Building Bridges
THERAPY CENTER

Welcome,

Thank you for choosing *Building Bridges Therapy Center*. Established in l988, Building Bridges has a team of experienced professionals who specialize in working with children. All of our therapists are certified or licensed and highly qualified in their respective fields. We are glad you have selected us, and we are committed to providing you and your family the best possible care.

As a parent, you know more about your child than anyone else. We recognize that your child's care and development involves the whole family, and we will work with you to establish the best individualized treatment program for your child. If you have any questions or concerns regarding your therapy, please make your therapist aware—they look forward to working closely with you. Additionally, please always feel free to contact me to discuss your child's treatment or your services (you can reach me at our main office number, 734-454-0866).

Again, we welcome you to our clinic.

Sincerely,
Janice Pagano, M.A., CCC-SLP
Clinical Director

Building Bridges
THERAPY CENTER

REGISTRATION

To get started, ALL of the below information must be completed and received in our office in order to receive a call to schedule your child's therapy session(s).

- **Complete our welcome packet**
- **Make a copy of your insurance card (front and back)**
- **Make a copy of your driver's license (front and back)**

- **When you have all of the above information**, please scan/email, fax, mail or drop off to:
  - Building Bridges Therapy Center
    46200 Port Street
    Plymouth, MI 48170
  - Fax# 734-454-1744
  - office@bridgestherapy.com

- Our Psychologist will contact you after receiving all of the information to schedule your child's therapy session(s).

- Please contact your insurance to verify benefits. An insurance verification form is included in the welcome packet. For more information regarding insurance, please see our website at www.bridgestherapy.com.

Building Bridges
THERAPY CENTER

CLIENT INFORMATION

Today's Date _____/_____/_____

CHILD'S INFORMATION

Child Name: _____ Sex:_____

Date of Birth ____/____/____

Address _____ City _____ State____ Zip _____

Referred By (Doctor): _____

PARENT/GUARDIAN'S INFORMATION

Parent/Guardian Name: _____ Sex:_____

Address (if different from above) _____

Phone #'s (indicate primary) Home_____ Cell(mom)_____Cell(dad)_____

Work(mom)_____Work(dad)_____

Email: _____ **Soc Sec #** _____

We require a parent's social security number. This is for delinquent account purposes only. If you do not wish to provide a parent's social security number we require payment at the time of each service. Please check in with the office to submit payment before each of your child's scheduled therapy appointment(s).

INSURED'S INFORMATION

Insured's Name: _____ Sex:_____

Address (if different from above) _____

Employer Name and Address _____

Phone #'s (indicate primary) Home_____ Cell_____ Work_____

Insurance Company _____ Policy #: _____ Group#_____

Email:_____ **Soc Sec #** _____

We require the primary insured parent's social security number. Since payment cannot be made the same day of service for insurance clients, the insured's social security number is a requirement with no exceptions.

Whom can we thank for referring you to Building Bridges?

◯ Dr: _____

◯ Friend: _____

No referral; we found Building Bridges through ...

◯ Social Media

◯ Internet Search

◯ Other: _____

Building Bridges
THERAPY CENTER

PAYMENT POLICY

Thank you for choosing Building Bridges Therapy Center…we welcome you to our clinic. Our goal, first and foremost, is to provide you with the highest quality care. Following is our payment policy, which enables us to best focus our resources on providing services. Please review carefully, and return a signed copy prior to your child's first therapy session.

