Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic

Application Assessment

Child's Full Name:____
Date of Birth:________________Race:___________Gender: Male or Female
Social Security Number:__________________________

Mother's Name:______________________________Date of Birth:___________
Father's Name:______________________________Date of Birth:___________
Is the child adopted: Yes No If Yes: Age when child was adopted? ____________
Is the child involved in Foster Care System: Yes No
If Yes when did placement start? _________
Name and address of person with whom the child resides (include street, city and zip code):____
____
Home phone number:____________________________
Parents:) circle one) Married Unmarried Separated Divorced Widowed
Who has legal custody of child?________________________________

Please list all persons living in child's home and their date of birth:
____
____
____
____

Mother's occupation:__________________Mother's work phone:______________
Mother's employer:________________________ Annual Salary ______________
Highest school grade completed:___________

Father's occupation:____________________Father's work phone:_____________
Father's employer:________________________ Annual Salary _______________
Highest school grade completed:____________

Birth/Medical History
Were there problems during the pregnancy, labor, or delivery? If so, explain:_____
How many weeks or months was the pregnancy?________Baby's birth weight:_______
Birth was:(please ircle) Normal Cesarea Breech Twins or more
Did baby have problems after birth?________If yes, please explain:_________________
____
Please list any major illnesses or injuries your child has had to this date:______________
Is your child taking any medications regularly? If yes please list below:
____

(over)

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Developmental History
At what age did your child: Roll over_________ Sit Alone___________
Pull up to furniture_________Crawl____________Walk______________
Say single words__________Say 3 word sentences_______________
Become toilet trained____________________________

Referral Concerns
What are your primary concerns about your child?
____
____
What have you been told regarding these concerns? (by your child's doctor, etc..)
____
Has your child received a behavioral or medical diagnosis? If yes please note:
____
Who referred you to the Therapeutic Day Program Outpatient Therapy Clinic?____

Please check the areas that you have current concerns about your child:

- ☐ Picking up small objects
- ☐ Toilet training
- ☐ Walking
- ☐ Running
- ☐ Climbing (play equipment/stairs)
- ☐ Using a crayon/pencil
- ☐ Jumping
- ☐ Using scissors

- ☐ Following simple directions
- ☐ Combining words into phrases
- ☐ Understanding what you say
- ☐ Speech being understood by others

- ☐ Awareness of others
- ☐ Interest in imitating others
- ☐ Seeking out others to play
- ☐ Enjoying simple interactions game
- ☐ Using eye-contact appropriately
- ☐ Taking turns during play with others
- ☐ Responding to affection

- ☐ Attention span
- ☐ Not obeying
- ☐ Ability to remain in seat when needed
- ☐ Temper tantrums
- ☐ Being always on the go
- ☐ Talking back

- ☐ Sleep problems
- ☐ Hitting, biting, or kicking peers or siblings
- ☐ Hitting, biting, or kicking parent/legal guardian
- ☐ Physical growth
- ☐ Learning what has been taught
- ☐ Eating skills (i.e., chewing, swallowing)
- ☐ Remembering things
- ☐ Unusual food preferences
- ☐ Vision
- ☐ Lack of eating
- ☐ Hearing
- ☐ Other:

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Pre-school/School History
Does your child attend daycare, preschool, or school? If yes, list name and address of program and how long has child been enrolled:

____
____
____

Has the child received a developmental evaluation? (If yes, who performed the evaluation?

____

Does child receive any special therapies or services (i.e., speech therapy, early intervention, other)? If so explain:

____
____

Does you child have an IEP? Yes☐ No☐
(If your child has an IEP kindly provide the program a copy of the plan)

Do you think your child needs additional services? If so explain:

____
____
____

What would you like to see accomplished for your child through counseling?

____
____

Please complete the following to assist us in obtaining information needed to plan for your child's treatment

Child's current doctor and address________________________________

____

Pleas list any other doctors/evaluators who have treated your child and their addresses:

____
____
____

Has your child ever been an inpatient or outpatient at NC Baptist Hospital or Brenner Children's Hospital (If so explain):

____
____

(over)

Name of person completing this form:______________________________

I do hereby give my permission as this child's parent or guardian to have him/her treated/evaluated by the Therapeutic Day Program Outpatient Clinic. I understand that this facility is both a service and a training program, and give my consent to have fully supervised students participate in the evaluation.

