SUMMER 2020 REGISTRATION FORM

CHILD'S NAME: ____
Last First

BIRTHDATE: ____________________ AGE: ______________ GRADE: ____________

PARENTS: ____

ADDRESS: ____

CITY: ______________________________ ZIP CODE: ______________

HOME TELEPHONE: ____________________ CELL: ______________________

EMAIL: ____

Visit www.bridgestherapy.com, to review program details and download the Summer Registration Packet. Click on **What's New at BBTC** and **Summer Registration Packets.**

Please submit all registration forms and payment by Monday, June 22, 2020.
We accept Visa, Mastercard, Cash and Checks.
Credit card payments may be made via phone.

This year, we are offering telegroups, due to the current social restrictions.
Please review the following telehealth requirements, to ensure your child is able to fully participate and benefit from their telegroup experience:

- √ Joint attention skills
- √ Ability to follow instructions
- √ Ability to attend to the screen
- √ Challenging behavior

Five Week Skill Workshops

Pay for five weeks, with the option of an additional sixth session at no cost.
We cannot refund missed sessions

- ☐ **Pencils, Pens & Practice:** ($250) age 5-10. Fridays 10-11 AM
- ☐ **Kid's Club: You GOT This!** ($225) age 8-11. Mondays 6-7pm
- ☐ **Social Skills Remix:** ($250)
  - ☐ Age 9-12 Tuesdays 6-7pm
  - ☐ Middle Schoolers Thursdays 10-11am
  - ☐ High Schoolers. Wednesdays 1:45-2:45pm

ADDITIONAL PROGRAMS

* These sessions are led by a licensed psychologist, and may be covered by insurance and require a personal intake session. (Private pay options are also available)
Please submit support group welcome packet.

Sibs are Special Too! Support Group: (ages 9-12 Years) Tuesdays 10:30-Noon

Teen Talk: Mondays 10:30am-12noon

Parent/Caregiver Support Group: Thursdays, either 10:30-Noon OR 4:45-6:15 PM.

Individual Speech, Occupational or Physical Therapy

Insurance billing rates may vary. Call for details regarding your specific plan.

Private pay therapy rates are listed below: (For insurance rates, contact the office)

Speech-Language Therapy	**Circle frequency:**	
___ 30-minute session	1x or 2x weekly	$64.00/session
___ 45-minute session	1x or 2x weekly	$96.00/session
___ 60-minute session	1x or 2x weekly	$128.00/session
Occupational Therapy		
___ 30-minute session	1x weekly	$64.00/session
___ 45-minute session	1x weekly	$96.00/session
___ 60-minute session	1x weekly	$128.00/session
Physical Therapy		
___ 30-minute session	1x weekly	$64.00/session
___ 45-minute session	1x weekly	$96.00/session
___ 60-minute session	1x weekly	$128.00/session
Music Therapy		
___ 30-minute session	1x weekly	$35.00/session
___ 45-minute session	1x weekly	$52.50/session
___ 60-minute session	1x weekly	$70.00/session

Counseling Services: For children and parents. Contact us to discuss best options.

Return registration forms and payment by June 22 to:

Building Bridges Therapy Center
46200 Port Street Plymouth, MI 48170
(734) 454-0866 or office@bridgestherapy.co

Client Information

Child's Name:____
Birthdate:____________________________age:__________
Parent's Names:______________________________________
Phone:____
Email:____
School:____
Grade:____

Please be as specific as you can when providing us with information.

Primary Diagnosis of your child:

List a few social skills that you would like your child to work on:

Are there any behavioral and/or emotional conditions which impact social interaction? Yes or NO If yes, please describe. What triggers these conditions and what behavior strategies work best for your child?

We want to make this a positive experience for your child, does he/she have special interests? What motivates him/her?

Parent Signature: ____________________________________

Building Bridges THERAPY CENTER

Consent for Therapeutic Services via Telehealth

This document is intended to provide you with important information regarding the practices, policies, and procedures of Building Bridges Therapy Center when providing therapy services via Telehealth.

Introduction
Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual Patient health information for the purpose of improving Patient care. Providers of therapeutic services may include Speech-Language Pathologists, Occupational Therapists, Physical Therapists, Music Therapist and/or Psychologists. The information may be used for therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Photographs
- Live two-way audio and video
- Telephonic communication
- Output data from health applications, sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of Patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Real-time Videoconferencing Telehealth
Real-time video conferencing consists of face-to-face provider and patient interactions that occur in real-time via two-way video and audio interactions.

Video Store-and-forward Telehealth
Video store-and-forward includes transmission of video and audio interaction to a provider at another site. As part of our service model, we may review videos of your child to evaluate progress and response to treatment. Videos will be stored in a secured manner consistent with our HIPPA policies.

Expected Benefits:

- Improved access to therapeutic services by enabling the client and family to remain in home

Possible Risks: As with any medical, behavioral or therapeutic health treatment, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate clinical decision making by the therapist
- Delays in treatment could occur due to deficiencies or failures of the equipment used for telehealth
- In rare instances, security protocols could fail, causing a breach of privacy of personal health information

Patient Consent to The Use of Telehealth
I have read and understand the information provided above regarding telehealth, have discussed it with my clinician, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my health care:

❑ Real-time videoconferencing telehealth

❑ Video store-and-forward telehealth

By signing this form, I understand the following:

1. I understand that an adult (e.g., parent/caregiver or other guardian) must be present during all telehealth sessions in case of an emergency.
2. I understand that the laws that protect privacy and the confidentiality of medical (including therapeutic health) information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to any third party without my consent, except when required under law.
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction.
5. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

I hereby authorize Building Bridges Therapy Center to use telehealth in the course of Speech Therapy, Occupational Therapy, Physical Therapy, Music Therapy, or Psychotherapy as deemed appropriate.

This policy has been fully explained to me, and I fully and freely give my consent and permission for my dependent.

____
Client Name

____
Parent or Guardian Name (please print)

____
Parent or Guardian Signature Date

____
Building Bridges Therapist Date

Click here to enter text.

CLIENT INFORMATION

Today's Date ______/______/______

CHILD'S INFORMATION

Child Name: ____ Sex: ____________

Date of Birth ____/____/____

Address ______________________________ City ________________ State____ Zip ______

Primary Care Provider: ____

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).

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** ______________

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