1. Each client is solely and individually responsible for all fees for services provided. It is up to the client to determine if therapy is a covered benefit under his or her particular plan. Clients' contracts with their insurance company are agreements between the clients and insurance company, and we are not a party to it. We urge clients to check the particulars of their policy prior to beginning treatment.
2. In the event that an outside organization or agency fails to provide the planned payment for your services for any reason, the client is solely and individually responsible for all fees for services provided.
3. Each client must establish a weekly or monthly payment schedule. Bills are sent at the end of each month. Note that certain programs may have an established payment schedule; if this is the case, clients will be informed of the applicable payment schedule.
4. All initial evaluations are to be paid on the date of service.
5. Payment can be made by cash, check or credit card. Payments can be made directly at the front office or left in the locked payment drop box through the window to the front office.
6. Please note that there is an Attendance policy (enclosed). Under this policy, if a client is a no show / late cancellation, the client may be charged 50% of the scheduled therapy fee to compensate the therapist for preparation and wait time. In situations of an emergency or illness, the above fee will not apply. If a client is late for a therapy session, the client is responsible for the fee for the entire scheduled session.
7. Prior to the last scheduled day of services, accounts must be paid in full or an alternate payment plan must be established.
8. In situations of divorce, separation, or other situations of shared custody, the adult who signs this policy shall be responsible in full for payment.
9. I agree, in order for Building Bridges Therapy Center to service my account or to collect any amounts that are due, Building Bridges Therapy Center and debt collection service providers may contact me by telephone at any telephone number or email address associated with my account.
10. In the event that: (a) no payment is made by a client receiving ongoing services for over sixty (60) days, or (b) that an account is not paid in full by the last day of services, Building Bridges Therapy Center reserves the right to assess a 2.0% late penalty per month from the last date of zero balance until the account is paid in full. This charge is to offset the cost and efforts required for collection of extremely delinquent accounts and to encourage timely payment of accounts.
11. The terms of this payment policy apply for all services currently being provided to as well as any future services provided by our clinic.
12. Building Bridges Therapy Center reserves the right to modify or replace this policy at any point in the future. Clients will be notified of any such changes.

We recognize that therapy services, while often essential to your child's development, are costly. If the financial considerations are prohibitive, please speak with Lauren Macuga to see if you are eligible for alternative arrangements. It is our desire to provide services to all who would benefit from them.

I have read this policy and consent to its terms and provisions. I agree to pay for services on a weekly/monthly schedule, or according to any established payment plan that may be applicable. I understand that I am directly responsible for payment for services, and that it is my responsibility to submit any claims to my insurance company for reimbursement.

Child Name _____ **Parent Name** _____

Parent Signature _____ **Date** _____

Building Bridges
THERAPY CENTER

Non-Covered Services Consent

It is recognized that patients might request non-covered and/or non-authorized services that are, therefore, payable by the patient's family. By signing below, I acknowledge that I am aware of such non-covered and/or non-authorized services and that my insurance company will not be responsible for the cost of such services.

Child Name _____ **Parent Name** _____

Parent /Guardian Signature_____ **Date** _____

Building Bridges THERAPY CENTER

INSURANCE VERIFICATION

We urge you to call and verify your benefits before your child begins therapy. It is extremely important to understand your deductible amount, out of pocket maximum cost, co-payment/co-insurance and visit limitations. Building Bridges only receives limited information regarding your insurance plan.

- What is your primary health insurance company? _____
- Please indicate if you have a secondary insurance company_____
- Effective date: Primary_____Secondary_____
- Co-pay: Primary_____Secondary_____
- Co-Insurance: Primary_____Secondary_____
- Deductible: Primary_____Secondary_____
- Out of Pocket Max: Primary_____Secondary_____

- Visit Limitations per year:
  - Primary Insurance: YES OR NO
    - If yes, # of visits:_____
  - Secondary Insurance: YES OR NO
    - If yes, # of visits:_____
- Is an authorization required for Evaluation? YES OR NO
- Is an authorization required for Therapy? YES OR NO

Insured's Signature_____ Date:_____

Print Name_____

INSURANCE CHANGES

Please inform us immediately if any part of your insurance changes or if you have a new health insurance. Verification of your benefits will need to be completed before continuing therapy.
Often insurance companies require pre-approval or authorization. They may not retro-date authorizations, which may result in a period in which you are personally responsible for payment for services.

