By Design Social Skills LLC
socialskillsnj@gmail.com
973-294-0519

Application Instructions

Please complete and return the following forms along with the applicable intake fee (See Fee Schedule):

- Client Information Form
- Stress Response Evaluation
- Scheduling Preference Form
- Parental Consent/Billing Agreement
- Privacy Policy & Authorization to Disclose Information
- Skill Evaluation Form ("Helpful Forms" section of website)

Forms can be emailed or mailed. If mailing, please send forms to:

By Design Social Skills LLC
3100 Route 138
Building 3, Suite 1
Wall Township, NJ 07719

Intake fees can be charged by major credit card via our website, www.socialskillsnj.com. Click on the "Make a Payment" link and follow the instructions. Checks should be made out to "By Design Social Skills LLC" and mailed to the above address.

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Client Information Form

Today's Date _______
Child's Name _____ *Age* _____ *Date of Birth* _____

Names of Immediate Family Members
_____

Address _____
_____
_____

Home Phone _____ *Cell Phone* _____
Email Address _____
Emergency Contact Name and Phone Number _____

School Name and District/City _____
Grade or Equivalent _____

Diagnosis (if any) _____

What kind of class does your child attend? (Please circle all that apply)
1 – Regular Education/Fully Mainstreamed
2 – Regular Education with Supports (Aide, 504 Plan, Other _____)
3 – Resource Room (If so, what subjects _____)
4 – Self-Contained Class
5 – Special Education School
6 – Homeschool

Is your child receiving any additional services? (Please circle all that apply)
1 – Discrete Trial or ABA Home Program
2 – School/Private Speech Therapy
3 – School/Private Occupational Therapy
4 – Other _____

Does your child exhibit any aggressive behaviors? (Self-injurious, hitting, biting or verbal threats) _____

Does your child have any serious allergies that we should be aware of?
_____

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1) Please provide a short narrative describing your child.

_____

_____

_____

_____

2) What are your child's strengths?

_____

_____

_____

3) What are your immediate goals for your child? What do you hope to achieve by utilizing this social skills program?

_____

_____

_____

4) What recommendations, if any, have you received from clinicians, teachers or other professionals regarding your child's need for social skills remediation?
Note: Please include a copy of IEP, School Evaluation, Reports, etc. if applicable

_____

_____

_____

5) Please share any other information that you feel will be helpful to us in working with your child/family.

_____

_____

_____

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Stress Response Evaluation

How does your child usually indicate he/she is becoming anxious or stressed? Check all that apply and add details as needed.

____ Asks inappropriate questions/makes inappropriate comments

____ Leaves seat/room

____ Becomes off task

____ Meltdown

____ Becomes silly

____ Noises/humming increase

____ Blurts/Yells out

____ Reduces eye contact

____ Cries/tearful

____ Refuses requests

____ Damages property

____ Repeats self

____ Distractibility increases

____ Shuts down

____ Facial expression/posture changes

____ Stares off

____ Fidgeting/restlessness increase

____ Voice tone/volume changes

____ Hurts self/others

____ Other

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Scheduling Preference Form

We will use your scheduling preference to schedule your child's present therapy as well as potential social skills groups. Please use the following system to fill in the schedule below.

- Write a "0" if your child can NOT attend during that time
- Write a "1" in each square for your preferred times
- Write a "2" for other possible times, but not your preference

EXAMPLE

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
If available before 3:00, write time available	**After 10:30**	**After 2:00**	**Not Available**	**Anytime**	**After 1:00**	**Anytime**
3:00	**0**	**1**	**0**	**1**	**1**	**2**
3:30	**0**	**1**	**0**	**1**	**1**	**2**
4:00	**1**	**1**	**1**	**1**	**1**	**2**
4:30	**1**	**1**	**1**	**1**	**1**	**2**
5:00	**1**	**1**	**1**	**0**	**2**	**0**
5:30	**0**	**2**	**0**	**0**	**2**	**0**
6:00	**0**	**2**	**0**	**0**	**2**	**0**

YOUR PREFERENCES

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
If available before 3:00, write time available						
3:00						
3:30						
4:00						
4:30						
5:00						
5:30						
6:00						

Are you available on Sundays? If so, what time do you prefer? _____

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Parental Consent

Thank you for choosing *By Design Social Skills LLC* for your child's therapy.

I, _____, hereby give permission for *By Design Social Skills LLC* to provide therapy services to _____.
Child's Name

_____ _____ _____
Signature (Parent/Legal Guardian) Relationship Date

Billing Agreement

This agreement will serve as notification that payment for all therapy services is due and payable at the time of service. You will receive a receipt of payment for each visit for your records. A comprehensive statement is available to you for all paid sessions at any time. It is your responsibility to pursue insurance reimbursement to determine if these services are covered. *By Design Social Skills LLC* does not accept or bill your insurance carrier. Any payment arrangement made between parents and/or legal guardians of the child is a private matter. This office will bill only one parent/guardian. Payment can be made via cash, check or major credit card through the "Make a Payment" section of our website, www. socialskillsnj.com. A $15 service charge will be added to all outstanding balances of 30 days or more. There will be a $30 charge for any check returned to us due to insufficient funds.

In the event that you need to cancel or reschedule an appointment, 48 hours' notice is appreciated. If a session is canceled with less than 48 hours' notice a $35 missed appointment fee will be charged.

If all terms in this Billing Agreement are agreeable and acceptable, please sign below. By signing you are hereby consenting to treatment and acceptance of policies outlined above.

_____ _____
Child's Name Signature (Parent/Legal Guardian)

_____ _____
Relationship Date

Please check here if you would also like your bill emailed to you: _____

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Privacy Policy

At By Design Social Skills we are vigilant about protecting client confidentiality. No information regarding our clients is shared with or distributed to any other person or organization without a signed authorization form from the client's parent or guardian. Any questions, comments or complaints can be directed to Beth Nardone-Troast at 973-294-0519.

I _____ have read the above privacy policy.
Parent/Guardian Signature

Date: _____

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Authorization to Disclose Information

I understand that the information about my child that is retained by By Design Social Skills LLC may not be disclosed to another person or organization without my express written authority. I hereby give authority to By Design Social Skills LLC to disclose any and all information regarding:

Child's Name (Print): _____

Date of Birth: _____

To the following individuals:

_____ _____
Name Telephone Number

_____
Name of Organization

_____
Address (Street, City, State, Zip)

_____ _____
Name Telephone Number

_____
Name of Organization

_____
Address (Street, City, State, Zip)

_____ _____
Parent/Guardian Signature Date

_____
Name of Parent/Guardian (Print)

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