their children 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 our child work toward his/her fullest potential through the use of the NACD program designed for our child.*
- *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 the specific needs of our child, 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.*

> ***NOTE:** ***If you have any religious or cultural reasons that limit or restrict your access to or ability to use the internet, NACD can make provisions so that internet access is not required.***

NACD will create an individualized TDI Targeted Developmental Intervention® program for my child that will be made available to me 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 our child.*
- *We understand that the information provided to us is specific to the needs of our child and agree that it will only be used for our child's 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): ______________________________

Address: ______________________________

____

Signature: ______________________________

Date: ______________ Email Address: ______________________________

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3/2014

NACD INITIAL EVALUATION & PROGRAM FEE PAYMENT AUTHORIZATION

Client Name: ______________________________

We understand that the initial evaluation and monthly membership fees are non-refundable.

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 program 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 second party does not pay fees, 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/Postal Code:** ______________

PRIMARY ACCOUNT

❑ **EFT** ❑ **Personal** ❑ **Business** ❑ **Savings** ❑ **Checking**

Name on Account: ______________________ **Name of Institution:** ______________________

Account Number: ______________________ **Routing Number:** ______________________

❑ **Credit/Debit Card** ❑ **VISA** ❑ **Mastercard** ❑ **Discover** ❑ **AMEX**

Name as it Appears on Card: ______________________ **CVC#:** ____________

Credit/Debit Card Number: ______________________ **Exp. Date:** ____________

SECONDARY ACCOUNT

❑ **EFT/CHECKING** ❑ **Personal** ❑ **Business** ❑ **Savings** ❑ **Checking**

Name on Account: ______________________ **Name of Institution:** ______________________

Account Number: ______________________ **Routing Number:** ______________________

❑ **Credit/Debit Card** ❑ **VISA** ❑ **Mastercard** ❑ **Discover** ❑ **AMEX**

Name as it Appears on Card: ______________________ **CVC#:** ____________

Credit/Debit Card Number: ______________________ **Exp. Date:** ____________

SIGNATURE (REQUIRED)

______________________ Signature

______________________ Signature (Print)

______________________ Date

______________________ Email Address

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