_____initial

Building Bridges
THERAPY CENTER

ATTENDANCE POLICY

Our office should be notified 24 hours in advance when a child cannot keep a scheduled therapy appointment other than for illness or emergencies. Failure to notify the office may result in a charge of 50% of the therapy fee. This fee goes directly to the therapist to compensate him or her for time spent planning for your child's session. If your child is late for a therapy session, you are responsible for the fee for the entire scheduled session. If you have an outside source of funding such as an insurance company or a community agency, the cancellation fees and/or fees for the portion of the session missed due to lateness will be charged directly to you and not the outside agency.

Most importantly, consistency of treatment is essential to your child's progress. If we sense that a child does not have consistent attendance in his or her treatment program, we will offer that time slot to someone on our waiting list. Any potential dismissals will be discussed with the parent prior to reaching a decision to terminate therapy.

Our staff is dedicated to work diligently to help your child reach his/her fullest potential. We ask your cooperation in helping us achieve that objective. If you have any questions, please do not hesitate to speak with me directly. We appreciate your cooperation in this matter.

X_____ I have read this letter and agree to the terms stated above.

Building Bridges

HEALTH POLICY

Staff, parents, clients and siblings are advised not to come to the clinic or sit in the waiting room when the following conditions are present:

- Oral temperature of 100.5 or higher
- Intestinal problems with diarrhea or vomiting
- Any type of undiagnosed rash
- Any type of communicable illness (chicken pox, measles, impetigo, pink eye, strep throat, etc.)
- Congestion or mucous discharge of the eyes, nose or ears
- Body aches, headache, and feeling very tired
- Persistent cough, sore throat

Anyone presenting with these symptoms will be asked to leave the clinic or waiting room.

A sick individual should not return to the clinic until he or she:

- Has been free of a fever (100.5 or greater) for at least 24 hours without the use of fever reducing medications.
- Has been free of vomiting, diarrhea, rash, eye, ear and nasal drainage for at least 24 hours
- Has received antibiotics for strep throat or medicated eye drops for the treatment of pink eye for a minimum of 24 hours
- An individual with chicken pox may not return to the clinic until 1 week after the eruption of first crop of lesions and after all lesions have crusted

We encourage staff and families to:

- Wash hands often with soap and water or an alcohol-based hand rub
- Cover coughs and sneezes with tissues or use elbow, arm, or sleeve instead of a hand when tissue is not available
- Know the signs and symptoms of the flu
- Report cases of flu or other communicable illness to Building Bridges staff within 24 hours of the last clinic visit
- Be cautious and keep potentially sick individuals at home

X _____

I have read this letter and agree to the terms stated above.

Thank you for your cooperation.

Building Bridges
THERAPY CENTER

Waiting Room Guidelines

Building Bridges Parents/Caregivers:

We hope you enjoy our waiting room. We try very hard to provide a space that adults and children can enjoy. We ask that parents/caregivers please:

- Help children keep play volume low. Loud play disrupts therapy and other clients in the waiting room. It also leads to escalating volume of other children's play.
- Direct children to calm, controlled play activities. Reading book with your children is a great activity for the waiting room—we will rotate the books on our bookshelf.
- Instruct children that climbing, running, and standing on furniture is not acceptable play.
- Please do not allow your child to play in the water fountain.
- Our children have a lot of allergies, please no eating in the waiting room.
- Be aware that we have a changing station in our bathroom. This is the only place in our office where diapers should be changed. If you do change a diaper, please notify a staff member and we will take the garbage out.

We understand that children like to play—that is what they do best. If the play volume has gotten too loud or the activities too rough, our staff may respectfully direct children and/or ask for your assistance. Please understand that this is being done to ensure a safe and pleasant environment for everyone, and do what you can to help.

Thank you for your cooperation. Following these standards will ensure that the waiting room is a clean, safe space that can be enjoyed by children and adults.