Parent/Guardian
Signature:___________________________Date:______________________

Kindly fax or mail this form once complete:
Attention: TDP Program Assistant
Fax to (336) 765-0842
Address: 3325 Silas Creek Pkwy
Winston-Salem, NC 27103

Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
3325 Silas Creek Parkway
Winston-Salem, NC 27103

Financial Coverage
(*Please Complete*)

Client's Name ____________________________ Birth date: _________

Social Security Number: _____________________________

Is client covered by any **private insurance**? Yes ☐ No ☐

Policy #1:
Policyholders Name: ______________________________

Employer: _______________________________________

Name of Insurance Company: ______________________

Address and Telephone Number: ____________________

Policy Number: ________________ I.D. number: ________________
Group Number: ________________
Claims Address: ____

Policy #2:
Policyholders Name: ______________________________

Employer: _______________________________________

Name of Insurance Company: ______________________

Address and Telephone Number: ____________________

Policy Number: ________________ I.D. number: ________________
Group Number: ________________
Claims Address: ____

Is client covered by **Medicaid**? Yes ☐ No ☐ Is client covered by **NC HealthChoice**? Yes ☐ No ☐

Medicaid Number: ___________________________ NCHealthChoice number: ________________

Mail To:
Amos Cottage Therapeutic Day Program
Attention: TDP Program Assistant
3325 Silas Creek Parkway
Winston-Salem, NC 27103

<u>School Information Request</u>
(To be completed by school or daycare staff)

Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
<u>Application Assessment</u>
3325 Silas Creek Parkway
Winston-Salem, NC 27103
Telephone: (336) 713-7444
FAX: (336) 765-0842

Child's Name:____

Dear Teacher:

The parent/legal guardians of the above named child are interested in receiving counseling services for their child at the Therapeutic Day Outpatient Clinic at Amos Cottage. Your responses to the following questions are an essential component to the evaluation for admission, and will be greatly appreciated.

A. Basic Information:
1. Name and Address of School: _____________________Phone:_____________
2. Hours of attendance: _____________Teacher:______________________
3. Number of students on class: _______________Age Range/Grade:_________
4. Number of adults (teachers, aides, volunteers) available for supervision of these children:_______
5. Does this child have an active IEP in place: (If the child has an IEP the program may request a copy)
6. Do you have any behavioral concerns at the present time Please include concerns regarding social & emotional functioning.
   1)_____________________
   2) ______________________
   3) ______________________
   4) ______________________

Kindly fax or mail this form once completed
Attention: Amos Cottage Therapeutic Day Program Outpatient Therapy Clinic
Administrative Assistant
Fax to (336) 765-0842
Address: 3325 Silas Creek Pkwy
Winston-Salem, NC 27103

Comments:

Signature: ____________________________
Title:__________________________________
Date:__________________________________

Dear Parents/Legal Guardian:

Thank you for choosing Wake Forest Baptist Health for your child's treatment. In order to make your treatment as successful as possible, please review our expectations of you and what you can expect of us.

Expectations of the Parents/Legal Guardians:

1. You are expected to come to all scheduled appointments and arrive early or on time. If you are unable for any reason to make your child's appointment, you are expected to call at least 24 hours in advance of your scheduled appointment. Please call Robin Powell, Administrative Assistant at (336) 713-7444.
2. Non compliance, such as two or more no shows or late cancellations in a 12 month period, excessive cancellations, not following through with treatment recommendations, or failure to make timely payments, may result in termination of services, and you will be referred to a mental health provider in the community.
3. You are expected to work with your provider in adhering to the treatment plan.
4. Payment is due at the time of service. If your treatment is authorized by your insurance plan, we will bill your insurance company directly. Deductable payments and co-payments are your responsibility and are required at the time of service. **If your insurance plan does not cover this level of service you will be responsible to pay the full session fee at the time of the appointment**.

Expectations of your Provider:

1. During week days, we will attempt to return all routine calls by the next business day. Regular weekday clinic hours are from 8:00am to 5:00pm. For emergencies on weekends, or when the clinic is closed, please call (336) 713-7400 and you will be directed to a specialized Pediatrician on call to receive consultation or you may call **911** and request assistance or you make take your child to the nearest emergency department.
2. We will work with you to develop a thorough treatment plan.
3. HIPPA (Health Insurance and Privacy and Protection Act) regulations protect the privacy of all communications between a patient and their mental health provider. The exceptions to this law include: 1) Dangerousness to self. 2) Dangerousness to others. 3) Suspicion of neglect, sexual or physical abuse of a child. Neglect and abuse are reported directly to the Department of Social Services which conducts its own investigation. It may also result in hospitalization. The clinician may during the course of treatment suggest a higher level of treatment if your child is at risk of harming themselves or others.
4. Request for your records will be reviewed by the provider. It is their professional judgment whether the information will be released as requested.
5. If for any reason it is determined that your child's counseling services should be discontinued, we will provide 30 days of care so that you can locate a new mental health provider. Upon written notification of termination of services, you will receive a release for medical records to sign and return. Records may be transferred to any new provider you may indicate after proper consent from you is received.

My signature below indicates that I have read and fully understand the above patient's services and agree to the specifications described therein:

______________________________	______	______________	______
Signature (or signature of Parent/Legal Guardian)	Date	Provider	Date