Survey for Directory of Physical Health Services Providers

Adoption Community of New England, Inc.

45 Lyman Street #2, Westborough, MA 01581
508.366.6812 • FAX: 508.366.6813 • info@AdoptionCommunityofNE.org • www.AdoptionCommunityofNE.org

Contact Information

First Name ________________	Last Name ________________
Agency/Clinic affiliation if applicable ________________	Second Agency/Clinic affiliation ________________
Street ________________	Street ________________
City, State, Zip Code ________________	City, State, Zip Code ________________
Is this site handicapped accessible? Yes ___ No ___	Is this site handicapped accessible? Yes ___ No ___
Primary Phone Number (_____) ________________	Primary Phone Number (_____) ________________
Secondary Number (_____) ________________	Secondary Number (_____) ________________
FAX Number (_____) ________________	FAX Number (_____) ________________
Hotline/Emergency (_____) ________________	Hotline/Emergency (_____) ________________
TDD (_____) ________________	TDD (_____) ________________
Email address ________________	Email address ________________

Services Provided

___ Physical Health Services ___ Evening Hours ___ Home Visits

___ Saturday Hours ___ School Visits Other ________________

Geographical Area Served: ________________

Languages used in addition to English: ________________

Professional Designation

___ MD/DO ___DDS/DMD ___ Psychiatrist ___ Physical Therapist ___ Occupational Therapist

___ Speech/Language Therapist ___ Massage Therapist Other, specifically ________________

License Number(s): ________________

Degree, school and year: ________________

Internship(s)/Residency/Fellowship(s): ________________

Primary Specialty: ________________ Secondary Specialty: ________________

Professional affiliations: ________________

Feel Free to submit additional information.

2006

Professional Experience

I have worked with (Check all that apply):

___ Children who have been adopted	___ ADD/ADHD	___ Language disabilities
___ Adopted internationally	___ Addiction problems	___ Learning disabilities
___ Reading pre-placement profiles	___ Anxiety	___ Post-institutionalization
___ Adopted U.S. infant	___ Autism	___ Post-traumatic stress
___ Adopted U.S. older/waiting	___ Depression	___ Ritualistic abuse
___ Children in foster care	___ Developmental delays	___ Sensory integration
___ Children post foster care	___ Eating disorders	___ Sexual abuse
___ Kinship/Guardianship families	___ FAE/FAS	___ Substance abuse
	___ HIV/AIDS	___ Tactile defensiveness
	___ Other ______________________________	

Do you provide potential patients/families with references? _______________

Optional Personal Information

Are you an adoptee?	YES	NO	No Response
Do you have adoptive siblings?	YES	NO	No Response
Are you an adoptive parent?	YES	NO	No Response
Are you a birthparent of an adoptee?	YES	NO	No Response

Ethnic background _________________________

Fees/Insurance Information

Do you give free initial interviews?	YES	NO
Fees for Services?	YES	NO
Are clients ever accepted without charge?	YES	NO
Are clients accepted on a sliding scale fee basis?	YES	NO
Do you accept Mass Health?	YES	NO

HMOs and/or Private/public Insurance accepted: ____________________________________

I certify that the above information is true and correct. I hereby authorize ACONE to release any or all of the above information to third parties seeking referrals to or information about physical health service providers and to publish any or all of such information in The Physical Health Services Directory.
In consideration for ACONE listing me in The Physical Health Services Directory, I hereby agree to indemnify and hold harmless ACONE from all liability arising as a result of my inclusion in The Directory or referral of any patients or person(s) to me.
I understand that ACONE is not endorsing or evaluating professionals or methods of treatment. ACONE is not responsible for any misrepresentation or misuse of this information or for any typographical errors in its reproduction.

_______________________________________ ____________________
Signature Date

Mail to: **Adoption Community of New England, Inc.**
45 Lyman Street #2
Westborough, MA 01581

Fax: **508.366.6813**

Feel Free to submit additional information.