Building Bridges
THERAPY CENTER

OPTIONAL

MONTHLY RECURRING Credit Card Authorization Form

THIS CREDIT CARD IS A: ❑ VISA ❑ MASTERCARD

CREDIT CARD NUMBER: Full card number: _____

EXPIRATION DATE: _____

CARD SECURITY CODE (CV2): _____

NAME (as it appears on the credit card): _____

BILLING ADDRESS (must be the exact billing address as it appears on the Credit Card Statement):

_____
Address

_____ _____ _____
City State Zip

I authorize Building Bridges Therapy Center (BBTC) to charge my credit card **monthly** for payment of services for the child listed. If BBTC is unable to process my payment I will be responsible for an alternate payment arrangement and any resulting processing fees that may be incurred. This authorization is in effect until I notify them otherwise in writing. I understand that all expenses will be charged on my behalf and these may include additional charges from any previous months.

By signing this authorization, I acknowledge that I have read and agree to all of the above information and warrant all information provided is true and correct.

THIS AGREEMENT REMAINS IN EFFECT UNTIL CANCELED BY THE APPLICANT WITH WRITTEN NOTICE. This agreement may be cancelled by the applicant by providing BBTC a written notice at least 30 days in advance of the cancellation date.

Applicant's Name (print): _____

Applicant's Signature: _____ Date: _____

Child's Name: _____ Account Number: _____

Building Bridges
THERAPY CENTER

MEDICAL INFORMATION

Client's Name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City_____ State____ Zip Code_____

Home Phone Number: _____ Parent Work Number:_____

Alternative Phone Number: _____ E-mail:_____

In case of an emergency, please contact:

Name: _____ Phone Number:_____

Alternative Phone Number: _____

Relationship: _____

Allergies: yes/no

If yes, please list allergies: _____

_____

Dietary considerations: yes/no

If yes, please list: _____

_____

Medications: yes/no

If yes, please list medications: _____

_____

Special Instructions: _____

Health Conditions: yes/no

If yes, please state condition and describe intervention that may be required by our staff during therapy, for example, epee pen or seizure medication: _____

_____

In an emergency, I authorize Building Bridges Therapy Center to obtain emergency medical treatment, if the parent is not immediately accessible.

_____ _____

Parent Name (print) Parent Signature Date

Building Bridges
THERAPY CENTER

RELEASE OF INFORMATION

I, _____, authorize the release of information
parent's name

regarding _____, from Building Bridges Therapy Center
child's name

to the following parties for the purposes of therapeutic and educational planning. Information may include evaluation reports, progress notes, and conversations with the parties listed below. I understand that copies of reports will be automatically sent as indicated below.

Name	Address & Phone #	Send copies of all reports (Y/N)

Signed_____

Dated_____

NON-GUARDIAN AUTHORIZATIONS AT BUILDING BRIDGES THERAPY CENTER

Name of Child: _____

I hereby inform Building Bridges Therapy Center that the people listed below are authorized to pick up the above-named child at any time, receive private health information (PHI) feedback, and/or receive health documents. Accordingly, Building Bridges Therapy Center is hereby instructed to release my child, share PHI, or distribute health documents as indicated to the following people.

			Is authorized to (check all that apply):		
Name	**Relationship to Child**	**Phone Number**	*pick up child*	*receive PHI feedback*	*receive health documents*

I understand that:

- Parents/guardians must inform BBTC (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not.
- The "Authorized Pick-Up Person" must be at least 18 years old and may be asked to provide a photo ID to the staff.
- This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by:

_____ _____

Parent/Guardian Signature *Date*

_____ _____

Parent/Guardian Signature *Date*

Building Bridges
THERAPY CENTER

NOTICE OF PRIVACY PRACTICES

(Effective April 1, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN BELOW TO INDICATE YOU HAVE BEEN INFORMED OF THIS POLICY.

Understanding your treatment record - A record is made each time your child is treated at our clinic. This information is most often referred to as a "treatment file" and serves as a basis for planning and monitoring your child's care at our Clinic. It also serves as a means of communication among any and all staff involved in the care of your child.

Understanding your health and treatment information rights - Your child's treatment record is the physical property of the Clinic, but the content is about your child and, therefore, belongs to you. You have the right to request restrictions on certain uses and disclosures of your information and to request amendments to this record. Your rights include being able to review or obtain a paper copy of the information and to be given an account of all disclosures. You may also request that communication of this information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your treatment information.

Our responsibilities – This clinic is required to maintain the privacy of your treatment information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about your child. This Clinic is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This Clinic reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient treatment information. In the event that changes are made, this Clinic will notify you at the current address provided on your medical file. Other than for reasons described in this notice, this Clinic agrees not to disclose your treatment information without your authorization.

Your child's treatment information will be used for treatment, payment, and healthcare operations –

- *Treatment* – Information obtained by your therapist in this Clinic will be recorded in your child's treatment file and used to determine the course of treatment. This consists of your therapist recording his/her own expectations and those of others involved in providing care. The sharing of this information may progress to others involved in your child's care, such as physicians.
- *Payment* – Your healthcare information will be used in order to receive payment for services rendered by this Clinic. A bill may be sent to either you or a third party payer with accompanying documentation that identifies your child, a diagnosis, and procedures performed. Information may also be shared with any organizations that may be helping with the payment process.
- *Healthcare Operations* – The medical staff in this Clinic will use your child's health information to assess the care he/she received and the outcome of treatment compared to others like it. This information may be reviewed for quality improvement purposes in our effort to continually improve the quality and effectiveness of the care and services we provide.
- *Understanding our Clinic policy for specific disclosures* – It is our policy to not disclose any of your child's information without your specific authorization to do so. We may be required by law to disclose health information to public health authorities. Also, your health information may be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena.

To receive additional information or report a problem – For further explanation of this notice you may speak with Stephanie or Brad Naberhaus. If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human Services.

NOTICE OF PRIVACY PRACTICES AVAILABILIITY: The terms described in this notice are posted in the waiting room. All clients will be given a hard copy and asked to acknowledge receipt.

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

NOTICE OF PRIVACY: I ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES.

_____ _____

Parent signature Date

Building Bridges
THERAPY CENTER

PERTINENT HISTORY QUESTIONNAIRE

Today's Date:_____

Name of Child:_____ Date of Birth:_____ Age:___

Address:_____
Street City State Zip Code

Home Phone #:_____

Ethnicity:_____ Language Spoken in Home:_____

Father's Name:_____ Daytime Phone #:_____
Occupation:_____

Mother's Name:_____ Daytime Phone #:_____
Occupation:_____

E-mail address:_____

Emergency Contact & Phone #:_____

Who referred you to Building Bridges Therapy Center?
_____

What is the relationship of the person completing this application to the child?
Biological Parent: Mother_____ Father_____
Adoptive Parent: Mother_____ Father_____
Step-Parent: Mother_____ Father_____
Foster Parent: Mother_____ Father_____
Other: _____

Marital Status: ____Married ___Separated ____Divorced ____Other

All persons living in the home:
Name Age Relation to patient Highest Grade Completed
_____
_____
_____
_____

PARENTAL CONCERNS

Please describe the major concerns you have in seeking help for your child.

_____
_____
_____
_____

How can this facility help you most with these concerns?

_____
_____
_____
_____

MEDICAL HISTORY

Child's Pediatrician or Family Doctor _____
Address _____
Street City State Zip Code

Please list any other doctors or clinics that have examined this child:

Name	Address	Purpose of Examination

Date of Last Medical Checkup:_____Height:_____Weight:_____

Has your child been diagnosed with any of the following, please check all that apply.
__ADD __ADHD __Anxiety Disorder or Mood Disorder(specify):_____
__Autistic Spectrum Disorder __Cognitive Delay __Down Syndrome __Dyslexia
__Emotional disorder(specify):_____ __Fragile X syndrome
__Learning Disabilities (specify if possible):_____
__Sensory Processing Disorder or Sensory Integration Dysfunction
__Tourette's Syndrome __Other (specify):_____

PREGNANCY

While pregnant did child's mother have any of the following:

	Yes	No		Yes	No
German Measles	_____	_____	Emotional Problems	_____	_____
Anemia(low iron)	_____	_____	Vaginal infection/bleeding	_____	_____
Diabetes	_____	_____	High blood pressure	_____	_____
High fever	_____	_____	Kidney problems	_____	_____
Smoke cigarettes	_____	_____	Drink alcohol	_____	_____

Were any medications taken during pregnancy? (include vitamins and iron)

_____
_____

Has child's mother ever had a miscarriage? Yes_____ No_____

BIRTH

Was the child born early? _____ Late?_____ or on time?_____
Was child born by C-section? Yes_____ No_____
If yes, please give reason for C-section_____
_____
Approximately how long was mother in labor?_____
What was baby's birth weight? _____ length?_____ Apgar Score?_____
What was baby's condition at birth?_____

ADOPTION

Describe the circumstances surrounding the adoption:

_____
_____

More Specifically:
Age when adopted:_____
Prior foster homes:_____
Physical appearance:_____
Response to new home:_____
Is child aware of his/her adoption?_____

HEALTH

Has child ever had the following:

	Yes	No		Yes	No
Eye or vision problems	_____	_____	Anemia	_____	_____
Ear or hearing problems	_____	_____	Vomiting spells	_____	_____
Allergies	_____	_____	Frequent diarrhea	_____	_____
Asthma	_____	_____	Meningitis	_____	_____
Convulsions or "spells"	_____	_____	Head Injury	_____	_____

Has child had any other health problems not listed above? (describe)

_____
_____
_____

Does child take medication on a regular basis? Yes_____ No_____
If yes, please list medication taken and amount:

_____
_____

Has the child ever been hospitalized? Yes_____ No_____

	Hospital	Year	Reason
1.			
2.			
3.			

DEVELOPMENT AND SCHOOL HISTORY

At what age did child first:

Sit Alone	_____	Feed self finger foods	_____
Crawl	_____	Speak first real words	_____
Stand Alone	_____	Speak first real sentences	_____
Walk	_____	Become toilet trained	_____

Is child currently enrolled in a school program? Yes _____ No _____
If yes, please answer the following:
Name of School: _____
Address: _____
Grade: _____
Type of Classroom: _____

Has child ever been evaluated by a school diagnostic team? Yes _____ No _____
If yes, when was evaluation completed and what were the results?

_____
_____
_____
_____

Please describe the child's performance at school? What subjects does he/she do well in? What subjects are more difficult?

_____
_____
_____
_____

Does child receive any special services at school? If yes, please describe:

_____
_____

What are the presenting problems of your child:
Academic: _____
Activities of daily life (eg. Eating, dressing): _____
Relationships: _____
Sensory: _____
Motor: _____
Play: _____
Other: _____

Please use back side of paper if you need more writing space.

SOCIAL – EMOTIONAL DEVELOPMENT

Does child exhibit behaviors at home or at school that concern you? If so, please describe:

_____
_____
_____

What methods are used to discipline child?

_____
_____
_____

Are these methods effective? Yes _____ No _____

What does your child like to do to occupy his/her time?

_____
_____
_____

Does child have regular playmates or friends? Yes _____ No _____

What are your child's strengths?_____
_____
_____

Is there anything else you would like for us to know about your child that was not covered above?

_____
_____
_____
_____

GOALS

What are your goals for your child's program? Please be as specific as possible.

1._____
2._____
3._____
4._____
5._____

Parent/Guardian Signature:_____
Date: _____

BBTC has permission to send a thank you letter to my referral source indicating that my child has been seen for an evaluation and/or sending report.

Parent or guardian signature:_____
Date:_____